

## **ABSTRACT**

AMOLA, OLUWAKEMI. The Effects of Internalized Homophobia on HIV Risk Behaviors among Black Men Who Have Sex with Men. (Under the direction of Dr. Marc Grimmett).

Background: African Americans, compared to other racial groups in the United States, have the highest HIV prevalence, the highest incidence of HIV/AIDS, the highest HIV mortality, and the greatest number of years of potential life lost. Although all segments of Black communities have been significantly impacted by this epidemic, Black men who have sex with men have disproportionately experienced the negative consequences. Internalized homophobia is a contributing factor to HIV infection and transmission in Black men who have sex with men. It is imperative to assess internalized homophobia in Black men who have sex with men in order to analyze the effects of internalized homophobia on HIV risk behaviors in order to adequately inform counseling interventions.

Methods: A quantitative approach was utilized to study the effects of internalized homophobia on mental health and HIV risk behaviors in a sample of Black MSM. The variables of interest were explored with a Web-based survey design. A convenience sample of 202 Black men, who reported sex with a male in the prior 12 months, were recruited via the Internet. Participants ranged in age from eighteen to sixty-five.

Results: The results revealed a direct relationship between age and religiosity and internalized homophobia and no significant relationship between relationship status and internalized homophobia. Participants who were HIV positive or were unaware of their status scored significantly higher on internalized homophobia than those who were HIV negative. In addition, men who identified as heterosexual or straight scored significantly

higher on internalized homophobia than those who identified as homosexual or gay. Mental health measured by self-esteem and depression had a negative relationship with internalized homophobia; for example, mental health functioning decreased as internalized homophobia increased. Finally, as internalized homophobia increased, participants were significantly more likely to engage in HIV risk behaviors.

Conclusions: The current study added to the limited data on the prevention needs of Black MSM. Overall, the results suggest that prevention efforts are not as effective among Black men experiencing internalized homophobia, which may influence these men to engage in HIV risk behaviors. When counselors are working with this population, it is important to understand how homophobia influences internalized homophobia and its effect on HIV risk behaviors. Future research efforts should be implemented in a manner that will be culturally competent and will minimize the negative consequences of HIV in African American communities.

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The Effects of Internalized Homophobia on HIV Risk Behaviors among Black Men Who  
Have Sex with Men

by  
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## **DEDICATION**

This paper is dedicated to my husband, DeSean Hill, and my two sons, DeSean Jr. and DeWale. Thank you for all of your constant love and support. Additionally, I would like to thank my family, friends, and colleagues for their support and encouragement.

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## CHAPTER 1

### INTRODUCTION

Acquired Immunodeficiency Syndrome (AIDS) was first reported in the United States in 1981 and has since spread to every country in the world, infecting more than 40 million people worldwide as of 2006 (Peterson & Jones, 2009). AIDS is caused by Human Immunodeficiency Virus (HIV). By killing or damaging cells of the body's immune system, HIV progressively destroys the body's ability to fight infections and certain cancers. People diagnosed with AIDS may get life-threatening diseases known as opportunistic infections. Since 1981, more than 1.5 million cases of AIDS have been reported in the United States. One-quarter of those infected are unaware of their infection, and more than 500,000 people have already died from HIV (CDC, 2003).

As an ever-increasing number of people infected with HIV are living longer healthier lives, concerns about continued transmission are growing along with an awareness of the need to target HIV prevention efforts to persons living with the disease (CDC, 2003). Numerous studies have shown that after a diagnosis of HIV, men and women in all HIV exposure categories continue to be sexually active, with an estimated 20–41% having unprotected sex (Beckett, Burnam, Collins, Kanouse, & Beckman, 2003; Crepaz & Marks, 2003; Heckman & Kalichman, 2000). In addition to transmitting HIV to uninfected partners, unprotected sex can expose those who are HIV positive to potentially serious viral and bacterial infections that may adversely affect their health and limit future treatment options (Kalichman, Rompa, & Cage, 2000). The epidemic, which is growing most rapidly among minority populations, has been the leading killer of African American males ages 25 to 44

(CDC, 2003). Black people are currently facing what may be one of the greatest threats to their existence since slavery. Every day in America, almost 100 persons of color become infected with HIV. Twenty-five years after the virus was first documented in gay white men, HIV has increasingly become a disease of color, with African Americans disproportionately represented. African Americans make up just 13 percent of the U.S. population but account for 57 percent of new HIV cases. More than two-thirds of all women in the United States infected with the AIDS virus are African American, and nearly 70% of the children infected with HIV in this country are African American (CDC, 2003). Decades into the epidemic, scientists have made enormous strides in understanding the disease at the molecular level, but understanding why HIV is so prevalent among Black American communities and how to prevent its spread has proven to be a far more daunting challenge.

Although all segments of Black communities have been hit hard by this epidemic, Black men who have sex with men (MSM) have experienced the negative consequences of the epidemic disproportionately. The term MSM was created because the word ‘gay’ or ‘homosexual’ as a descriptor for all males involved in homosexual activity proved inappropriate, inaccurate, and alienating to a number of males, especially Black males (Adams & Kimmel, 1997). The label MSM encompasses a very diverse population of males at HIV risk (Adams & Kimmel, 1997). Black MSM have the highest rates of unrecognized HIV infection, the highest HIV prevalence and incidence rates, and the highest AIDS mortality rates among MSM in the United States (CDC, 2007). HIV and AIDS prevalence rates have disproportionately affected Black MSM since the early years of the epidemic. Black MSM are the only population in the U.S. with HIV prevalence and incidence rates

that resemble those in developing countries (CDC, 2007).

Homophobia in Black communities, or more specifically, internalized homophobia in Black men who have sex with men (MSM), may be a contributing factor to the disparity in HIV rates. Internalized homophobia has been defined by clinicians (Malyon, 1982) as the internalization of homophobic attitudes and has been identified as a substantial factor affecting the mental health of gay and lesbian individuals (Gonsiorek, 1988; Troiden, 1989). Empirical research has also linked internalized homophobia to low self-esteem and depression (Shidlo, 1994; Waldo, Kegeles, & Hays, 1998).

Discrimination against gay and lesbian people stands as one of the few remaining socially acceptable and institutionally sanctioned forms of prejudice (Boykin, 1997). Various manifestations of society's intolerance of homosexual populations have been empirically associated with both mental and physical health problems in these populations (Cole, Kemeny, Taylor, & Visscher, 1996; Hershberger & D'Augelli, 2002). Perhaps the most detrimental consequence of American culture's homophobic sentiments is the internalization of those values by gays and lesbians.

According to the Centers for Disease Control and Prevention, reducing incidence of HIV/AIDS among men of color who have sex with men is one of the major HIV prevention challenges in the United States (CDC, 2006; Laurencin, Christensen, & Taylor, 2008). African American men who have sex with men (MSM) show high risk for HIV infection (Blair, Fleming, & Karon, 2002). According to 2007 surveillance data from 34 states with confidential name-based HIV reporting, men accounted for approximately 63% of the HIV

infections among African Americans, and 51% of African American HIV-infected men acquired HIV through same-sex contact (CDC, 2009).

### **Statement of the problem**

Although men who have sex with men comprise less than 5% of the U.S. male population, in 2007, 57% of all new HIV diagnoses in the United States occurred in MSM (CDC, 2007). Among MSM, HIV disproportionately affects African American men. A CDC-funded study of MSM conducted in five U.S. cities (Baltimore, Los Angeles, Miami, New York City, and San Francisco) between June 2004 and April 2005 found that 46 percent of African American MSM tested were HIV positive, and 67 percent of these men were unaware of their status. The reasons for this disparity in HIV rates are unclear. The federal Centers for Disease Control has linked homophobia and internalized homophobia to an increased risk of infection by HIV, according to a recent CDC report on AIDS among African American men. Homophobia is classified as a risk factor for AIDS along with poverty, high unemployment, and poor access to health care services. The CDC also stated that men who have sex with men (MSM) remain at high risk for HIV infection and called for continued efforts to promote behavioral risk reduction among at-risk youth (CDC, 2007). Ethnic minority community leaders, according to the CDC, should promote dialogue about sexual orientation issues. The CDC believes that such action could overcome social barriers to HIV prevention for racial minority MSM especially among young men (CDC, 2007). The underlying social factors that may promote the observed racial disparities among MSM remain ill defined, but stigma toward same-sex behavior has been proposed as an explanation. This stigma manifests as sexual prejudice from the larger heterosexual

population as well as a person's own internalization of society's negative views toward homosexuality.

Negative attitudes toward homosexuality may inhibit MSM from coming out. Greater acceptance of homosexuality may be fostered by social interactions with gay individuals. Widespread disapproval of homosexuality, similar to that which has been documented in Black communities, is self-perpetuating. This disapproval also promotes internalized homophobia among MSM. It inhibits men from adopting behaviors, like HIV testing, that are likely to decrease HIV transmission at the population level. HIV prevention is less effective when homophobia undermines the social value of the lives of the people prevention efforts are targeting.

### **Purpose of the Study**

Despite epidemic rates of infection among black MSM, the overwhelming majority of HIV prevention interventions developed for African Americans do not target homosexual men (CDC, 2005). To add to research related to culturally appropriate HIV prevention interventions for Black MSM, counseling researchers should examine significant factors, which contribute to the mental health impact of internalized homophobia on HIV risk behaviors. In addition, researchers should continue to evaluate and adapt current counseling interventions. This research seeks to understand the effects of internalized homophobia and its correlation with HIV risk behaviors among Black MSM in order to address gaps in the literature and inform future prevention efforts. The purpose of this study is to: (a) assess internalized homophobia in Black men who have sex with men; and (b) analyze the effect of internalized homophobia on HIV risk behaviors.

## **Significance of the Study**

Although the links between internalized homophobia and HIV-related sexual risk behaviors are becoming increasingly clear, few studies have analyzed the effects of internalized homophobia on efforts to prevent sexual risk behavior in Black MSM. Given that men with high-internalized homophobia may engage in riskier sexual behavior, and thereby be at a greater risk for contracting HIV, it is important to investigate whether internalized homophobia also has implications for the methods used to prevent sexual risk behavior.

This study will add to the very low volume of research data surrounding the contributing factors for the high rates of HIV infections in Black MSM and help to inform prevention efforts. The study will also aid in understanding the link between homophobia in Black communities, internalized homophobia, mental health, and HIV risk behavior among men who have sex with men.

## **Methodology**

A quantitative, descriptive, survey design was utilized to collect data on internalized homophobia, sexual orientation, religious ideology, depression, self-esteem, demographics (age, income, geographic location, ethnicity, and education), relationship status, outness and HIV risk behaviors. All information was gathered via Qualtrics, an internet survey program. Qualtrics is a widely used and respected Internet survey tool (Lealand 2008). This program allowed the researcher to gain information from a wide audience while maintaining anonymity of respondents, which is not possible with the traditional paper and pencil method.

Participants were recruited via Web sites, such as social networking sites. Potential participants were asked to follow a survey link and complete an anonymous sexual health survey. Recruitment was targeted to a general audience, but only the responses of Black MSM were analyzed. Confidentiality, risks, benefits, compensation, and other factors were explained in the informed consent. Respondents provided their electronic consent by proceeding through the survey. The anonymous consent and Internet questionnaire format allowed participants to remain anonymous, which likely increased the possibility that they responded openly and honestly. The survey and procedures were beta-tested by leading researchers and clinicians working in the field of online research with Black MSM. Feedback was solicited on survey design and optimal online venues for recruitment. The researcher evaluated the results, discussed the implications of the findings, and provided recommendations for additional research.

### **Rational for Using Internet Survey**

More than 60% of the U.S. population uses the Internet, and more than 70 million Americans log onto the Internet on a typical day (Rainie, Cornfield, Horrigan, & Pew, 2005). Every month, the population of Internet users is coming closer to resembling the demographics of America as a whole. Both in the U.S. and abroad, researchers are rapidly developing both quantitative and qualitative interventions, utilizing the Internet for populations identified as most at risk for HIV (Rhodes, DiClemente, Cecil, Hergenrather, & Yee, 2002; Ross, Daneback, Mansson, Cooper, & Tikkanen, 2003; Ross, Mansson, Daneback, Cooper, & Tikkanen, 2005; Ross, Tikkanen, & Mansson, 2000; Tikkanen & Ross, 2003). Several aspects of the Internet make it a significant asset in HIV prevention research.

First, the Internet has become the world's most extensive venue for sexual information and sex negotiation; therefore, undertaking HIV/STD prevention studies within the online environment is needed and is appropriate (Bull & McFarlane, 2000; Elford, 2002). Second, the populations most infected and affected by HIV also appear to be early and enthusiastic adopters of the Internet for sexual and non-sexual communication. Several studies confirm that Black MSM are receptive to Internet-based data collection and interventions, such as completing surveys, chat discussions, individual outreach, educational services and message board forums (Bull, McFarlane, & King, 2001; Klausner, Levine, & Kent, 2004).

In addition, difficult to access or invisible populations at increased risk for HIV have organized online including men choosing to engage in unsafe sex, young Men who have Sex with Men, and sensation seekers. The Internet enables research on populations that were, previously, logistically or economically unfeasible to capture. Many MSM might not be reached with traditional survey methods because they may not have "come out," thus making them unable to be recruited. One study of Black MSM via the Internet suggests that the majority of those in this population who have access to the Internet come out on-line before doing so in their personal life (Ross, Tikkanen, & Månsson, 2000). Differences between Internet samples and conventional samples of men who have sex with men have further implications for research and HIV interventions. The Internet also has distinct advantages for data collection (Bowen, Williams, Daniel, & Clayton, 2008), data monitoring (Rhodes, DiClemente, Yee, & Hergenrather, 2002) and tailoring of survey instruments to specific groups of users (Hospers, Harterlink, van den Hoek, & Veenstra, 2002). Building to the

strengths of the Internet has the potential to improve the ease in which quantitative research is conducted. HIV prevention survey research inherently involves sensitive questioning. Internet-based interactions appear to be characterized by less inhibited behavior (Joinson, 1998), causing participants to be more willing to share personal information (Parks & Floyd, 1996) or reveal normally protected information about themselves (Joinson, 1998). Research has found that participants using the Internet respond with less social desirability and social anxiety (Joinson, 1999), thus increasing the potential for honest self-report.

Well-constructed and executed online studies can improve participant confidentiality their control of research participation, and reduce risks to participants. The anonymity and accessibility of the Internet allows data collection from samples that may otherwise be unreachable, especially for research related to sexuality. The ease of recruitment and data collection allows extensive samples to be readily achieved. Furthermore, those samples may be more representative, on some variables, than those obtained through traditional methodologies. Utilizing the Internet for this study will also add to the literature on using Internet surveys with this population.

### **Research Questions**

1. What is the relationship between age, relationship status, religiosity and internalized homophobia in Black MSM?

Hypotheses:

- a. There is no relationship between age and homophobia in Black MSM.
- b. There is a positive relationship between religiosity and internalized homophobia in Black MSM.

- c. There is a positive relationship between relationship status and internalized homophobia in Black MSM.

Analysis:

A multiple linear regression was conducted on the independent variables age, relationship status, religiosity, and the dependent variable internalized homophobia.

2. Is there a difference in internalized homophobia for HIV positive, HIV negative, and Unknown HIV status Black MSM?

Hypothesis:

HIV positive and Unknown HIV status Black MSM will have higher internalized homophobia than HIV negative Black MSM.

Analysis:

A one-way ANOVA was conducted on the independent variable HIV status (positive, negative, or unknown) by the dependent variable internalized homophobia. The assumption of normality was assessed by examining skew and kurtosis. Post-hoc pairwise comparisons were conducted to determine differences between each status group.

3. What is the relationship between internalized homophobia and HIV risk behaviors in Black MSM?

Hypothesis:

There is a positive relationship between internalized homophobia and HIV risk behaviors.

Analysis:

A logistic regression was conducted to determine the relationship between internalized homophobia and HIV risk behavior, when controlling for age, income, education level, relationship status, religiosity, and HIV status.

4. What is the relationship between internalized homophobia and sexual identity in Black MSM?

Hypothesis:

Black MSM who identify as heterosexual, straight, or other will report higher internalized homophobia than Black MSM who self identify as homosexual, gay or queer.

Analysis:

A point-biserial correlation was conducted to determine the relationship between internalized homophobia and sexual identity in Black MSM.

5. What is the relationship between internalized homophobia and mental health in Black MSM?

Hypothesis:

There is a negative relationship between internalized homophobia and mental health.

Analysis:

Two Pearson correlations were conducted to determine the relationship between internalized homophobia and mental health.

## **Definition of Terms**

1. African American – A scholarly term describing Black people born in the United States to American parents.
2. AIDS - Acquired Immunodeficiency Syndrome, a condition in humans in which the immune system begins to fail, leading to life-threatening opportunistic infections.
3. Black - a broad racial category reflecting ethnic diversity, for example, Caribbean and Haitian. African American is a subset.
4. Down Low - Men who discreetly have sex with other men while in sexual relationships with women. These men often do not consider themselves gay or bisexual and their female partners are not aware that they have sex with men.
5. Heterosexism - A term used to describe a bias, exhibited by a society or community that is often subtle but pervasive; cultural institutions and individuals are conditioned to expect others to live and behave as if everyone were heterosexual.
6. HIV- Human immunodeficiency virus, a retrovirus that causes AIDS.
7. Homosexual – A term used for intimate relationships and/or sexual relations between people of the same sex, who may or may not identify themselves as gay.
8. Homophobia - The fear of, aversion to, or discrimination against homosexuality or homosexuals. It can also mean hatred, hostility, or disapproval of homosexual people, sexual behavior, or cultures.
9. Internalized Homophobia – Homophobia directed against oneself. Homosexuals

- who suffer from internalized homophobia may discriminate or be violent towards other homosexuals in the same way and to the same extent as anyone else with homophobia.
10. Internalized Homo-negativity- Another term some researchers use for homophobia directed toward oneself. The author defines this as the same construct as internalized homophobia.
  11. LGBT- A term that collectively refers to lesbian, gay, bisexual, and transgender people. In use since the 1990s, it is intended to emphasize a diversity of sexuality and gender identity-based cultures. Generally used to describe the white non-heterosexual community.
  12. MSM - Men who have sex with men. MSM refers to any man who has sex with a man, whether he identifies as gay, bisexual, or heterosexual. MSM represent a wide variety of people and lifestyles.
  13. Outness – The degree to which lesbian, gay, and bisexual individuals are open about their sexual orientation.

### **Outline of Dissertation**

This dissertation is divided into five chapters. The first chapter provides a brief introduction about the effects of internalized homophobia on HIV risk behaviors among black MSM, the rationale for the study, an overview of the methodology, and the rationale for using the Internet for data collection. Chapter 2 presents a comprehensive review of the literature, including sections on homophobia, sexual identity, internalized homophobia, and mental health and HIV risk behaviors. The second chapter also provides recommendations

for research with the target population. Chapter 3 describes the research methods, including construction of the survey, recruitment of participants, analysis of data, and an overview of the instrument, assumptions, and limitations. Chapter 4 presents and highlights the results of the quantitative analysis. Chapter 5 discusses the results of the study, the implications for practice, the impact on public policy, the potential for future research, and the strengths and limitations of the study.

## **CHAPTER II**

### **LITERATURE REVIEW**

The purpose of Chapter 2 is to offer insight into the breadth of research focusing on the population of Black men who have sex with men. An overview of the research is provided describing how homophobia impacts internalized homophobia and mental health, which can lead to increased HIV risk behaviors. Additionally, limited historical perspectives and an overview of research describing sexual orientation identity, homophobia, internalized homophobia, and mental health were explored with additional discussion on how these variables affect HIV risk behaviors. Each topic was discussed in reference to the larger society, Black communities specifically, and its effects on HIV risk behaviors. Recommended treatment approaches by leading researchers in the field were also discussed.

When AIDS first came on to the scene, it was considered a “gay disease” and was attributed to the lifestyle of gay men. Many African Americans have historically been in denial about the fact that there are Black gays. Because of this faulty belief, AIDS has come to be viewed by some as a gay White disease that Blacks get when they associate too closely with White gays. This distorted view allows homophobic people in Black communities to dismiss the disease and cite it as proof that God is somehow punishing gay people.

When faced with the new epidemic, the predominantly White gay community began to mobilize. They challenged the government, the private sector, and the larger community to make the disease a health priority. They marched in the streets in demonstrations, committed acts of civil disobedience, and started organizations to assist the sick. They also challenged the homophobic teachings of some religious institutions. Over a short period, as

many in Black communities turned a blind eye to the burgeoning epidemic, AIDS showed that it did not discriminate as the cases of HIV in these communities began to skyrocket (Hudson & Robinson, 2001). There are many factors that made Black communities a fertile ground for the epidemic; a few those factors were discussed in this review.

### **Homophobia**

Homophobia is defined as a range of negative attitudes and feelings towards lesbian, gay, bisexual, and transgender people and behaviors. The definitions refer to irrational fear, with the implication of antipathy, contempt, prejudice, and aversion. Homophobia is observable in critical and hostile behavior, such as discrimination and violence, on the basis of a perceived homosexual orientation, or in some cases, any non-heterosexual orientation (Lewis, 2003). Homophobia is a psychological construct that can fluctuate over time. For example, homosexuality was accepted in Greece and Rome, and is at present in some Melanesian cultures (Money, 1987). The opposite is true in contemporary Western culture, which is firmly rooted in maintaining heterosexuality as the only accepted orientation in maintaining traditional roles of men and women (Morin & Garfinkle, 1978). According to Herek, Western culture only legitimizes the sexual relationship between a man and a woman with power being attributed to people remaining obedient to gender roles. For example, men that are more masculine and more feminine women are considered closer to ideal and are highly regarded within society (Cohen & Jones, 1999). Cohen and Jones assert that those who are most valued within a particular group, community, or society as a whole, often use their power to reinforce their positions of privilege and to perpetuate the marginal status of those who are not part of their group. Studies have shown that heterosexual men hold more

negative attitudes toward members of the LGBT community, particularly gay men, than do heterosexual women (Herek & Capitano, 1999). A link between exaggerated masculinity and homophobia and heterosexist behaviors has also been documented by researchers (Kilianski, 2003; Parrott, Adams, & Zeichner, 2002).

What contributes to homophobia? One widely accepted and somewhat controversial explanation is that discrimination and prejudice are means of expressing unresolved sexuality issues within oneself. Adams Wright and Lohr (1996) found that heterosexual men who were homophobic exhibited sexual arousal to homoerotic material, whereas heterosexual men who were not homophobic showed no arousal to homoerotic material. This implies that a conflict exists within homophobic men between homoerotic arousal and homophobic beliefs. This suggests that homophobia may stem from reaction formation (Maylon, 1982 & Morin & Garfinkle, 1978), in which an individual represses an impulse and expresses it as the opposite (Fancher, 1973). In this case, the homophobic individual denies his own homosexual arousal, and, in turn, expresses repulsion at his own attraction.

### **Homophobia in Black Communities.**

While attitudes in Black communities are slowly changing, homophobia and negative attitudes toward gay men persist. The sexual identity of Black gay men is usually regarded negatively by heterosexuals and other homosexuals. As in mainstream American culture, African Americans prefer heterosexuality and consider it normative (Lewis, 2003). There are very few studies that have explored this phenomenon, but the few studies that have been conducted indicate that African Americans are more homophobic than Whites (Lewis, 2003). Lewis explored the different attitudes between African Americans and Whites

toward both homosexuality and gay and lesbian rights; Lewis found that African Americans are more likely to perceive homosexuality as always wrong and to view AIDS as a punishment from God. Studies have also shown that African Americans with same sex attractions experience more pressure than Whites to hide their homosexual behavior, to marry, and to have children (Cohen & Cathy 1999; Icard 1986).

Among men who have sex with men (MSM), Blacks are more likely than Whites to think their friends and neighbors disapprove of homosexuality (Stokes, Venable, & McKirnan 1996; Stokes & Peterson 1998; CDC, 2002). In a study conducted by Tewksbury and Moore (1997), gay men were asked if they had disclosed their sexuality to family members, heterosexual friends, gay friends, coworkers, health care workers, and members of their church, if they associated with groups made up of gays, and if they had gay friends. The study showed that African American men were less likely than White men to disclose their sexuality, to have associated with LGBT groups, and to have gay friends. As the highest level of education increased, White men were more likely to disclose sexuality and associate with LGBT groups and African American men were less likely to do so. The researchers believe this is due to the higher social stigma attached to being gay in African American communities, which may be exacerbated for more educated men (Meyer, 2003).

Homophobia is intensified by this lack of acceptance by friends and family. Many African American gay men are taught that their sexual orientation and behavior is at odds with being African American and is inconsistent with their religious teachings (Welsing, 1990). Boykin (1996) suggests that homosexuality is not preferred by African Americans and that African American gay men must negotiate their sexual orientation with social

acceptability. Herek and Capitanio (1995) found that when discussing homosexuality and gay men, most African American respondents within the sample did not view African American men as being gay. In fact, another study showed that many African Americans tend to see homosexuality as something that only occurs among Whites and those who are African American and members of the LGBT community are viewed as traitors to their race (Rust, 2000). In a poll conducted in Atlanta and Chicago, 776 self-identified gay African American men agreed that negative attitudes toward homosexuality are common and rarely discussed openly in African American communities. Similar to the studies referenced throughout this review, some African Americans even viewed open homosexuality as something that was imposed on African Americans by the gay white culture. Many respondents, even those who claimed to be comfortable with their homosexuality, said they often hide their same sex attractions from others because of perceived homophobia (Stokes & Peterson, 1998). African American heterosexual men tend to show their disapproval of homosexuality by openly and actively objecting to it (Collins, 2000).

This inability to be open about their sexuality may cause many Black MSM to avoid association or affiliation with gay communities. This has an impact on HIV prevention because affiliating with gay communities provides men access to HIV prevention and other resources (Mills, Stall, Pollack, Paul, Binson, & Canchola, 2001). It also provides this population with role models to teach them to cope with homophobia and to develop and maintain positive relationships (Hetrick & Martin, 1987). The lack of affiliation with MSM communities can lead to what Hetrick and Martin (1987) refer to as cognitive isolation, which relates to the lack of access to accurate information about homosexuality. Research

has shown that being involved in gay and lesbian activities was found to reduce unsafe sex behaviors through exposure to HIV education and prevention (Rosario, Hunter, Maguen, Gwadz, & Smith, 2001). A study conducted among men who have sex with men in Dallas revealed that men who were involved with their local gay community, through regularly reading gay publications and belonging to at least one organization of gay men, were more likely to use condoms during anal intercourse. The authors speculated that given that HIV prevention messages are disseminated via gay newspapers and organizations, men acculturated into gay communities engage in safer sex because they are exposed to HIV prevention messages both when reading gay publications and through the organization of gay men in which they belong. This theory is further validated by research that has shown internalized homophobia to be negatively related to awareness of HIV prevention programs, comfort in group level interventions, and post-intervention condom use efficacy (Huebner, Davis, Nemeroff, & Aiken, 2006).

Research among MSM has continued to show that being connected to a community can have a powerful influence on the cognitions and behaviors of MSM (Herek & Glunt, 1995). A study conducted in Sacramento among a group of predominately White MSM explored the relationship of identity, internalized homophobia, and community on sexual risk behavior as well as several cognitive variables believed to be associated with sexual risk. Men who were connected to the community were more likely to have a high self-efficacy, a perception of social support for engaging in safe sex, and a belief that safe sex was effective. Research indicates that African Americans tend to be less involved in their local gay community. Mills and colleagues (2001) examined differences between men

living in the gay areas with those residing elsewhere and found that African American and Latino MSM tended to live outside the gay area. Men living outside the gay area of the city were less involved in gay communities and less likely to positively embrace gay communities. These men were also more inclined to engage in sex with women, less apt to disclose their sexuality to other people, and less likely to have ever been tested for HIV. Studies making racial and ethnic comparisons have also shown that both African American and Latino MSM tend to be less likely to be involved in the gay community than White men (Rosario, Schrimshaw, & Hunter, 2004).

In addition to homophobia, racism may be a roadblock to Black MSM embracing the LGBT community. A large survey of black LGBTs revealed contention with white LGBTs due to racism (Battle, Cohen, Warren, Fergerson, & Audam, 2002.); perhaps, as a direct result, blacks report less involvement in the LGBT community (Stokes, Venable, & McKirnan, 1996). A quality connection with a community means more than simple group membership. It includes having a sense of belonging to the community, a perception that the community is influenced by its members and, vice versa, a common set of values, a means of meeting members' needs, and a shared emotional bond with other members.

The finding that African American and Latino MSM are inclined not to associate with gay communities is not surprising. In most communities, gay communities tend to be comprised predominately of White men; MSM of color have expressed experiencing social rejection in the form of discrimination or disrespect from the community (Stokes et al., 1996). Such discrimination and disrespect may lead African American and Latino men to refrain from getting involved in gay communities (Wright, 1993; Stokes, Venable, &

McKirnan 1996) and to cope by using behaviors that increase their likelihood of having HIV related risk (Diaz, Ayala, & Bein, 2004). Members of this group are often victims of double discrimination: Black gay and bisexual men are simultaneously alienated from African Americans because of homophobia and from White gays because of racism (Boykin, 1996). Studies have shown that African American communities view Black gays who are public about their homosexuality as threatening to the stability of the family and the strength of the Black male. White gays, on the other hand, have historically marginalized the concerns of Blacks, highlighting White experiences and politics and ignoring issues of racial discrimination (Pettiway, 1996). Experiencing discrimination from gay communities may explain why men who do not identify as “gay” engage in risky sexual behavior. If these men perceived gay communities to be unwelcoming, they may not associate with it. As a result of not associating with gay communities, they miss prevention messages prevalent in gay communities for MSM and may perceive HIV to be less of a threat.

Homophobia can affect sexual risk behaviors of African American MSM in several ways. To cope with homophobia, MSM may internalize homophobic attitudes about their group (Goffman, 1963). Internalizing homophobic attitudes may be linked to self-destructive behaviors stemming from self-hatred directed towards characteristics of their group (Allport, 1954). Self-destructive behaviors associated with internalized homophobia could range from suicide to failing to protect one’s self from harm. Research supporting this theory in a multi-ethnic population of MSM found that a large percentage of gay youth who had attempted or thought about attempting suicide reported doing so because of their sexual orientation (Hammelman, 1993). Researchers have also linked internalized homophobia to

failure to use condoms (Meyer 1995; Perkins, Leserman, Murphy & Evans, 1993) as well as using drugs and alcohol (Meyer 1995), which can both be directly and indirectly associated with HIV infection as the use of drugs is thought to impair decisions about using condoms (Seal, Kelly, Bloom, Stevenson, Coley, & Broyles, 2000).

Prevention efforts may not be as effective among men experiencing internalized homophobia and, in turn, these men may engage in risky sex. Because of this linkage between gay communities and sexual behaviors, some have hypothesized that the higher prevalence of infection among African American MSM is due to the high levels of homophobia in the community; these men are less inclined to identify as gay or do not disclose their sexuality to others, which leads to increased risk behaviors. Although there is little empirical research in this area (Millett, Peterson, Wolitski, & Stall, 2006), conclusions from a study examining men who do not disclose their same-sex sexuality suggest that homophobia may be the root of HIV transmission, because the non-disclosers were more likely not to know they were infected (Centers for Disease Control and Prevention, 2003). Therefore, homophobia, and not sexual identity, may be influencing the risk behaviors of African American men.

It is possible that the high levels of homophobia in African American communities may explain why some studies have shown that African American MSM tend to have more female partners than their white counterparts; Black MSM may feel pressured to maintain a heterosexual façade in order to avoid the possibility of a homophobic response from their communities. Black MSM often experience discrimination or disrespect within their communities. Maintaining the facade reinforces the perceptions of homophobia and helps

them avoid further devaluation. When working with this population, it is important for researchers to have an understanding and sensitivity of the participant's feelings and actual experiences of social rejection due to homophobia. It is also important to understand how homophobia influences internalized homophobia and its effect on HIV risk behaviors.

**The Down Low.** Black MSM encounter many stressors which have been linked to closeted homosexuality, often referred to as "down low." The down low will not be discussed at length but the down low has been an increasingly hot topic in African American MSM literature, and so it warrants a brief discussion. The down low commonly refers to African American men who are in relationships with women and who secretly have sex with men. African American men are being demonized and blamed for the high rates of HIV/AIDS among middle-class African American women (Boykin, 2005). This castigation of African American men persists despite the fact that there is no empirical evidence to support the claim of increased rates of HIV/AIDS in African American communities due to Black men on the down low (Ford, Whetten, Hall, Kaufman, & Thrasher, 2007). This negative characterization has become so common that the down low has become almost synonymous with Black men and HIV/AIDS. This stigmatization further stereotypes African American male sexuality as deviant and shifts the focus of HIV education from awareness to blame (Ford et al., 2007), which is highly problematic to HIV prevention efforts. The damaging characterization also increases levels of homophobia within African American communities and exacerbates misunderstandings of HIV transmission while further perpetuating mistrust of Black men. A more constructive approach would be to try to

reduce stigma and homophobia and educate people about safer sex and homosexuality instead of contributing to the further demonizing Black men.

It is important to note that few empirically based statements can be offered about African American men on the down low because of the absence of research among this population (Malebranche, 2003). Most research pertaining to African Americans tends to ignore the issue of sexual orientation, and most research pertaining to LGBTs tends to ignore the issue of race.

**Origins of Homophobia in Black Communities.** With the vastly different histories experienced by African Americans and Whites in the United States, the source of homophobic attitudes for African Americans differ from the source of these attitudes for Whites (Herek & Capitanio, 1995). These sources of heterosexism and homophobia must be addressed when attempting to study homophobia within the African American heterosexual community.

For centuries, African Americans, as well as people of other racial and ethnic groups, have been subjected to negative and distorted representations of their sexuality. African American sexuality, generally, is not looked at in a favorable light by Whites and is always seen in relation to White sexuality and how it can best serve Whites (West, 2001). African Americans are often viewed as either asexual (Aunt Jemimas or Uncle Toms) or hypersexual (Jezebel) and macho (Davis, 1981; Collins, 2003). Many of these perceptions have to do with slavery and the development and reinforcement of masculine and feminine roles in the African American community.

One of the ways in which slavery was justified was by making African Americans appear to be subhuman. The denial of African American humanity made it easier to own humans as property and warranted the forced labor, beatings, and rapes. This ideology was particularly necessary to justify slavery during an era where “all men are created equal” was the ideology, while African Americans were considered three-fifths of a person and were banned from learning to read or write. It followed that this denial of African Americans’ right to a human identity would strip them of fundamental aspects of their identity (Collins, 2003). During this era, Whites also attempted to strip the gender identity away from both African American women and men, and slavery provided convoluted gender roles and expectations for the enslaved. The White man usurped the typical breadwinner role; the master provided food and shelter for them, as well as owned them. He would force African American women, often the wives of male slaves, to have sex with him while their partner could do nothing. The African American man was neither able nor allowed to protect and provide for his family and offspring (Collins, 2003).

Even though slavery has been abolished, both African American women and men are still held up to the White, Western, patriarchal, capitalist standards of femininity and masculinity, and due to continued societal racism and oppression, women and men are still prevented from actively taking part in these roles. This has proven to be especially problematic for many African American men. Because many of these men have historically been denied the stereotypical role of the man, which is characterized as being the main breadwinner in the home, a number of African American men have had to prove their masculinity in a variety of ways that are easier to perform. This includes strongly

reinforcing other stereotypically male behaviors and attributes, such as strength, athletic prowess, and high rates of sexual activity and potency (Collins, 2003). As stated in this review, homophobic African American heterosexual men try to separate themselves as much as possible from gay men, men who are perceived to have voluntarily given up their male privilege (Battle & Lemelle, 2002).

**Black Churches.** There is evidence of homophobia in the Black family, church, and community on both a personal and institutional level (Stokes & Peterson, 1998). One of the institutions that has contributed to homophobia in the African American community the most is the very institution that most African Americans have traditionally turned to for help: the African American church. Silence about AIDS from African-American churches was the most notable and difficult to comprehend because of the traditional role of black churches in identifying and speaking out against threats to the health and welfare of African American communities. In the past, these churches have helped to mobilize blacks to fight against injustice and have offered spiritual support, especially in times of crisis (Hudson & Robinson, 2001). The Black Church has been charged with preventing the African American community's initial mobilization against the AIDS crisis and for currently influencing many African Americans' negative perceptions of same-sex marriage and encouraging a general sense of homophobia within the African American community (Dalton, 1989; Douglas, 1999; Cohen & Jones, 1999; Constantine-Simms, 2001).

The lackluster response of the black church to the AIDS crisis is inconsistent with the magnitude of the problem for African Americans. The response of Black religious congregations to the AIDS epidemic has varied. Some church leaders turn a blind eye to the

issue because of their adherence to homophobic and heterosexist biblical interpretations, which restricts HIV prevention programming (Fullilove & Fullilove, 1999). Some Black religious organizations have prioritized helping those in need. Other congregations are in the middle and try to negotiate the tension of wanting to provide support for those who are in need with the concern that such service provisions may be endorsing an unacceptable lifestyle. This tension diminishes effective service delivery. Many African American congregations that do sponsor AIDS ministries or provide HIV prevention education do so while ignoring, minimizing, or repudiating same-sex behavior, which further perpetuates homophobia.

Homophobia has been shown to decrease the self-worth and self-esteem of homosexual congregants and those who love them (McGinley, 2004; Miller, 2000). This stigmatization also diminishes the self-efficacy of black gay men and their ability to engage in HIV prevention efforts (Fullilove & Fullilove, 1999). The black church has been a resource for many African Americans confronting various life events. Because of homophobia, heterosexism, and AIDS phobia, African American gay men with AIDS are not typically offered the much needed support from the church.

There have been countless stories from African-Americans living with AIDS, both gay and straight, of being turned away from their churches because they have AIDS. There have been numerous reports of African-American ministers using their pulpits to attack gay people. These actions on the part of some black churches and silence from others created a situation where many HIV-infected and gay persons have to carry a burden with them into what is supposed to be a space where their burdens can be lifted. In a published discussion

about the African-American church and its view on AIDS and gays, clergy people and gay Christians were interviewed (Ellison, Musick, & Henderson, 2008). The 51 clergy people interviewed found many churches stigmatized both substance abusers and gays. Many of the gay men interviewed gave personal accounts of being asked to leave their church after disclosing their gay lifestyle or being permitted to remain on the condition that they suppress public recognition of their homosexuality and not discuss it.

Although African American churches differ in their views on homosexuality, most teach that it is a sin and an abomination in the sight of God. The relationship between African American gay men and religious leaders is very interesting. Most pastors know they have homosexuals in their congregations. There are many homosexuals active in churches that are subjected to foul and degrading language as a part of the sermon. The church belittles them and makes them feel less than human. The African American church does not embrace its gay members. Ironically, men who are known homosexuals are involved in key functions in the church. Fullilove and Fullilove (1999) suggested that some gay men are accorded special status in many churches because they provide the creative energy necessary for the transcendent religious experiences. Gay men having this role in the church are a widely known but largely unaddressed truth. The paradoxical but not uncommon scene of gay men singing in the choir while homosexuality is denounced from the pulpit illustrates the idea that an "open closet" exists at the center of church life (Fullilove & Fullilove, 1999). This paradoxical relationship adds to the self-hatred and self-loathing that many homosexuals experience (Crawford, Allison, Zamboni, & Soto, 2002). Despite negative messages about homosexuality from the African American church, when polled, the

majority of homosexual African Americans reported that they attend church regularly; the study also revealed that most of the respondents had not disclosed their orientation to anyone at their church (Peterson & Stokes, 1998). This finding displays the powerful role of religion in the African American community. Many believe that the church's opposition to homosexuality is a major reason for negative attitudes within the community at large.

Because of the importance of the church for African Americans, the dominant view that homosexuality is a violation or sin constitutes an important assault on the self and prompts a variety of coping responses for gay men. To assuage the negative feelings that can arise in the face of religious castigation, some men feel they have to make a choice: they must either forego their sexual orientation and behavior to remain consistent with the scriptural interpretation of their clergy or they must reject the clergy's interpretation and potentially lose access to their church affiliation (Miller, 2002). The consequences of such choices are severe, potentially leading to diminished self-esteem and limited ability or willingness to pursue further spiritual development (Hicks, 2000). For some men, religious castigation and the forced choice it imposes encourage unsafe sexual practices and drug use (Fullilove & Fullilove, 1999).

Homophobia is a great problem throughout America, but in the African American community, it is an even larger problem. There are many reasons why the black church's condemnation of homosexuality may increase the impact of AIDS on the African American community. Some men are so disoriented by their experiences of stigma, both in the church and in the general community, that they do not feel empowered to care for themselves. Such feelings can undermine the individual's ability to practice safe sex, seek medical care, or

follow health practices essential to well-being. Some men said they avoid discussing HIV/AIDS or condom usage because they do not want to be perceived as gay or bisexual. Homophobic men are also less likely to have relationships with other men, causing them to engage in risky behavior with multiple partners (CDC, 2006).

### **Homophobia and HIV Risk**

Associations between socio-cultural factors and HIV risk behaviors are an important area to explore. Socio-cultural factors relevant to sexual and racial identity experienced by culturally diverse groups of MSM may influence HIV risk behaviors. Although the effects of socio-cultural factors are not directly related to the current study's questions, which explored associations between internalized homophobia, mental health, and sexual risk practices, these studies focused on socio-cultural factors and provide an important context to understanding the multiple HIV risk factors for this population.

Several authors (Diaz, 1998; Diaz, Ayala & Bein, 2004; Hart & Peterson, 2004; McKirnan, Ostrow, & Hope, 1996; Stokes, Vanable, & McKirnan, 1996) have examined socio-cultural factors related to HIV risk behaviors. The Cognitive escape model of HIV risk behaviors of gay and bisexual men was proposed by McKirnan, Ostrow, and Hope (1996). Their model was created specifically within a gay identified cultural context; the socio-cultural factors examined in the model relate specifically to gay male identity and culture. McKirnan and colleagues believed that gay and bisexual men who had experienced the HIV crisis of the 1980s and early 1990s would be aware of risky sexual behaviors, and as such, would work to avoid engaging in such behaviors. Furthermore, the authors asserted that these men would be likely to have high self-efficacy regarding the likelihood of

following through with intended safer sex behaviors. McKimman et.al's assumptions were shown to be incorrect; results revealed that rates of unprotected sex and HIV sero-conversion remained high among gay and bisexual men. The authors proposed their cognitive escape model to explain these findings. They proposed that many gay and bisexual men might be motivated to cognitively escape from HIV awareness and restrictive safer sex norms, a process exacerbated by alcohol and drug use. They also asserted that drugs and alcohol, along with stimuli associated with gay male sexuality such as certain locations, music, people, and images, could automatically trigger this escape strategy. These automatic cognitive scripts encourage unsafe sexual behaviors by rewarding gay men for temporarily avoiding HIV anxiety, fatigue, and a sense of fatalism. The model further asserts that gay men adjust their belief systems about engaging in safer sex to match their behaviors in order to reduce cognitive dissonance. McKirnan, Ostrow, and Hope's (1996) model provides an interesting framework with which to understand socio-cultural barriers to safer sex among gay and bisexual men. Although thought-provoking, it requires more empirical validation. The model is focused primarily on White gay male culture; this model may not be relevant to MSMs who do not identify with or primarily interact with White gay male culture.

Similar to McKimman's and colleagues (1996) cognitive escape model, Diaz (1998) proposed that for many Latino identified men, the socio-cultural factors of machismo, family loyalty, sexual silence, racism, homophobia, and poverty often created cognitive barriers to safer sex in spite of safer sex intentions. Expanding on this work, Diaz, Ayala, and Bein (2004) conducted a quantitative study exploring associations between racism, homophobia, poverty, and sexual risk practices in a sample of almost 1,000 Latino gay men in Los

Angeles, New York, and Miami. The author's study assessed experiences with racism, poverty, and homophobia specific to gay Latino men. In addition, the authors assessed what they identified as difficult sexual situations, such as the frequency participants engaged in sex in public settings under the influence of drugs or alcohol in order to escape from negative feelings within relationships of unequal power, with instances of sexual dysfunction, and with partners resistant to using condoms. The 19 percent of participants who reported engaging in unprotected anal intercourse with a casual or non-monogamous partner were considered to engage in high risk sexual activity. All other participants were considered to engage in low risk sexual activity. Results indicated that 62 percent of participants felt racially objectified by members of the larger gay community. Sixty-one percent could not pay for their basic needs at least one time in the last year. Eighty percent displayed depressive symptoms, 44 percent anxiety or panic symptoms, and 17 percent reported suicidal ideation. Forty-one percent of participants had used sex to alleviate loneliness or depression, 31 percent had sex under the influence of drugs, and 54 percent under the influence of alcohol. The study found that men who engaged in high sexual risk, as defined by the authors, reported experiencing more psychological distress, homophobia, racism, and poverty, and engaged in more sexually difficult situations than other participants.

Psychological distress, as well as experiences of racism, homophobia, and poverty, predicted sexual risk practices and difficult sexual situations.. Diaz and colleagues' (2004) study highlights the fact that homophobia increases isolation, undermines a sense of self-worth, and produces psychological distress. In this study, those who are oppressed and distressed participate more often in sexual situations in which risk behavior is likely to

occur. The author asserts that these factors are often more influential than intentions to engage in safer sex. This is one of a few studies that provide quantitative evidence suggesting a relationship between homophobia, psychological distress, and sexual risk practices in a sample of Latino gay men. The current study tests a similar theory in a sample of African American HIV-positive MSMs and considers the related but distinct internalized homophobia instead of just experiences of discrimination or homophobia. The current study also extends Diaz and colleagues' work measuring the behaviors of engaging in unprotected sex outside of a committed relationship when assessing HIV risk behaviors.

Quantitative research investigating the impact of relevant socio-cultural experiences on sexual risk practices among African American MSMs has not yet supported or generated theory to the extent that Diaz and colleagues' (2004) results have done with Latino gay males. Hart & Peterson (2004) began to examine how socio-cultural experiences relevant to racial identity may be associated with safer sex behaviors among African American men. Hart and Peterson (2004) surveyed 758 African American MSMs from Atlanta, Georgia between ages 18 and 25. The authors assessed rates of unprotected insertive and receptive anal intercourse in the past three months, sexual identity status, HIV status, the frequency that participants' carried condoms with them, and perceptions of peer norms regarding condom use. Twenty-six percent of participants admitted to having unprotected anal intercourse within the past three months, but most did so within a relationship with a main partner. Interestingly, results revealed that perceived unsupportive peer norms around condom use, and not carrying condoms, predicted unprotected receptive anal intercourse, while only perceived unsupportive peer norms around condom use predicted unprotected

insertive anal intercourse. In summary, carrying a condom only reduced unprotected receptive, but not insertive, anal intercourse.

Hart and Peterson's (2004) results may be partially explained by the myth that one cannot contract HIV through unprotected insertive anal intercourse. This myth is harmful, from a prevention perspective, if the insertive partner is HIV-positive and unaware of his status, a finding that has repeatedly been shown among MSMs and most strongly among young African American MSMs (CDC, 2002, 2003, 2005; Valleroy, MacKeller, Karon, Rosen, McFarland, & Shehan, 2000). In contrast to other studies, Hart and Peterson's assessed the degree to which participants were engaging in sexual behaviors inside and outside of committed relationships. It is also valuable that they focused specifically on African American MSM without requiring participants to identify as gay or bisexual, which allowed them to report on how norms regarding condom effectiveness and use among a broader group of African American MSM impact sexual risk practices.

It is important to assess the associations between identity status components, developmental processes, socio-cultural factors relevant to racial and sexual identity development, and sexual risk practices among culturally diverse groups of MSM. What remains a gap in the literature are studies going beyond identity status components to examine links between identity salience and sexual risk practices. Race specific studies looking specifically at links between the meaning of minority racial and sexual identities, and sexual risk practices, among HIV-positive African American MSM are needed.

## **Sexual Identity Development**

Over the past twenty years, there has been an abundance of research devoted to the study of homosexual identity development (Coleman, 1982; Troiden, 1979; 1989). Initial research viewed homosexual development as a mental illness; current research seeks to gain understanding of the emotional and psychological process as experienced by individuals undergoing development (Cass, 1979). Recent models find that homosexual identities develop over long periods and involve a number of growth points or changes, which may be stage oriented. Many models assert that homosexual identity formation includes an increasing acceptance of the self-identified label of being homosexual and that the final process includes disclosing personal sexual identity to others (Cass, 1979, Trodien, 1989, Lociacano 1989, Yarhouse, 2003). Homosexuals encounter several stages of identity development (D'Augelli, Hershberger, & Pilkington, 2001). The first stage commonly includes an awareness of attraction to individuals of the same gender. The second includes self-labeling as gay, lesbian or bisexual while at the same time making tentative contacts with other homosexual individuals. The final stage involves the ability to self identify as a non-heterosexual to others. Individuals may go through several degrees of disclosure or self-identifying. Some may choose to first disclose to close friends or to those who they have the highest level of trust with and believe the risk is lower to disclose to. In addition, individuals may first disclose to others who also identify as homosexual and may begin to participate in gay organizations or social settings. Many people often choose to disclose to family members later because of the perceived emotional risk and fear (Gortmaker & Brown, 2006; Rankin, 1997; Rhodes, 2004; Stevens, 2004). The success or failure of these combined tasks

determines if the individual will move on to other stages. The risk and stress of completing this multilayered process is so immense that it may be a lifelong process (D'Augelli, Hershberger, & Pilkington, 2001).

### **African-American Sexual Identity Development**

In order to understand black male homosexual identity development one must first understand African American masculinity development.

Theorists attribute the historical context of slavery with the development of black masculinity. In 2003, Malebranche describes black masculinity as a by-product of black male roles constructed during slavery. During slavery, black men were expected to breed and endure strenuous physical labor. Due to the history of white supremacy, which has included slavery, oppression and discrimination, African-American men have been socialized to accept the fact that the accumulation of wealth, education, property, or public recognition, all elements reinforced by traditional descriptions of masculinity, are not available to them. From the 19<sup>th</sup> century to the 1960s, Black men faced Jim Crow Laws that lead to numerous socio-cultural disadvantages. Many believe that the results of these disadvantages have manifested in high rates of unemployment, chemical dependency, incarceration, crime victimization, and premature death by preventable diseases and violence.

As a coping mechanism, many African-American men have attempted to maintain a sense of being a man in a new cultural context through the emphasis of masculine characteristics that do not depend on economic successes (Brandt, 1999). To deal with the environmental, socio-cultural, and negative racial images, African-American males have developed coping skills that include bravado, an attitude that encourages aggression,

deviance, and other hyper-masculine characteristics (Ward, 2005). These hyper-masculine characteristics of toughness, risk-taking, athleticism, violence, and exploitation of women are reflected in the hyper-masculine posturing than many African-American males endorse (Stokes & Peterson 1998).

This compulsory expression of hyper masculinity has also been thought to be an important strategy for coping with racism, oppression, and marginalization, particularly among young black men. Majors and Billson's (1992) conceptual framework termed "Cool Pose" describes a black masculine strategy to cope with and survive in the face of social oppression and racism. Adoption of the "Cool Pose" provides a sense of power to men who have been disempowered by racism, discrimination, and loss of opportunities. It also serves as an ego booster for black men who do not have access to opportunities to build esteem that are afforded to white men, such as good schools, prestigious jobs, and the earning of a decent wage. Majors and Billson (1992) assert that "Cool Pose," in many ways, is a type of impression management; it provided a mask that suggests competence, high self-esteem, control, and inner strength and hides self-doubt, insecurity, and inner turmoil (Majors & Billson 1992). The mask of the "Cool Pose" allows black men to preserve pride, dignity, and respect in a society that typically denies them these attributes. The "cool pose" can also be associated with poor health and social outcomes. In summary, because many African American males lack the resources to obtain the traditional American societal prescription for masculinity, Cool Pose fosters the development of compulsive masculinity an alternative to traditional definitions of manhood that compensates for feelings of shame, powerlessness, and frustration by typifying toughness, sexual promiscuity, manipulation, thrill-seeking

behavior, and willingness to use violence to resolve personal conflicts (Majors & Billson 1992).

Whitehead (1997) discusses the notion of maintaining a sense of self, particularly a masculine sense of self. He argues that the formation of self emerges from interactions with others and that one's sense of self can be influenced by evaluations of his performance of certain societal roles. Being left with only these alternative strategies to express their masculinity creates what Whitehead describes as a fragmented gender self in Black men because they cannot live up to all of the expectations placed on them as men (Whitehead, 1997).

Masculinity and homosexuality occupy distinct social positions within the black community. While the expression of potentially detrimental hyper masculine behavior has been associated with community and peer acceptance as well as fortification of self-image and self-esteem (Harris, 1992; & Whitehead, 1997), homosexuality has been associated with depressive distress, alienation and isolation of black men within African American communities (Lociacano, 1989; Peterson, Folkman, & Bakeman 1996; Stokes & Peterson 1998). The literature suggests that the social sanctions applied to homosexuality may be due to the perception that homosexuality is in direct opposition to the gender role expectations of black men. For example, several studies have shown that gay identity carries a stigma which contradict norms of black masculinity. As patterns of gender role conflict suggests (O'Neil, 1981), this may be due to perceived direct contradictions between hyper-masculine gender role expectations for black men and stereotypical effeminate beliefs about homosexual men (Brandt, 1999; Ward 2005). The term gay often denotes a specific lifestyle

characterized by public disclosure of same-sex behavior and a culture specific to white gay men in major cities (Wright, 1993). In addition, many black MSM may perceive gay identity as associated with effeminate, flamboyant behavior and inconsistent with masculine expectations (Malebranche, 2003). This compulsory expression of masculinity in black men not only espouses sexual prowess, physical strength, violence, competition, and dominance, but must also despise the lack of these qualities as weak and effeminate. Hyper masculinity is inherently heterosexist and homophobic (Ward, 2005). Antagonism toward homosexual men is often used to define masculinity (Connell, 1992). Indeed, studies have found that heterosexual black men may feel compelled to denounce homosexuality to reinforce their own masculinity (Kennamer, Honnold, & Bradford, 2000).

Given this discord between black masculinity and homosexuality, many black MSM are thrust into a position where they must find a way to justify their homosexual behavior in such a way that does not threaten or detract from their masculinity. In a study by Wright (2001) focused on black male sexual behavior, he found that the men in his sample did not view same sex behavior as homosexual. They believed they were not homosexual as long as they maintained the insertive role, either orally or anally. The study also revealed that the participants believed that taking on the aggressive or insertive position during sex with a man ensured retention of one's masculinity and manhood. The terms many black MSM use to label their sexual identity often reflects a desire to protect their masculinity from the images associated with the term gay. Malebranche (2003) found that many black MSM had a negative association with the word gay, often choosing not to use it to identify themselves because they associated it with femininity, flamboyance, and promiscuity. These findings

suggest that some black MSM negotiate their homosexuality and masculinity by disassociating themselves from the feminine stereotypes associated with homosexuality.

### **Sexual Identity and HIV Risk.**

During the 1990s, rates of HIV transmission spiked among African American MSM; by 1992, AIDS cases among African American men rose by 31% (Peterson, Coates, Catania, Middleton, Hilliard, & Hearst, 1992). Despite this fact, data on sexual risk practices of African American MSM was almost nonexistent. Peterson and colleagues implored the scientific community to conduct research on sexual risk practices among African American MSM in order to more effectively prevent and respond to what they viewed, at that time, as a potential HIV crisis among African American MSM. Their research examined the frequency and correlates of unprotected anal intercourse (UAI). In the literature, UAI is characterized by sexual behavior consisting of engaging in anal intercourse without use of condoms and is known to be strongly associated with the spread of HIV and other sexually transmitted infections (STIs). The Peterson et.al study collected self-reported data from African American male participants who identified as gay or bisexual. Twenty-two percent of participants admitted to engaging in UAI with primary partners. Primary partners were defined as living together or in long-term committed relationship, and 35 % acknowledged engaging in UAI with secondary partners who were defined as all other partners. The authors measured participants' comfort with disclosing same-sex behaviors, self and partner's HIV status, knowledge about AIDS, endorsement of racial myths regarding AIDS, social support, perceived HIV risk, and attitudes, norms, and self-efficacy regarding condom use. In addition, they measured frequency of anal intercourse and condom use, injection

drug use, having sex for money, and help seeking to change risky sexual behaviors. The study results found higher rates of UAI was correlated with two or more of the following variables: discomfort disclosing same-sex behaviors to others, low socioeconomic status, having had sex for money, having used injection drugs, greater perceived HIV risk, and low social support for same sex related sexual concerns. Knowledge about HIV risk alone did not predict sexual risk practices, although factors related to a marginalized status did. The results revealed interesting information about condoms. Participants were more likely to use condoms if they considered condom use normative among African American gay and bisexual men, felt competency about using condoms, and had positive expectations toward having sex with condoms. Group norms around perceived condom use among African American MSM, and erotic expectations regarding condom use also influenced actual condom use. These findings suggest that informational HIV campaigns, by themselves, may not be enough to address the sexual risk prevention needs of African American MSM. These findings are important in implementing and designing interventions for this population.

The Centers for Disease Control (CDC, 2002, 2003, 2005) and Valleroy, MacKeller, Karon, Rosen, McFarland, and Shehan (2000) have conducted several studies focused on the prevalence rate of HIV among all MSMs in the United States. These studies are highlighted because they look at the sexual risk practices of MSM and provide insight into current sexual risk behavioral patterns. Between 1994 and 1998, Valleroy and co-authors (2000) surveyed and performed HIV tests on more than 3000 MSM between 15 and 22 years of age in Baltimore, Dallas, Los Angeles, Miami, New York City, San Francisco, and Seattle.

Among the participants, 41 percent reported engaging in previous UAI with a male partner. Seven percent of participants were HIV-positive, with the highest prevalence of HIV among 22-year-olds. Of those who were positive, only 18 percent of HIV-positive participants were aware of their HIV status before being tested for the study. HIV-positive participants previously unaware of their status reported engaging in more UAI than HIV-negative participants. The participants aware of their HIV-positive status reported engaging in the same amount of UAI as HIV-negative participants. Some of the factors that were associated with higher HIV prevalence included being African American, ever having had anal intercourse with another man, ever having had unprotected sex with another man, ever having used injection drugs, ever having a previous sexually transmitted infection, ever having run away from home, being between 20 and 22-years-old, ever having been forced to have sex, and having had sex with twenty or more male partners.

A second study (CDC, 2002) looked specifically at unrecognized HIV infection, sexual risk practices, and perceptions of risk among African American MSMs between 15 and 22-years-old. The author's analyzed data was collected from almost 1,000 African American participants from the above mentioned study conducted by Valleroy and colleagues (2000). They found that 16 percent of African American participants in the study were HIV-positive, and a staggering 93 percent of those who were positive were unaware of their HIV status before being tested by the study. These results revealed a much deeper disparity than Valleroy and colleagues' results (2000) from their study of young MSMs of diverse ethnicities. The Valleroy (2000) study found 7 percent of participants to be HIV-

positive and 82 percent to be unaware of their HIV status. Seventy-one percent of those who were HIV-positive and unaware of their status (CDC, 2002) believed that they had no chance or were very unlikely to contract HIV. Fifty-two percent of those who were HIV-positive and unaware of their status admitted to previous UAI without using condoms.

A third study (CDC, 2003) examining the same set of Valleroy et al. (2000) participants, focused on HIV and other sexually transmitted infections prevalence rates between MSM who did and did not disclose their same sex attracted sexual orientation. Eight percent of non-disclosers were HIV-positive in this study, compared to 11 percent of disclosers. Among African American participants, 14 percent of non-disclosers and 24 percent of disclosers were HIV-positive. Ninety-eight percent of non-disclosures across all ethnicities were unaware of their HIV status before being tested for this study. Disclosure differed by ethnicity, with 18 percent of African American, 14 percent of multiracial, 13 percent of Latino, ten percent of Asian, and eight percent of White participants being non-disclosers. African Americans comprised the highest proportion of non-disclosers. They found a positive correlation between age and disclosure among White participants; younger participants were less likely to disclose, but there was no relationship between age and disclosure among African American participants. Non-disclosers across ethnicities also had higher levels of internalized homophobia and social isolation and perceived there to be less approval of their same sex attracted sexual orientation within their respective ethnic group(s).

A fourth study (CDC, 2005) surveyed and performed HIV tests on 1,700 MSM, comprised of various ethnicities. They were randomly sampled from venues that cater to the

MSM population in San Francisco, New York City, Los Angeles, Miami, and Baltimore. Participants' average age was 32-years-old, slightly older than the Valleroy cohort. Thirty five percent were White, 27 percent Latino, and 25 percent African American. In this study, 25 percent of MSM were HIV-positive, and 48 percent of those who were positive were unaware of their HIV status before being tested for this study. Seventy-six percent of those who were HIV-positive were 30-years-old or older. HIV positive participants were more likely to be unaware of their HIV status if they were younger than 30-years-old, non-White, and not from San Francisco. Seventeen percent of Latino, 21 percent of White, and 46 percent of African American participants were HIV-positive. Out of those who were HIV-positive, 11 percent of White, 18 percent of Latino, and 64 percent of African American participants were unaware of their HIV status before being tested for this study. In addition, more HIV positive participants than HIV-negative participants had previously never been tested for HIV due to fears of learning their HIV status and others' potential reactions. In this study, as with the others, African Americans were by far the most likely to be HIV positive and unaware of their infection.

The studies reviewed above by Valleroy et al. (2000) and the CDC (2002, 2003, &2005) provided a measure of HIV prevalence and associated risk factors among MSM of various ethnicities and from a variety of geographic locations in the United States. These studies helped to fill in the gaps and provide much needed descriptive data regarding the link between MSM identity and sexual risk practices for African Americans. These studies could be enhanced by assessing for whether or not participants were involved in long-term, committed relationships; this will help researchers understand whether participants engaged

in unprotected sex with committed or casual partners, which represents distinct levels of risk for HIV transmission. The current study will address this gap by distinguishing between unprotected sex with a committed v. casual partner. Generalizability of results is limited to a few geographical locations and may not apply to men in other areas of the United States. The current study is conducted over the Internet, so it will collect data from a wider geographic cohort. The current study attempts to build on the strengths of these studies and address some of the limitations by assessing for sexual risk practices inside and outside of committed relationships and utilizing the Internet to capture a wider geographic participant base.

### **Internalized Homophobia**

The prevalence of antigay attitudes within western culture frequently results in stigmatization and discrimination of gays and lesbians. Gay men often experience this intolerance in the form of physical violence, familial rejection, social alienation, and discrimination in employment, housing, and civil rights. One potential outcome of this on-going rejection and stigmatization of gay men is the internalization of the prejudice experienced within a homophobic society, commonly referred to as internalized homophobia (Davies, 1996; Isay, 1989; Plummer, 1995). There are a number of definitions of internalized homophobia. Meyer and Dean (1995) define it as, “the gay person’s direction of negative social attitudes toward the self, leading to a devaluation of the self and resultant internal conflicts and poor self-regard.” Locke’s definition is, “the self-hatred that occurs as a result of being a socially stigmatized person.” Internalized homophobia is often

experienced as homo-negative beliefs of inferiority discomfort with one's own homosexual orientation, and negative perceptions of gay peers. These homo-negative self-perceptions are reinforced by negative social attitudes toward and discrimination against gay people (Gonsiorek & Rudolph, 1981). Internalized homophobia has also been defined as the perception that one's homosexuality or same sex attraction is something sinful (Crawford, Zamboni & Soto, 2002). It is also conceptualized as an individual's negative feeling or even as self-hate that results from living in a homophobic society that devalues homosexuals (Rust, 2000).

The concept of internalized homophobia has become widely used in gay research and theory, particularly within gay-affirmative psychotherapeutic models in which internalized homophobia is a central concept often related to mental health issues faced by gay men (Williamson, 2000). Shidlo (1994) argues that internalized homophobia “can be a heuristic construct that organizes factors unique to gay men in the areas of development, psychopathology, psychotherapy, and prevention.” Hudson and Ricketts (1980) used the term “homo-negativism” to characterize the belief and value system of gay men, which evolves from the dominant culture's homophobia or the underlying belief that heterosexuality is the natural, normative, even superior form of sexuality. Plummer (1995) describes the impact of homo-negativism upon the evolving identity of gay males: “the awareness of stigma that surrounds homosexuality leads the experience to become an extremely negative one; shame and secrecy, silence and self-awareness, a strong sense of differentness—and of peculiarity—pervades the consciousness.” Numerous lesbian and

gay social scientists (Cody & Welch, 1997; Williamson, 2000) have argued that internalized homophobia is a major precipitating factor in gay male depression, anxiety, and other emotional disorders.

An array of studies have highlighted relationships between internalized homophobia and a variety of hardships in the lives of gays and lesbians, including suicide (Meyer, 1995), depression, demoralization, anxiety (Otis and Skinner, 1996), substance abuse (Finnegan and Cook, 1984; Glaus, 1988; Meyer and Dean, 1995), high-risk sexual behavior (Ratti, Bakeman, & Peterson, 2000), conflicts in romantic relationships (Friedman, 1991), and defense mechanisms, such as denial, projection, and identification with the aggressor (Margolies et al., 1987).

Almost every theory of gay and lesbian identity development holds as a fundamental assumption that homosexual identities are formed in the context of extreme cultural stigma towards homosexual behavior (Trioden, 1989). In contrast to other members of stigmatized groups, such as ethnic minorities, gay and lesbian children usually do not grow up with parents who share their stigmatized identity, and thus they have neither appropriate gay or lesbian role models nor parental buffers against the often hostile culture (Trioden, 1989). Therefore, long before they develop an awareness of their own same-sex attractions, gay and lesbian children begin to learn all of the popular myths and stereotypes related to homosexuality that are prevalent in society (Malyon, 1982). Widespread homophobic social attitudes begin to have a psychological impact on individuals as they start to label themselves as gay or lesbian (Meyer & Dean, 1998). Upon first recognizing their same-sex attractions, gay and lesbian people may simply feel different and have vague perceptions

that their “differentness” is socially undesirable (Gonsiorek & Rudolph 1981). As the process of self-labeling progresses, learned negative attitudes toward homosexuality may be incorporated formally into an individual’s self-concept. Thus, this process leads inevitably to some degree of internalized homophobia in gay and lesbian people.

### **Internalized Homophobia in African Americans.**

There is very little research on the effects of internalized homophobia on African American men who have sex with men. The little research that has been done suggests that racial-ethnic and sexual minorities may be at a greater risk for internalized homophobia and poor mental health because they encounter a greater stigma from their community and racism from the majority of society (Rotherham-Borus, Hunter & Rosario 1994; Savin-Williams 1996). There is some tolerance or acceptance of homosexuality in African American communities, but this tolerance is based on an unspoken agreement that the gay or bisexual must not disclose or display their sexual identity. (Savin-Williams, 1996). As long as they do not make their lifestyle overtly explicit, gay and bisexual African Americans are marginally accepted within their communities.

Despite the fact that internalized homophobia can lead to negative health outcomes, little is known about how MSM of color manage or cope with their experiences of racism and internalized homophobia. Currently, there are only two major studies that have specifically investigated how Black MSM cope with the stigma associated with race and/or sexuality (Wilson & Miller, 2002; Brown, 2005). Wilson and Miller (2002) conducted qualitative interviews to explore strategies employed by gay and bisexual Black men to manage homophobia. Wilson and Miller operationalize homophobia as the institutionalized

negative beliefs about and systematic discrimination against people who are not heterosexual. They found that gay and bisexual Black men cope with homophobia by changing the image they present to others, relying on faith for emotional comfort, standing up for themselves, or attempting to change their sexual behavior and feelings.

In 2005, Brown studied the various ways African American men identify themselves sexually, and described how internalized homophobia among these men may be shaped. Brown noted that the ability to be open about one's sexual identity is an important component for healthy maturation. In his case study, he analyzed data gathered from surveys given to 110 male respondents about sexual identity and disclosure. Brown found that African American MSM do not feel that they can be open about their identity to their family, partners, and friends. Brown compared African American MSM's fear and reticence about disclosing their sexual identity to that of wearing a mask. Living a double life, or the wearing of the mask, results in the loss of identity and the refusal to identify as being gay. According to Brown, African American MSM often portray hyper-masculinity and sexism in order to escape homophobia from other individuals, act homophobic as a means of being accepted by others, and assume a homophobic mentality by keeping their racial and sexual identity separate. Brown (2005) further examined the divide between African American MSM's sexual identity and their gender identification. He noted in his studies that sexual identification is based on sexual relationships, but the MSM's sexual partner determines his gender identification. To African American MSM, having sex with another man is unrelated to his sexual identity. The reason, according to Brown, appeared to be an attempt to avoid the social stigma in the African American community of being gay.

### **Internalized homophobia and HIV Risk.**

According to Wilson, Kastrinakis, D'Angelo, and Getson, P (1994), African American men who have sex with men, but do not disclose their sexual orientation (non-disclosures), have a high prevalence of HIV infection, nearly three times higher than non-disclosing men who have sex with men of all other races combined. Confirming previous research, the study by Wilson et al. of 5,589 men in six U.S. cities who sleep with men aged 15-19 found that African American MSM were more likely not to disclose their sexual orientation compared with White MSM. HIV-infected non-disclosures were less likely to know their HIV status, and more likely to have had recent female sex partners. The authors postulated that African American non-disclosures might be due to higher levels of internalized homophobia in the African American community, although they did not present any empirical evidence to support the assertion.

Stokes, Vanable, and McKirnan (1996) conducted a study looking at ethnic differences in psychosocial variables and sexual risk practices between African American and White MSM. More than 1,000 participants were surveyed using self-report measures on the following: number of sexual partners, sexual behavior and condom use, internalized homophobia and self-acceptance of being same sex attracted, perceived acceptance of same sex attracted behavior by others, amount of disclosure to others of same sex attracted behavior, involvement in the gay community, perceived norms around same sex sexual activity according to participants' age and ethnicity, perceived vulnerability to HIV, and attitudes toward condom use. The authors looked extensively at the number of sexual partners. The authors included all partners throughout participants' lives, which was further

broken down into the number of monogamous partners, partners who were well known to participants but not steady partners, and casual or anonymous partners. The authors categorized participants who had had male and female partners in the past six months as bisexual, and men who had had sex with a man within six months and no sex with a woman within three years as gay. The results revealed that African American men, compared to White men, tended to be less involved in gay communities, have more internalized homophobia, disclosed same sex attracted behavior to less people, and predicted that less of their peers used condoms when engaging in anal intercourse with other men. White men, compared to African American men, reported a higher number of sexual partners, were more likely to report engaging in receptive anal sex with men, were less likely to report engaging in insertive anal sex with men, and perceived friends and neighbors to be more accepting of same sex attracted behavior. African American participants estimated that 48 percent of African American men were bisexually active at some point in their lives, while White men estimated that 27 percent of White men were bisexually active during their lives. There were no significant ethnic differences regarding self-reported condom use, self-acceptance of being same sex attracted, and perceived acceptance by participants' immediate families of same sex attracted behavior. Analysis also showed that specifically among bisexual participants, involvement in a gay community, self-acceptance of same sex attracted behavior, and perceived acceptance by others of same sex attracted behavior predicted more engagement in receptive anal sex for African American participants, but more engagement in insertive anal sex for White participants. These findings seem to suggest that receptive anal sex might be more associated with male homosexuality in the African American

community, while insertive anal sex with a man may be more associated with homosexuality in the White community. The authors assert that while both of these activities are risky without the use of condoms, receptive anal sex carries a higher risk of HIV transmission than insertive anal sex. Thus, the authors suggest these psychosocial variables might better serve to protect White men who admitted to not using condoms consistently from acquiring HIV. Another finding was that participants with more education, more income, and of full-time employment or student status perceived themselves to be less at risk of acquiring HIV. Although African American men perceived themselves to be at a higher risk for acquiring HIV than White men in the sample, this finding was reversed, with White men perceiving themselves to be at a higher risk for acquiring HIV when education, income, and employment status were controlled.

The researchers did not require that participants identify as gay or bisexual, a criteria maintained in the current study. These findings shed light on the fact that there might be different cultural definitions of homosexuality associated with African American and White identities that encourage different sexual behaviors associated with differing degrees of HIV transmission risk. This observation provides validation for studies that address sexual trends among specific racial groups. Perceived condom norms tended to be higher among White participants.

The Stokes et al study provides descriptive data linking racial and sexual minority identity statuses with sexual risk practices. The findings in the Crawford and Soto study that suggest that more than one in three African American non-disclosures reported having a recent female sex partner also suggests that non-disclosing MSM might have an important

role in HIV transmission to women. To help prevent further HIV transmission among both MSM and their female sex partners, greater efforts are needed to increase public awareness and to develop or expand HIV testing and prevention programs to meet their needs (Jemmott, Jemmott, Fong, & McCaffree (1999). The results of these studies suggests that public-awareness and prevention programs should be developed for non-disclosing MSM to reduce internalized homophobia and other factors that influence non-disclosure, including the risk for transmission to male and female sex partners. Additional studies are also needed to examine the saliency of minority, sexual, and racial identity in order to understand why such links between minority, sexual, and racial identities and sexual risk practices exist.

### **Mental Health**

Studies focused on the mental health of homosexual men have produced convincing results showing increased risks of psychiatric disorders (Meyer, 2003), depression (Nurius, 1983; Snyder, Weinrich, & Pillard, 1994), stress (DiPlacido, 1998; Savin-Williams & Ream, 2003), generalized anxiety disorder (de Vroome, de Wit, Stroebe, Sandfort & van Griensven Sandfort, de Graaf; 2001), panic attacks (Cochran, Sullivan, & Mays, 2003), eating disorders (Beren, 1997), conduct disorder, nicotine dependence, other substance abuse and/or dependence, multiple disorders or co-morbidity of diagnosable disorders (Fergusson, Horwood, & Beautrais, 1999), and suicide attempts (DiPlacido, 1998; Fergusson, Horwood, & Beautrais, 1999). Jorm, Korten, Rodgers, Jacomb, and Christensen (2002) surveyed 4824 adults measuring anxiety, depression, risk of suicide, alcohol misuse, positive and negative affect, and a range of other risk factors for poor mental health. They found that the bisexual group reported the highest levels of anxiety, depression, and negative

effect, and that the homosexual group reported higher outcomes than those of the heterosexual respondents.

In 2006, Cochran and Mays examined correlations between an LGBT identity status and clinical symptoms of psychological distress and substance use disorders within data collected by the CDC (CDC 2000). The data indicated, in general, that individuals who identify as LGBT have a higher rate of clinical depression and substance use disorder symptoms, and that they seek treatment for these symptoms more frequently than others seek. Although gay men were not more likely to have a lifetime history of mood disorder symptoms, they were more at risk for currently experiencing major depression and had significantly more suicide attempts before age 30 than their heterosexual peers. Cochran and Mays' observations suggest that an LGBT identity is correlated with higher psychological distress, broadly defined, than a heterosexual identity.

Discrimination against gay and lesbian people stands as one of the few remaining socially acceptable and institutionally sanctioned forms of prejudice (Vaid, 1995). Varied expressions of society's intolerance of gay and lesbian people have been empirically associated with both mental and physical health problems in these populations (Cole, Kemeny, Taylor, Visscher & Fahey, 1996; D'Augelli, Grossman, Hershberger & O'Connell 2001). One of the destructive consequences of the culture's sentiments is the internalization of those values by gay and lesbian people. This phenomenon has been dubbed "internalized homophobia" by clinicians (Malyon, 1982), and theorists have identified it as a substantial factor impacting the mental health of gay and lesbian individuals (Gonsiorek, & Rudolph 1981; Troiden, 1988, 1989). Previous empirical research has linked internalized

homophobia to low self-esteem and depression (Shidlo, 1994; Waldo, Kegeles, & Hays, 1998), maladaptive coping styles (Nicholson & Long, 1990), and low social support (Turner, Hays, & Coates, 1993).

Two empirical studies of younger gay and bisexual men found that internalized homophobia is positively associated with HIV-related sexual risk taking (Meyer & Dean, 1998), and a qualitative study of African American men who have sex with men yielded similar findings (Stokes & Peterson, 1998). Finally, one empirical study (Herek & Glunt, 1995) found that internalized homophobia was negatively associated with feelings of self-efficacy, for safe sex, for example, how to use a condom, and positively associated with perceptions of interpersonal barriers to engaging in safe sex, for example, believing that suggesting condom-use with a partner might be offensive.

### **Mental Health Among African Americans.**

Consolacion, Russell, and Sue (2004) examined the correlations between multiple minority statuses based on gender, ethnicity, and sexual orientation, and self-report of suicidal thoughts, depression, and self-esteem. They found that many combinations of identity status predicted psychological well-being variables. Among their findings were that African American and Latina young women had more suicidal thoughts than did young men of the same ethnicity. Homosexual African Americans had more suicidal thoughts than did heterosexual African Americans. Overall, homosexual young women had the most suicidal thoughts, but homosexual young men were one and one half times more likely than their heterosexual peers to have suicidal thoughts. Regarding depression, White homosexual young women displayed the most depression, followed by homosexual White young men.

Latina homosexual young women had more depression than did other Latino participants. Heterosexual African American young women and homosexual African American young men displayed more depression than did other African American participants. Results regarding self-esteem were similar to those regarding depression, with White homosexual young women displaying the lowest self-esteem, Latina young women displaying less self-esteem than Latino young men, and heterosexual African American young women and same sex attracted African American young men displaying less self-esteem than other African American participants.

Consolacion and colleague's (2004) study suggests that dealing with multiple minority identities such as gender, sexual orientation, and ethnicity seems to impact psychological well-being. Same sex attracted African American young men displayed more depression and less self esteem than did other African American participants, suggesting that same sex attracted African American men may experience distinct cultural pressures related to the intersections of ethnicity, gender, and sexual orientation, impacting psychological well-being. In contrast, the fact that same sex attracted White young women experienced the highest levels of psychological distress suggests that some same sex attracted people of color may develop resilience and adapt to the stressors associated with negotiating multiple minority identity statuses (Consolacion, Russell, & Sue, 2004). This resiliency among African American MSM is an area that needs further research.

Peterson, Folkman, and Bakeman (1996) conducted a study looking at connections between demographic identity variables and psychological well-being in which they specifically compared HIV status, depressed mood, stress levels, coping methods, and

psychosocial resources between gay, bisexual, and heterosexual African American men. Results indicated that physical symptoms, daily hassles (including financial stressors), negative life events, and a detachment coping style were positively correlated with a depressed mood, and social support was strongly negatively correlated with a depressed mood. Physical health, stress, and psychosocial resources also predicted depressed mood, and social support mediated the impact of high stress and low optimism levels on depression. Sexual orientation and HIV status were not associated with psychological distress.

The Peterson and colleagues (1996) study is important because it suggests that among African American male participants, sexual orientation and HIV status did not predict psychological distress, while daily hassles related to money, optimism, physical symptoms, major life stressors, and social support predicted distress, including depressed mood. This study is useful in that it suggests that social support may be an important buffer from depression for African American men. Even though sexual orientation and HIV status were not found to relate directly to depression in their sample, other authors (Williams et al, 2004) have found evidence suggesting sexual orientation and HIV status may impact social support. Therefore, it is possible that sexual orientation and HIV status could have indirectly influenced participants' levels of psychological distress through social support; further research is needed to examine this source of resiliency.

Wagner, Brondolo, and Rabkin (1996) were interested in the impact of internalized homophobia on psychological distress and coping style in a sample of mostly HIV-positive gay men. They analyzed data from a five-year longitudinal study of self-identified gay men.

Internalized homophobia was shown to contribute to psychological distress at follow up, in addition to baseline psychological distress, stage of HIV illness, and an interaction between internalized homophobia and stage of illness. Internalized homophobia was the strongest predictor of psychological distress at follow up with HIV-positive asymptomatic participants. Wagner and colleagues (1996) study is noteworthy because it examines an important challenge involved in homosexual identity developmental, the factor of coping with internalized homophobia. The study specifically examines the impact of internalized homophobia on psychological well-being. Results of their study imply that homosexuals who have developed effective means with which to cope with internalized homophobia may be psychologically healthier than those who have not. Their results are also important because they specifically apply to a sample of mostly HIV-positive gay men who may experience internalized homophobia differently than other gay men as a result of their HIV status. It is important to explore if these results are applicable to Black MSM.

Crawford, Allison, Zamboni, and Soto (2002) examined associations between ethnic and sexual orientation identity development and psychological well-being among mostly gay and bisexually identified African American men. Crawford and colleagues found that participants with high ethnic and gay identities had less overall psychological distress than marginalized participants. This was characterized by low ethnic and gay identities and less male gender role stress as compared to marginalized and assimilated participants. High ethnic and low gay identities led to higher life satisfaction and self-esteem than did marginalized and separated participants. Low ethnic and high gay identities led to higher HIV prevention self-efficacy than separated participants, and higher social support than

marginalized or assimilated participants. Assimilated participants also had more female sex partners than did separated or integrated participants. The authors also found that higher ethnic identity scores and fewer experiences with racism predicted more life satisfaction. Higher psychological distress levels, higher gay identity scores, and higher life satisfaction levels predicted more sexual risk taking. Interestingly, gay identity and experiences with homophobia did not significantly predict life satisfaction in this sample.

Another study conducted by Crawford and colleagues (2002) examined the negative effects of homophobia on African American gay and bisexual men's life satisfaction, psychosocial functioning, and engagement in risky sexual behaviors. One hundred and seventy four African American gay or bisexual males were recruited in Chicago and Richmond. The respondents were given a questionnaire packet containing the Life Satisfaction Scale, HIV prevention self efficacy scale, Coppersmith Self Esteem Inventory, Social Support questionnaire, Symptoms Checklist, Minority multi-group Ethnic Identity Measure, Schedule of racist events, and Gay Bashing scale. The results of the study indicated that African American gay or bisexual males who possess a positive self-identification towards being an African American and gay reported higher levels of self-esteem. The more African American gay bisexual males are able to integrate and hold positive self-attitudes toward their racial ethnic identities, the more likely they are to value themselves, protect their health, and experience greater levels of personal contentment (Crawford et. al, 2002). These findings provide additional empirical support for the importance of combating homophobia and the self-hatred and internalized homophobia it perpetuates.

African American MSM experience sexuality and identity in complex ways that affect their risk for contracting HIV. African American MSM do not necessarily view coming out and publicly claiming a gay identity as relevant; in fact, many do not believe that same-sex desires and behaviors are an indication that a person is gay, identifying instead as heterosexual (Prachakul, Grant, & Keltner 2007). Often, identity is characterized by ambiguity: men identify with African Americans in terms of history, family, and church, and they connect with gays based on sexual desire.

### **Mental Health and HIV Risk**

The current study seeks to examine associations between internalized homophobia and HIV risk behaviors in a sample of African American MSM. A secondary question to be explored in the current study is the association between internalized homophobia, psychological well-being, demographic characteristics, and HIV risk behaviors in this sample. Two studies have focused specifically on the link between psychological well-being and sexual risk practices among MSM.

Bancroft, Janssen, Strong, and Vukadinovic (2003) explored the relationship between mood and sexual behaviors in gay identified men. They surveyed more than 600 White gay men and found that of the 84 percent who had been tested for HIV, 15 percent reported being HIV positive. The authors assessed for participants' depression and anxiety levels, and physiological levels of sexual inhibition and excitation including erectile responsiveness. They found that although 47 percent of participants experienced a decrease in sexual interest when depressed, 16 percent experienced increased sexual interest. The

authors also interviewed 42 of the participants. Twenty-one percent of interview participants indicated an increased interest in sexual activity when depressed, and 17 percent indicated an increased interest when anxious. One common theme that emerged was a tendency among some interview participants to use sex to seek out intimacy or validation when depressed or stressed. The authors compared these results to a similar study among heterosexual men and noted that during interviews, some gay identified participants, but no heterosexually identified participants, discussed experiencing a decreased concern regarding sexual risk practices when depressed (Bancroft, Janssen, Strong, Carnes, Vukadinovic, & Long, 2003).

Bancroft and colleagues' (2003) results suggest that depression may intensify a sense of fatalism about HIV, which is already experienced by some gay men. It is also interesting that some participants used sex to alleviate depression. This finding is counterintuitive to depressive criteria found in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000), which suggests decreases in sexual desire with depression. This discrepancy may indicate a specific cultural phenomenon among gay and bisexual identified men; further research is necessary to determine if this finding is truly associated with gay male culture and if can be generalized to Black MSM.

De Vroome, de Wit, Stroebe, Sandfort, and van Griensven (1998) also investigated the impact of psychological well-being on sexual risk practices among gay identified men living in Amsterdam. The authors assessed for attitudes, social norms, behavioral control, intention, and risk perception regarding sexual behavior and condom use with a steady and casual partner, as well as depression, at different points in time. They found that HIV

positive men were more likely to restrict sex to their steady partner, less likely to have sex with casual partners, and had less unprotected anal intercourse with steady partners than casual partners. When the authors included oral sex with ejaculation as a sexual risk practice, they found that the numbers increased to 30 percent of HIV-positive men and 50 percent of HIV-negative men admitting to engaging in sexual risk practices with a steady or casual partner. They also found that the positive men were not more or less depressed than the HIV-negative men, but that the overall sample exhibited higher depressive symptoms than the general Dutch population, as measured by a subscale of the Dutch adaptation of the General Health Questionnaire (Goldburge, Gater, Sartorius, Ustun, Piccinelli, Gureje, & Rutter, 1997). HIV-positive men also scored higher than HIV-negative participants on attitudes, social norms, behavioral control, and intention regarding safer sex with a steady partner, while there was no difference between these two groups on these same variables with casual partners.

HIV-negative men showed a reverse pattern, scoring lower on these variables with steady partners, as compared to casual partners. The authors speculated that the results are likely due to HIV-negative men perceiving greater risks and therefore taking more preventative steps against HIV with casual partners, and HIV-positive men worrying more about transmitting HIV to steady partners. Specifically exploring the link between depression and sexual risk practices, the authors found no direct relationship between depression and condom use. However, they found an interaction between HIV status and depression as HIV-positive participants with depressive symptoms had more negative attitudes regarding condom use with a steady partner, lower intentions to use condoms with

a steady partner, less reported behavioral control around using condoms with a steady or casual partner, and more perceived barriers to condom use overall. HIV-negative men with depressive symptoms reported lower behavioral control and intentions to use condoms with a casual partner. De Vroome and colleagues' (1998) study indicated that depressive symptoms may encourage sexual risk practices among some gay men, and do so differently among HIV positive and negative men. Specifically, depression may cause HIV-positive men to be less careful with steady partners, which possibly places their partners at greater risk, while causing HIV-negative men to be less cautious with casual partners. By including oral sex with ejaculation as a sexual risk practice, the authors were able to show that many participants did not take the same precautions to protect themselves from the consequences of unsafe oral sex as they did for unsafe anal sex (de Vroome, de Wit, Stroebe, Sandfort, & van Griensven 1998). It is unknown if these findings generalize to gay men, and in particular, African American MSMs in the United States.

There is not much research done in this area especially with African American MSM. The current study attempts to build on the components of these two studies by exploring whether psychological well-being is associated with sexual risk practices in a sample of African American MSM.

### **Implications for Counselors**

There are multitudes of psychosocial stressors associated with HIV that dramatically affect mental health delivery. It is estimated that most counselors will at some point be presented with clients whose concerns relate to HIV (Hoffman, 1991). The American Counseling Association has underscored the importance of preparing counselors to deal with

this issue in their position statement on AIDS (American Association for Counseling and Development, 2006). Moreover, specific research has found that mental health professionals who have had specific training regarding the HIV disease report feeling more willing and able to treat people experiencing the full range of the disease (Crawford, Humfleet, Ribordy, Ho, & Vickers, 1991; Lawrence, Kelly, Owen, Hogan, & Wilson, 1990). Several surveys have investigated the amount of graduate training mental health practitioners receive related to treating people with HIV. Hunt (1996) surveyed 64 counselor education graduate programs and found that about one-half of these programs offered no training in even basic information about HIV/AIDS. Only approximately 25% of the programs offered a course on HIV/AIDS or at least designated a large section of a course that focused on HIV/AIDS issues. Clearly, the recommendations in the literature (Hoffman, 1991), as well as those of the American Counseling Association, have not yet been implemented nationally, although the need for such services continues to expand.

Hunt (1996) recommended enhancing cultural sensitivity among mental health practitioners when offering preventative treatment efforts with clients with HIV/AIDS. Even more target training will be needed to work with African American men in order to promote disclosure and reduce unsafe sexual practices. Counselors must educate and prepare themselves to address the complex concerns and needs of this population. Hunt recommended that culturally specific educational trainings be offered to counselors and other mental health practitioners working with HIV positive African American men. Counselors must be knowledgeable about the unique factors experienced by this population. In addition, more research needs to be conducted to identify and address the thought process

and behavior patterns of African American men who are HIV positive, including working with the African American community in order to better serve this population (Hunt, 1996).

Although counselors are always encouraged to become culturally competent and sensitive to the concerns of their clients, Smith (2003) found that African American men are hesitant about going to a counselor for assistance because they do not feel that counselors have this sensitivity and competence. Smith also found that in most cases, unless mandated to attend, African American men tended to avoid seeking counseling services (Smith, 2003). Madison, Colmore and Moore (2002) stressed that although there are general issues common to counseling men, the life experiences of African American men are markedly different from that of European American men, who are commonly the referent group traditional counseling programs train counselors to work with. Madison, Colmore and Moore (2002) found that African American men may be apprehensive about counseling for a number of reasons including: (a) fear that the counselor might have negative, preconceived notions about Black men, (b) fear of being misdiagnosed, and (c) fear of being misunderstood or mistreated. Smith pointed out that these fears are compounded if the counselor is White, and that for some African American men, counselors, regardless of color, may be seen as part of the establishment who simply should be avoided. Smith noted that also being socialized in a culture of masculinity might discourage African American men from seeking counseling services. Madison and colleagues believed that three factors should be taken into consideration when counseling African American men: (a) historical hostility, (b) the client's level of self-disclosure, and (c) trust issues (Madison, Colmore & Moore 2002).

Burlew and Serface (2006) conducted a study using a constructivist theoretical framework to examine the cultural experiences of African American gay men. The purpose of Burlew and Serface's study was to address the counseling needs of this population. Based on extensive research, Burlew and Serface underscored the importance of counselors providing affirming and culturally sensitive counseling to this distinct population of men. Counselors must be sensitive to the strategies these men use to construct and deconstruct their identity. Burlew and Serface cautioned that counselors should also be aware that these clients might be uncomfortable talking with them, and not interpret this apprehension as resistance; this apprehension may stem from the client's fear of disclosing their sexual identity and losing their status within the African American community. If the client prefers to remain closeted about his sexual identity, Burlew and Serface recommended that the counselor respect the client's choice and help them deal with the stress and the transition of being a closeted, African American gay man in society.

In a study by Operario, Smith, Arnold, and Kegeles found MSM in their qualitative study expressed anxiety around disclosing sexual behaviors to counselors who might be judgmental or who might use sexual identity language that is inconsistent with how men identify themselves. When asked to provide suggestions for conducting outreach and counseling to African American MSM, respondents preferred counselors with whom they could identify with, a counselor with an understanding of the gender and cultural dynamics in this group and who empathize with their need for secrecy. Respondents remarked on the need for counselors to be frank, honest, and straightforward in their discussion of HIV risk yet also to respect their masculinity and privacy.

One of the main formative findings of this study was that these men tended to compartmentalize MSM activity as a behavior, something they do, rather than an identity, which they are; they avoided placing personal or emotional significance on same-gender sex. Taking this into account, the authors assert that counseling should be focused on participants' sexual episodes with men, including the motivations and triggers of high-risk sexual episodes including emotional states, substance use, and arousal, without placing emphasis on sexual identity. Counseling can also help to address internalized homophobia and attempt to normalize men's same-sex activity in order to reduce feelings of guilt and shame that might contribute to risk-taking behavior. Their formative research also uncovered ambivalent and sometimes hostile attitudes toward women, which might underlie unsafe sexual behavior with women. In response to this finding, counseling can address men's beliefs about masculine and feminine gender roles and encourage personal responsibility to protect oneself and one's partner against HIV and other sexually transmitted infections. Formative research also revealed that unsafe sex among these men often occurs in spontaneous and anonymous encounters. Counseling and role-play exercises can explore how to incorporate brief communication about condoms and status disclosure into spontaneous sex episodes.

Despite clear documentation of HIV risk among African American MSM, few interventions have been developed that consider the social context of HIV for this population (Peterson & Jones, 2009). The Bruthas Project (2010) by Operario, Smith, Arnold, and Kegeles developed the first known HIV prevention intervention to show promising results, utilizing a counseling intervention developed specifically for African American MSM. This

study showed significant reductions in unsafe sexual behaviors with male partners, fewer numbers of unsafe female and male partners overall, and less sex while under the influence of drugs following completion of the intervention. Improvements in psychological well-being—including increased feelings of social support and self-esteem and reduced loneliness—were also observed.

The Bruthas Project is a community-collaborative intervention designed to reduce HIV risk behavior among African American men who have sex with men but who do not form an identity around their same sex behavior. The intervention was developed based on formative qualitative research with members of the population and involved four individualized risk reduction counseling sessions. The counseling sessions were conducted as follows:

During Session 1: counselors provided general HIV prevention risk reduction counseling, including a personal assessment of sexual risk, condom demonstration, and opt-out HIV testing.

During Session 2: counselors and participants explored interpersonal dynamics with female partners that contribute to unsafe sex, including gender norms, communication, and sexual preferences with women; although participants were not explicitly encouraged to disclose same-sex behavior to their female partners, counselors and participants discussed strategies for introducing condom use and safer sex negotiation in their heterosexual partnerships.

During Session 3: counselors and participants explored interpersonal dynamics with male partners that contribute to unsafe sex, including homophobia and HIV-related stigma, communication, and sexual preferences with men; counselors minimized emphasis on sexual

identity or orientation, focusing instead on sex behavior episodes and the social factors that might increase risk-taking behaviors with men.

During Session 4: counselors and participants explored motivations of sexual episodes, particularly spontaneous and anonymous sexual encounters, and engaged in role play exercises to identify triggers for unsafe sex, such as alcohol or drug use, and to practice partner communication and condom use strategies. Each session closed with a discussion of personal risk reduction goals, and each subsequent session opened with a review of previously stated goals.

Because participants included both HIV-positive and HIV negative men, counselors were trained to tailor the counseling topics according to each participant's status. Counseling sessions with HIV-positive men included issues related to sero-status disclosure with sex partners, partner selection based on sero-status, and the use of health and social services for people living with HIV.

The intervention was based on theoretical principles from the information motivation-behavioral skills model of HIV preventive behavior change (Fisher, Fisher, Bryan, & Misovich, 2002) and the AIDS Risk Reduction Model (Catania, Kegeles, & Coates, 1990). Counselors were trained in motivational interviewing counseling skills (Miller & Rollnick, 2002), which include expressing empathy, identifying discrepancies between participants' HIV prevention goals and their actual behaviors, identifying and accommodating participant resistance by meeting them where they are rather than imposing rules, and reinforcing self-efficacy and personal responsibility to change behavior.

Many men who are not open about their sexuality feel they have no one to talk to about their feelings and no support network to rely on if they are rejected from family, friends, or from the church. Battle and Lemelle (2002) found that there is a relationship between shame and internalized homophobia toward gay men that contributes to the African American man's avoidance of social supports and health resources in the community. When Jennings (2006) interviewed a group of HIV-positive, African American gay men about the fact that they did not disclose their sexual feelings to their family, partners, or friends, one of the respondents asked, "Who can we go to [to] say we're having these feelings?" (Jennings, 2006). Properly trained counselors could be a resource for this population to turn to in order to fill the gap that is left void by their family, friends and church.

### **Treatment Approaches**

Researchers are beginning to become aware that the time has come to move beyond what can be learned from traditional public health surveillance and epidemiologic studies that only focus on infection rates, risk behaviors, and attitudes of gay men. Research may better meet the needs of African American MSM by gaining a better understanding of the social influences and interpersonal interactions (Constantine-Simms, 2001; Denizet-Lewis, 2003). Currently, much of the research on HIV risk and risk reduction on African American MSM has been epidemiologic and individual levels of risk. Others areas, such as close and intimate relationships, neighborhood and community ties, sources of social support (Mays & Cochran, 1998; Mays, Cochran, & Zamudio, 2004), definitions of Black MSM masculinity, social inequalities, experiences of discrimination and prejudice, and community expectations and norms (Cheng, 1999; Kurtz, 1999) have been largely ignored.

There is an old debate in public health about whether to focus programs on individuals and the prevention of disease or on the population to improve overall well-being (Bonell, Hickson, Hartley, Keogh & Weatherburn, 2000). Based on the constantly rising rates of HIV in the Black MSM community, there is clearly a need for a two-pronged approach focusing on both the individual as well as the population.

It is important for researchers to recognize that although mainstream society tends to think of homosexuals as homogenous, it is more accurate to view them as diverse populations (Cheng, 1999). African American MSM consists of a diverse group, not just in socioeconomic status, but in the way they define relationships (Cheng, 1999). This manifests as differences in relationships, environments, and access to HIV-related preventions efforts. Research that can help in understanding how these diverse factors impact higher risk environments, vulnerabilities, or reduced access to support for HIV-related risk protection is imperative in designing effective interventions that decrease the rate of new infections in African American MSM. It is equally important to understand how these factors may promote resiliency and protective factors that may act as a buffer in HIV prevention (CDC, 2003; Cochran & Mays, 1994; Mays & Cochran, 2001).

### **Treatment Recommendations**

There is a critical need for data that can help guide the development of evidence-based prevention to meet the needs of the diverse range of African American MSM. Mays, Cochran and Zamudio (2004), leading researchers on Black MSM, have made several recommendations to help inform the direction of intervention design. Their recommendations are targeted at governmental agencies, such as the National Institutes of

Health (NIH), which serves as the government's mechanism for funding investigator-initiated research, and the CDC, which is entrusted with the planning and execution of the HIV/AIDS prevention agenda by the Department of Health and Human Services. They choose to target their recommendation at the federal level because of the nature of how research is funded.

Their recommendations are as followed:

1. A renewed emphasis in the prevention and research agenda of CDC and NIH to examine the role of social, interpersonal, and community contexts in HIV risk-taking behaviors and their possible role in the development of risk reduction.
  - a) While this research should document and differentiate the types of subgroups within the African American population of men who have sex with men, the
  - b) focus needs to be on exploring and explicating the multiplicative and conjoint relationships between these identities, disclosure of sexual orientation, and community context. This will allow for the determination of conditions and needed interventions to increase HIV testing and appropriate disclosure of HIV status.
  - c) Typically, identification of risk behaviors is the focus of investigations.

However, there is a critical need to determine pathways of resiliency in coping with stressors and traumas, to identify stressors specific to sexual orientation and race, and to find methods for addressing those stressors that enhance HIV-related protective behaviors. We suggest strong encouragement of research that identifies the relationship structures and patterns of social interactions of African

American MSM and the avenues for enhancing the risk reducing properties of these relationships.

2. Efforts by the Agency for Healthcare Quality Research and the Substance Abuse and Mental Health Administration to identify, if available, best practice mental health procedures that contribute to enhancing the mental health of African American MSM as part of the HIV prevention agenda.
3. Development of an articulated rationale by CDC and NIH to encourage investigators to include the measurement of sexual orientation and sexual behavior in large
4. national studies or targeted specific studies in large African American populations. African American MSM are deeply embedded in primarily heterosexual communities. General population sampling provides a means of reaching this subpopulation and also will yield important contextual data that can be used for HIV prevention efforts.
5. To encourage this work, we suggest that CDC and the NIH use a variety of mechanisms at their disposal. These possibly include:
  - a) Using existing funding mechanisms to create the above research focus.
  - b) Convening a workshop that applies the expertise of mental health researchers and methodologists to the current set of national mental health studies with the purpose of examining mental health status and needs of African American MSM.
  - c) Identifying datasets and availability of short-term funding for secondary data analyses of research questions that will inform our understanding of the

Black gay male and MSM experience, organizing publication mechanisms with wide distribution, and engaging in translation of the findings to prevention programming.

- d) Convening an outside expert panel of researchers and community leaders to develop a request for applications for secondary data analyses of CDC-collected HIV and STI data with a particular focus on social and interpersonal relationships, identity patterns, sources of support, social networks and structural contexts of African American gay men and MSM. This might include linkages with national and local datasets, such as the Census or Behavioral Risk Factors Surveillance Systems supplements. The goal of the expert panel is to identify domains of analyses most germane to community prevention efforts.
- e) Holding a consensus/brainstorming meeting to identify the HIV-related mental health needs of African American men who have sex with men. Central to this meeting are local prevention planning council members who can help CDC and NIH prioritize objectives and strategies to incorporate into new Requests for Proposals.
- f) Collecting information on sexual orientation and/or same gender sexual behavior along with ethnicity, nationality and country of origin in the large national studies collected by the National Center for Health Statistics and NIH, such as the National Health Interview Survey, or National Household

Survey of Drug Abuse, in order to provide overall health data on African American men who have sex with men (Mays, Cochran & Zamudio, 2004).

In contrast, Jemmott, Jemmott, Fong and McCaffree (1999) targeted their recommendation directly to researchers. Although their recommendations were made in 1999, more than 12 years ago, their recommendations are still relevant today. They conducted a rigorous search of literature, examined research studies, and contacted leading researchers to identify several crucial components for effective HIV prevention programs. Their recommendations are as follows:

1. Culturally sensitive interventions facilitate risk reduction, and future interventions that are aimed toward African-American participants should address homophobia and internalized homophobia among MSM.
2. Interventions focusing on condom use need to be tailored for men and women in order to achieve the optimal benefit for both genders.
3. Skills training produces yields positive reductions in HIV risk behavior in African Americans, and should be included in future interventions. This includes practical skills training, such as the correct use of a condom, but also encompasses techniques such as improving communication skills regarding negotiating safer sex practices.
4. Interventions should be theoretically based, and programs that have been grounded in cognitive-behavioral theory have produced the most consistent positive results.
5. Interventions should be designed with more than one session (but not necessarily more time), as they positively influence behavior change. Although this might

6. appear less cost-effective on the surface, it will improve the likelihood that behavior change will be maintained over longer periods.
7. Interventions should incorporate "booster sessions" into their design in order to prolong behavior change achieved in the short-term time following an intervention. Positive behavior changes that are observed following an intervention often disappear after several months. Booster sessions can prevent the recurrence of high-risk behavior.
8. Peer educators often have the same degree of efficacy as trained health educators. Thus, using peer educators increases the likelihood of maintaining the integrity and effectiveness of interventions delivered by community based organizations. This would increase the cost-effectiveness of translating some of the interventions from research to the community.

These recommendations provide a framework for obtaining needed insights into the diversity of African American MSM, understanding how each group varies in their risk environments, and identifying the support they need for maintaining an HIV negative status. In order to effectively research and understand the complex, multi layered, intimate, and often coded behaviors of this stigmatized group, researchers must develop both an appreciation for the behaviors uncovered and a commitment to developing appropriate, effective, and sensitive interventions.

### **Effects of the Approaches**

The mainstream HIV prevention model is a broad-brushed attempt based on how things worked in other communities. It has not been and is not effective for African

American populations. When prevention models were designed and training was developed on how to provide HIV/AIDS related services, the white gay community was where everyone, including African Americans, went to learn how to do “AIDS work” (Tewksbury & Moore, 1997). African Americans, primarily gay-identified homosexuals, also faced rampant death rates, in addition to a frustrating history of silence and ridicule. Emulating white gays, they attempted to create an African American gay movement as the template to create AIDS services for African Americans. While the White gay community service and training models were eagerly adopted, the concepts of cultural affirmation, pride, and activism, so crucial to the gay community’s success, were not carried over or implemented. This set the pace for how HIV services were delivered and proved alienating to many at risk and HIV positive peoples in African American communities. Many African Americans who are homosexuals or bisexual do not identify as gay or as members of the gay movement (Stokes & Peterson, 1998).

In 1996, the Centers for Disease Control and Prevention developed and implemented HIV prevention programs targeted at African Americans gay and bisexual men ages 15 to 25. They wanted to help fund organizations that needed HIV prevention services the most (CDC,2000). Most of the HIV prevention programs were held in gay bars or other gay identified venues, rendering them useless. An effective approach to decreasing the HIV/AIDS epidemic in African American communities must acknowledge and affirm the diversity of the communities and the diversity of the epidemic (heterosexual, homosexual, male, female, youth, religious, nonreligious) African Americans must be a central aspect of

how HIV/AIDS services are provided to the community (Fong, Jemmott, & Jemmott, 1999). Funding or declaring a state of emergency alone without reconstructing traditional models of service for African Americans will create a multimillion-dollar public health disaster and do little to address the real problem.

As we enter the third decade of the AIDS epidemic, the African American community continues to be at an increased risk for HIV infection. This review demonstrates how important it is to understand the effects of internalized homophobia on African American MSM, the call for culturally sensitive counselors, and the need for African American churches to get involved. Funding, designing, and implementing intervention specifically targeting African American men who have sex with men should be an immediate priority.

### **Summary**

In surveying, the literature there are a few glaring gaps:

- 1) There are not enough studies focused on examining the socio-cultural predictors of HIV risks among Black MSM. There is also limited data on the influence of racism, homophobia, religion, or dual minority status on HIV risks in black MSM. In addition, few studies identify resiliency factors. Greater research emphasis must be placed on identifying factors that may inhibit high-risk behaviors; a few that have been identified in this review are connectedness to community, spirituality, and racial identity. Researchers need to find ways to incorporate these factors into HIV prevention interventions that either encourage or sustain preventive behaviors.

2) Currently there is a lack of social network interventions targeting black MSM.

Capitalizing on the social and sexual networks of MSM, rather than other recruitment methods, may reach non-gay identified MSM, more MSM with unrecognized HIV infection, and more MSM who engage in sexual risk behavior. Internet-based sexual networks of black MSM must also be explored for both recruitment and interventions.

3) Finally, there is a lack of structural interventions. Structural issues that affect black MSM include low economic status, high incarceration rates, and limited access to antiretroviral therapy. Interventions are needed to assist in gaining and maintaining employment and access trainings and other resources for advancement opportunities. With respect to incarceration, because African American men have such a high incarceration rate, interventions offered to black MSM while in prison may affect their HIV risk behaviors before and after release. Structural interventions that promote improved healthcare delivery and address the effects of negative attitudes of health providers, which may inhibit black MSM from seeking appropriate healthcare, are needed.

The current study seeks to help address the gaps and add to the literature focused on African American MSM. It is important to emphasize that even if these identified gaps in intervention research are addressed, HIV prevention interventions effective in one black MSM community may not be directly transferable to another black MSM community. Success in altering the current patterns and rates of HIV infection in African American

MSM rests on the ability of researchers, mental health providers, policy makers and community leaders to work together to create a conceptual frameworks that is employed in the collection and interpretation of data, as well as in the design and implementation of programs and policies designed specifically with the unique needs of African American MSM.

## **CHAPTER III**

### **METHOD**

This chapter describes the methods used in the research. The purpose of this study was to: (a) assess internalized homophobia in Black men who have sex with men; and (b) analyze the effect of internalized homophobia on HIV risk behaviors. Specifically, this study investigated how the variables of internalized homophobia, sexual identity, and mental health, as well as selected demographic variables, predicted the HIV risk behaviors of Black men who have sex with men. The methods chapter includes discussion of the research questions, research design, instrumentation, recruitment procedures, and the data analysis utilized in this study.

#### **Research Questions**

The quantitative, descriptive survey design of the study utilized an anonymous, Internet-based, self-report survey administered to Black men to determine if there are relationships between the variables to answer the following questions:

- 1) What is the relationship between age, relationship status, religiosity and internalized homophobia in Black MSM?
- 2) Is there a difference in internalized homophobia for HIV positive, HIV negative, and Unknown HIV status Black MSM?
- 3) What is the relationship between internalized homophobia and HIV risk behaviors in Black MSM?
- 4) What is the relationship between internalized homophobia and sexual identity in Black MSM?

5) What is the relationship between internalized homophobia and mental health in Black MSM?

Table 1 depicts research question, hypothesis, instrument, and type of analysis used for each research question.

Table 1

*Research question, Hypothesis, Instrument, and Type of analysis used for the study.*

Question	Hypothesis	Instrument	Type of Analysis
What is the relationship between age, relationship status, religiosity and internalized homophobia in Black MSM?	<p>a. There is no relationship between age and homophobia in Black MSM.</p> <p>b. There is a positive relationship between religiosity and internalized homophobia in Black MSM.</p> <p>c. There is a positive relationship between relationship status and internalized homophobia in Black MSM.</p>	Internalized Homo Negativity Inventory Demographic Questionnaire	A multiple linear regression was conducted on the independent variables of age, relationship status, and religiosity and the dependent variable of internalized homophobia.

Table 1 Continued

<p>Is there a difference in internalized homophobia for HIV positive, HIV negative, and Unknown HIV status Black MSM?</p>	<p>HIV positive and Unknown HIV status Black MSM will have higher internalized homophobia than HIV negative Black MSM.</p>	<p>Internalized Homo-Negativity Inventory. HIV Risk Behaviors Questionnaire</p>	<p>A one way ANOVA was conducted on the independent variable HIV status (positive, negative, or unknown) by the dependent variable internalized homophobia. The assumption of normality was assessed by examining skew and kurtosis. Post-hoc pairwise comparisons were conducted to determine differences between each status group.</p>
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Table 1 continued

<p>What is the relationship between internalized homophobia and HIV risk behaviors in Black MSM?</p>	<p>There is a positive relationship between internalized homophobia and HIV risk behaviors.</p>	<p>Internalized Homo Negativity Inventory HIV Risk Behaviors Questionnaire</p>	<p>Logistic regression was conducted to determine the relationship between internalized homophobia and HIV risk behavior when controlling for age, income, education level, relationship status, religiosity, and HIV status.</p>
<p>What is the relationship between internalized homophobia and sexual identity in Black MSM?</p>	<p>Black MSM who identify as heterosexual, straight, or other will report higher internalized homophobia than Black MSM who self identify as homosexual, gay, or queer.</p>	<p>Homo Negativity Inventory HIV Risk Behaviors Questionnaire</p>	<p>A point-biserial correlation was conducted to determine the relationship between internalized homophobia and sexual identity in Black MSM.</p>

Table 1 continued

<p>What is the relationship between internalized homophobia and mental health in Black MSM?</p>	<p>There is a negative relationship between internalized homophobia and mental health.</p>	<p>Homo Negativity Inventory HIV Risk Behaviors Questionnaire Rosenberg Self Esteem Scale Center for Epidemiologic Studies</p>	<p>Two Pearson correlations were conducted to determine the relationship between internalized homophobia and mental health.</p>
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### Research Design

Researchers advise that when considering the type of research methodology to use (quantitative versus qualitative), there should be a match between the problem and the approach. More specifically, a quantitative approach is preferred when researching factors that influence an outcome or understanding the best predictors of an outcome (Creswell & Miller, 2000). For this study, a quantitative approach was utilized to study the effects of internalized homophobia on HIV risk behaviors in a sample of Black MSM. The variables of interest were explored with a Web-based survey design. A survey design is used when the researcher wants to obtain a description of attitudes, trends, opinions, or behaviors of a population based upon a sample of that population (Creswell & Miller, 2000). In general, surveys offer several advantages to the researcher, including cost-effectiveness, efficiency, and ease of replication. Web-based surveys offer these advantages as well as rapid data

collection and ease of data entry (Granello & Wheaton, 2004; Kaplowitz, Hadlock, & Levine, 2004); the respondent is not pressed for time in completing the survey (Daley, McDermott, Brown, & Kittleson, 2003); and ease of follow-up and confidentiality (Rea & Parker, 2005; Schonlau, Fricker, & Elliot, 2002). Additionally, Web-based surveys can provide anonymity to the respondent. Daley McDermott, Brown and Kittleson (2003) state that Web surveys offer a sense of social distance that may allow the respondent to be more honest and self-disclosing. This unique characteristic of web-based surveys is an important consideration when studying sensitive issues such as sexual behavior in gay men. This was even more imperative with this population of Black MSM, many of whom often operate in secrecy. Some researchers have recommended using a Web-based survey when surveys contain questions of a sensitive nature to counter the social desirability effect (Kittleson, 1995; Schonlau et al., 2002).

Special consideration should be taken when utilizing the Internet to record and transfer sensitive information. The researcher needs to incorporate specific measures to assure confidentiality and anonymity. In order to address this issue and anticipate participant concerns about confidentiality and anonymity, the Web-survey for this study used the data encryption technology known as Secure Sockets Layer (SSL) to encode participants' responses. An online Web survey company, Qualtrics, was used to create the survey and store data. Qualtrics also provided firewall technology to further protect the data from unauthorized access. Additionally, Qualtrics used a filter that prevented the recording of the participants' IP computer addresses. The researcher did not collect any identifying information, such as the subject's name, address, email address, phone number, or social

security number. The survey was given a specific Uniform Resource Locator (URL), which was then provided to potential participants. The participants' responses were encoded using SSL technology and stored to a private database. The researcher had access to the data using a login and password, which prevented unauthorized access.

Although there are many advantages to a Web survey design, researchers should be aware of the disadvantages. Some respondents may lack computer skills that could interfere with completing the survey. This could cause a sampling bias, essentially limiting study participants to those who are either computer literate or have access to email and the Internet (Daley et al., 2003; Granello & Wheaton, 2004; Schonlau et al., 2002). Frequently, respondents either fail to complete the survey or abandon the survey altogether. However, Solomon (2001) discovered that personalized cover letters and follow-up reminders have been shown to improve response rates. Due to the sampling method for this study and concern with anonymity, it was not possible to address the concern regarding response rates by sending follow-up reminders or personalized cover letters.

Given the population targeted for this research study, the advantages of using a Web-based survey outweighed the disadvantages. Participant anonymity was of high concern because the study collected data on sexual behaviors of a highly stigmatized population. In addition, the population of Black MSM the researcher intended to reach is often not open about their sexual behaviors, making them unreachable by other means. The researcher hoped the Web-based design countered the social desirability effect inherent in collecting data on sensitive issues by allowing participants the opportunity to be more honest and self-disclosing.

**Beta testing.**

Before data collection began, the survey was beta tested to obtain feedback about the clarity and sensitivity of the questionnaire designed by the researcher. Thirty five experienced researchers and clinicians who worked with the targeted population, some whom may also have been members of the targeted population, provided feedback on study procedures. Persons who assisted with beta testing were prohibited from participating in the actual survey. The feedback from the beta testing was used to revise and refine the language in the questionnaire to make it more understandable and palatable to the study population. Questions that were considered offensive or confusing were removed from the final survey. Guidance was also provided on the best places to post the survey in order to reach the targeted population.

**Participants**

Participants were 202 Black men who reported sex with a male in the prior 12 months. Participants ranged in age from eighteen to sixty five. Participants were recruited via the Internet over a two-week period in January 2012.

**Sampling Procedure**

To reach individuals from diverse geographical regions and personal backgrounds, advertisements were placed on the Internet to recruit participants nationally (see appendix C). A convenience sample was drawn from several sources including Web sites, list serves, and social networking sites. In order to increase the likelihood of recruiting males who were not open about their sexuality, the advertisement targeted all Black men regardless of sexual orientation. Five hundred and four people responded to the survey over a two-week period;

only the results of participants who reported sex with a male in the previous 12 months were analyzed.

### **Facebook.com Web site**

Participants were primarily recruited from Facebook utilizing a snowballing technique. Facebook is a social utility Web site used by individuals for socializing and maintaining contact with family and friends. The recruitment ad and a link to the survey were posted on the author's page. The author asked friends, family, colleagues, and others to post the ad on their pages and request that those friends post it to their pages. The ad was also placed on the Facebook pages of user groups designed to reach the target audience of Black men. Individuals who elected to participate in the study clicked on the recruitment ad and were directed to the online survey.

### **Sampling Size**

In determining the number of cases required for the study, Eng (2003) suggested a sample size equation when comparing two means. For this research study, the standard values for power of .80 and criterion significance of .05 were used. For the purpose of conducting a power analysis, we proposed a two level categorization of the primary independent variable, internalized homophobia, with subjects equally distributed between the two categories. For binary outcomes, such presence/absence of HIV risk behavior, and population rates of 40% v. 60% between the two independent variable groups, the power to reject the null hypothesis of no between group differences is 80%. For continuous outcomes and population mean differences of 0.4 standard deviations (small to medium as defined by

Cohen), the power to reject the null hypothesis of no between group differences is also 80%. These figures are based on two tailed tests and  $\alpha=0.05$ .

### **Inclusion and Exclusion Criteria.**

The targeted population for this study was Black men who self- report having sex with men. No one under the age of 18 was allowed to participate in the study. All of the survey materials were written in English, therefore limiting the survey pool to English speakers.

### **Informed Consent**

The informed consent form provided a brief background of the study, a description of the procedures, a discussion of confidentiality, an emphasis on the voluntary nature of the study, and a brief summary of ethical considerations. This form was the first page of the Internet survey. An affirmative response of YES was required to continue to subsequent pages of the study. If a respondent answered NO, they were taken to the final page of the study, and thanked for their time. At the end of the survey, participants who completed the survey were given the option to enter a drawing for a \$100.00 Visa check card. If the participant chose to participate, he followed a link to another survey that collected his contact information. There was no link between the participant's answers and his contact information. The information was kept by Qualtrics secure technology. The researcher only had access to the information for the winning participants in order to mail the gift card. All identifying information was deleted after the winner was selected.

## **Instrumentation**

The survey instrument was constructed using principles of Web-based survey design from Dillman's (2007) Tailored Design Method (TDM). The TDM utilizes principles of social exchange theory to help improve survey response rates. Elements of the TDM used in designing this survey were the strategic ordering of the survey questions, explicit instructions for each section, utilizing jargon familiar to the participants to avoid confusion and increase response rate, use of positive regard in the recruitment statement, providing clear and simple response choices, and labeling each Web page with a progress bar at the bottom of the page. The survey instrument was designed to collect data in four areas: internalized homophobia, mental health (self-esteem and depression), HIV risk behaviors, and participant demographics.

## **Demographic Questionnaire**

Information was collected regarding the participant's age, sex, race, geographic location, religiosity, education level, sexual orientation, experience with mental health services, and income. The demographic questionnaire was used to identify relationships between demographic characteristics, internalized homophobia, mental health, and HIV risk behaviors. The demographic questionnaire is included in appendix B.

## **Internalized Homophobia Scale**

The Internalized Homo Negativity Inventory (IHNI) is a measurement of global homo-negativity and personal homo-negativity. According to Mayfield (2001), global homo-negativity refers to the attitudes that gay men have toward homosexuality in general, such as their beliefs about homosexuality's normality, morality, and potential for fulfillment.

Personal homo-negativity represents the attitudes that gay men possess about their own homosexual feelings, desires, and behaviors, such as the self-directed attitudes in response to sexual attraction to men and intimate relationships with men. The IHNI consists of 23 Likert-type items that use a six-point scale (1=strongly disagree, six=strongly agree), where higher scores suggest greater internalized homo-negativity. These 23 items are subdivided into three subscales: (a) Personal Homo-negativity: “I have tried to stop being attracted to men in general”; (b) Gay Affirmation: “I am thankful for my sexual orientation”; and (c) Morality of Homosexuality: “In general, I believe that sexual minority men are more immoral than straight men.”

Personal homo-negativity consists of 11 items and refers to the negative emotions, such as shame and depression, and negative attitudes, such as resenting one's sexual orientation and wanting to control same-sex attractions. Mayfield (2001) found that coefficient alphas for each of the subscales were .70 or above, and that the coefficient or Cronbach alpha for the entire instrument was .91. Moreover, all of the subscales were significantly positively correlated.

The IHNI was adapted for use among Black MSM by Graham, Aronson, Stephens, and Rhodes (2011) because it was originally validated on gay men primarily of European descent. Graham and colleagues adapted the IHNI to Black MSM by consulting a panel of experts who assessed translation validity by examining face and content validity of items in the three subscales (personal homo-negativity, gay affirmation, and morality of homosexuality). Language referencing homosexual and gay behavior was broadened to encompass a wider range of behavior and identity, and two items were added to the personal

homo-negativity subscale: “I feel ashamed when I see or am around other sexual minority men who are obviously homo/bisexual or who are acting gay” and “I believe homo/bisexual men are weak.” The authors report that principal axis factor analysis with varimax rotation suggested deletion of 8 items (four from the first subscale, three from the second, and one from the third). The original tool and the modified tool were highly correlated with an  $r = .96$ , which established convergent validity. Factor analysis revealed a slightly better performance of the altered IHNI as compared to the original in their sample. Cronbach’s alphas for the adapted 17 item IHNI used in Graham et.al study were total—  $\alpha = .97$ , Factor 1— $\alpha = .95$ , Factor 2— $\alpha = .91$ , Factor 3—  $\alpha = .89$  (Graham, Aronson, Stephens, & Rhodes, 2011).

The IHNI was used in this study for several reasons: the scale provided easy self-administration and the Likert-type responses were consistent with other measures within the study. The instrument demonstrated robust internal consistency, with coefficient alphas of .70 or greater for each of the subscales. Moreover, the IHNI demonstrated strong convergent, discriminant, and construct validity. In addition to the empirical strength of this instrument, the IHNI possessed strong content validity.

### **HIV Risk Behaviors Questionnaire.**

The sexual behaviors questionnaire was specifically designed by the researcher for this study. The questionnaire consisted of 19 questions such as “In the past 12 months have you had oral sex (sex in the mouth) vaginal sex (sex in the vagina), or anal sex (sex in the butt) with a female?” or “In the past 12 months have you had oral sex (sex in the mouth) anal sex (sex in the butt) with a male where you were either the giver or receiver?”

Questions were developed utilizing suggestions for survey questionnaire design from Dillman's (2007) Tailored Design Method (TDM). An important component of the sexual behavior questionnaire was designing questions that were easy for participants to understand, thereby assuring that participants gave an accurate response about their sexual behavior. Technical phrases such as "anally insertive or intercourse" were avoided and more informal terms such as 'sex' or 'sex in the butt' were used to adhere to the TDM model's suggestion to use familiar jargon to the population being surveyed. The sexual behaviors questionnaire was also designed to measure the number of sexual partners both male and female and the number of times the participant engaged in vaginal and anal sex with male and female partners. In addition, questions were asked about relationship status, sex of partner, and monogamy status. Another important component was condom use. Participants were asked about condom use with both male and female partners, including both vaginal and anal sex. HIV status and testing history were also assessed.

### **Outness Inventory.**

The Outness Inventory (OI) (Mohr & Fassinger, 2000) is an 11 item self-report measure of the degree to which individuals are open about their sexual orientation within different relationships throughout their lives. Responses on the OI utilize a 7-point Likert type scale to indicate the degree to which respondents' sexual orientation is known and discussed within various relationships (mother, father, and peers). The Likert scale ranges from 1 (person definitely does not know about your sexual orientation status) to 7 (person definitely knows about your sexual orientation status, and it is openly talked about). Higher

scores indicate greater outness of sexual orientation. However, similar to the IHP, the instrument potentially excludes those individuals who self-identify as straight. Therefore, the instructions are altered to focus on behavior. The items are rated categorically and describe three indices of outness, which include out to family, out to world, and out in religious relationships. Psychometric data have displayed internal consistency: Out to Family (.74), Out to World (.79), and Out to Religion (.97) (Mohr & Fassinger, 2000; 2003), and Global Outness (.87) (Balsam & Mohr, 2007). This scale has not been validated specifically with Black MSM, but the author chose to include it due to the lack of available data on this construct.

### **Self Esteem Scale.**

The Rosenberg Self Esteem Scale (1978) is a global measure self-esteem. This scale has been a vital part of self-esteem measure in social science research and has been used to examine a variety of populations. The scale is a validated measure of self-esteem containing 10 items whose responses are captured using a 5-point Likert scale with responses ranging from 0 (strongly disagree) to 4 (strongly agree). The negatively worded items are reversed scored and then item values are summed scored. The higher the score, the higher the measured level of self-esteem (Rosenberg, 1978). Psychometric data displayed internal consistency of 0.77; minimum Coefficient of reproducibility is at least 0.90. A varied selection of independent studies each using such samples as parents, African Americans, men, high school students, and civil servants showed alpha coefficients ranging from 0.72 to 0.87. This scale has not been validated specifically for Black MSM, but the author chose to use the scale because it has been widely accepted and used for a variety of populations.

## **Depression Questionnaire**

The Center for Epidemiologic Studies (Radloff, 1977) 12-item questionnaire was used to measure depressed mood. The CESD assesses symptoms of depressed mood that have occurred over the past week. The 20-item CESD has been used as a screening measure of depressed mood (McQuaid, Stein, McCahill, Laffaye, & Ramel, 2000; Munoz, McQuaid, Gonzalez, Dimas, & Rosales, 1999). The 12-item CESD, although less frequently reported, was used in a study comparing depression symptoms among African Americans, Mexican Americans, and Caucasians (Roberts & Sobhan, 1992). The 12-item CESD measure was administered to African American adolescents ages 12 to 17 years who participated in the National Household Survey on Drug Abuse in 1985 (National Institute on Drug Abuse, 1994). Furthermore, a study comparing the 20-item CESD with multiple shortened forms found that “the briefer forms measure the same symptom dimensions as does the original CESD” with little reduction in precision as indicated by reliability statistics (Kohout, Berkman, Evans, & Cornoni-Huntley, 1993).

The alpha coefficient for the National Household Survey on Drug Abuse (1985) for the African American sample was 0.77, indicating good internal consistency reliability. Another study using the 12-item CESD reported an alpha coefficient of 0.70 for the African American sample (Roberts & Sobhan, 1992). CESD yields a summary score, which ranged from 0 to 33 for the NSAL sample. The summary score represents the number of current depression symptoms endorsed with higher values coinciding with more reported depression symptoms.

## **Data Analysis**

As the data was collected, it was coded and entered into a database in SPSS. Frequencies and percentages were calculated for age, income, education, relationship status, religiosity, HIV testing, HIV status, HIV risk behaviors, and results of the Outness Inventory. An exploratory factor analysis (EFA) on the Internalized Homo-Negativity Inventory was conducted to determine the strength of the relationship between each factor and each observed measure. The EFA revealed only 1 factor, and thus 1 factor was used for the rest of the analyses.

For research question 1, a multiple linear regression was chosen to determine the relationship between the dependent and multiple independent variables. A multiple linear regression was conducted on the independent variables age, relationship status, and religiosity to predict the dependent variable internalized homophobia. An ANOVA was conducted to compare the means for research question 2. More specifically, a one-way ANOVA was conducted on the independent variable HIV status (positive, negative, or unknown) by the dependent variable internalized homophobia.

Logistic regression was used for prediction of the probability of occurrence of an event; this analysis was used for question 3. Logistic regression was conducted to assess if internalized homophobia predicted engaging in HIV risk behavior while controlling for age, income, education level, relationship status, religiosity, and HIV status. HIV risk behaviors were defined as multiple sexual partners (more than 1 partner in the past 12 months) and inconsistent condom use (less than always using condoms).

A point-biserial correlation is best used when there are dichotomous variables; therefore, it was used for research question 4. A point-biserial correlation was conducted to assess if there was a relationship between sexuality and internalized homophobia. Sexuality was coded as 0 if the participant only thought of himself as straight or heterosexual and 1 if the participant thought of himself as any of the other answer choices (i.e., gay, homosexual, queer, etc). A Pearson correlation is a measure of the correlation between two variables and measures the strength of linear dependence between two variables. In order to assess research question 5, two Pearson correlations were conducted to assess if there was a relationship between internalized homophobia and depression and self-esteem.

### **Summary**

Chapter three provided a description of the methodology that was used to conduct the study, including specific information on Web-based survey design, sampling procedure, data collection, instrumentation, research questions, and analysis. The Web-based survey instrument was used to: (a) assess internalized homophobia in Black men who have sex with men; and (b) analyze the effect of internalized homophobia on HIV risk behaviors. This chapter detailed the survey instruments that were used, how the researcher recruited the study participants, and how the data was collected. This chapter also discussed how the research questions were analyzed utilizing various analyses.

## CHAPTER IV

### FINDINGS

#### Descriptive Statistics

Two hundred and two participants took part in this study. The largest age group was 18 - 24 (39.8%) and the largest income group was \$40,000- \$49,000 (38, 19.5%). The majority had at least a four-year college degree (102, 52.8%). Most of the participants were not in a monogamous relationship (109, 54.0%). Most participants (73, 50.7%) considered religion to be very important and 72 (50%) participants felt their religion rejects same sex relationships. One-hundred fifty-five participants tested for HIV (76.7%) and 93 results were negative (46.5%). Most of the participants (78, 83.9%) in a monogamous relationship had a male partner as their monogamous partner. A participant was deemed as engaging in HIV risk behaviors if they had multiple partners and they reported inconsistent condom use during any type of sex. The majority (136, 67.3%) of participants engaged in HIV risk behaviors.

Most of the participants have visited a mental health practitioner (100, 51.3%). Of those that did visit one, most did not have their needs met (65, 65.0%) but would consider visiting one in the future (59, 59.0%). Of those that had not visited one, most were not open to receiving one in the future (49, 51.6%). Frequencies and percentage for participant demographics are presented in Table 2.

Table 2

*Frequencies and Percentages for Demographic Variables and Research Characteristics*

Age	<i>n</i>	%
Under 18	46	22.9
18-24	80	39.8
25-34	63	31.3
35+	12	6.0
<b>Income</b>		
Under 9,000	18	9.2
10,000-19,000	20	10.3
20,000-29,000	15	7.7
30,000-39,000	22	11.3
40,000-49,000	38	19.5
50,000-59,000	25	12.8
60,000-69,000	33	16.9
Over 70,000	24	12.3
<b>Education</b>		
Less than High School	5	2.6
High School/GED	29	14.9
Some College	32	16.4
2-year College Degree	26	13.3

Table 2 Continued

4-year College Degree	50	25.6
Master's Degree	46	23.6
Doctoral Degree	5	2.6
Professional Degree (JD, MD)	2	1.0
Relationship status		
Yes/Committed	93	46.0
No/Not committed	109	54.0
Religiosity		
Very important	73	50.7
Somewhat important	46	31.9
Not very important	9	6.3
Not important at all	16	11.1
Church views on homosexuality		
Welcomes	27	18.8
Tolerates	31	21.5
Rejects	72	50.0
Don't know	14	9.7
HIV testing		
Yes	155	77.5
No/Unsure	45	22.5

Table 2 Continued

HIV status		
Positive	42	21.0
Negative	93	46.5
Unknown	65	32.5
Gender (of monogamous partner)		
Male	78	83.9
Female	15	16.1
Had female partner		
No	156	77.2
Yes	46	22.8
HIV risk behavior		
No	66	32.7
Yes	136	67.3
Visited mental health practitioner		
Yes	100	51.3
No	95	48.7
Open to receiving one		
Yes	46	48.4
No	49	51.6
Needs were met		

Table 2 Continued

Yes	35	35.0
No	65	65.0
Consider visiting one in the future		
Yes	59	59.0
No	41	41.0

Table 3

*Breakdown of participants who engage in HIV risk behaviors*

Risk breakdown		<i>n</i>	%
Multiple partners			
<b>Yes</b>		<b>109</b>	<b>54.0</b>
No		93	46
Sex with female			
No		156	77.2
Yes		46	22.8
Use a condom always or most of the time: vaginal sex			
	Yes	4	8.7
	<b>No</b>	<b>42</b>	<b>91.3</b>
Use a condom always or most of the time: anal sex			
	Yes	6	13.0

Table 3 Continued

	<b>No</b>	<b>40</b>	<b>87.0</b>
Sex with male			
No		0	0.0
Yes		202	100.0
Use a condom always or most of the time: anal sex			
	Yes	72	35.6
	<b>No</b>	<b>130</b>	<b>64.4</b>

*Note.* Responses in bold represent “HIV risk behavior.”

Participants were asked how open they were about their sexual orientation to different people. Responses could range from 1 = person definitely does NOT know about his sexual orientation with other men to 7 = person knows about his sexual activity with other men, and it is OPENLY talked about. Of all of the people connected to the participants, new straight/heterosexual friends represented the largest group associated with “knows, openly talked about sexual activity with men” responses (101, 51.5%) followed by work peers (100, 51.3%) and siblings (95, 51.1%). The people connected to the participants that had the highest number of “definitely does NOT know” responses was religious community leaders (95, 60.1%), followed by religious community members (92, 59.0%). Frequencies and percentages for the responses are presented in Table 4.

All of the questions from the Outness Inventory were averaged together to create an Outness score. The average Outness was 4.30 ( $SD = 2.45$ ), which suggests, on average,

participants selected “probably knows, rarely talked about” as it relates to Outness to Different People in their lives. The means and standard deviations are displayed in Table 5.

Table 4

*Outness Inventory*

Person	<i>n</i>	%
<b>Mother</b>		
Definitely does not know	54	27.7
Might know, never talked about	8	4.1
Probably knows, never talked about	9	4.6
Probably knows, rarely talked about	4	2.1
Knows, rarely talked about	9	4.6
Knows, sometimes talked about	16	8.2
Knows, openly talked about	95	48.7
<b>Father</b>		
Definitely does not know	67	35.6
Might know, never talked about	20	10.6
Probably knows, never talked about	16	8.5
Probably knows, rarely talked about	2	1.1
Knows, rarely talked about	27	14.4
Knows, sometimes talked about	7	3.7
Knows, openly talked about	49	26.1

Table 4 Continued

Siblings			
	Definitely does not know	51	27.4
	Might know, never talked about	10	5.4
	Probably knows, never talked about	4	2.2
	Probably knows, rarely talked about	4	2.2
	Knows, rarely talked about	9	4.8
	Knows, sometimes talked about	13	7.0
	Knows, openly talked about	95	51.1
Extended family/relatives			
	Definitely does not know	54	27.8
	Might know, never talked about	13	6.7
	Probably knows, never talked about	16	8.2
	Probably knows, rarely talked about	5	2.6
	Knows, rarely talked about	6	3.1
	Knows, sometimes talked about	16	8.2
	Knows, openly talked about	84	43.3
New straight/heterosexual friends			
	Definitely does not know	58	29.6
	Might know, never talked about	8	4.1
	Probably knows, never talked about	3	1.5

Table 4 Continued

	Probably knows, rarely talked about	7	3.6
	Knows, rarely talked about	2	1.0
	Knows, sometimes talked about	17	8.7
	Knows, openly talked about	101	51.5
Work peers			
	Definitely does not know	60	30.8
	Might know, never talked about	11	5.6
	Probably knows, never talked about	5	2.6
	Probably knows, rarely talked about	3	1.5
	Knows, rarely talked about	6	3.1
	Knows, sometimes talked about	10	5.1
	Knows, openly talked about	100	51.3
Work supervisors			
	Definitely does not know	63	32.5
	Might know, never talked about	12	6.2
	Probably knows, never talked about	9	4.6
	Probably knows, rarely talked about	3	1.5
	Knows, rarely talked about	3	1.5
	Knows, sometimes talked about	7	3.6
	Knows, openly talked about	97	50.0

Table 4 Continued

Religious community members		
Definitely does not know	92	59.0
Might know, never talked about	13	8.3
Probably knows, never talked about	5	3.2
Probably knows, rarely talked about	2	1.3
Knows, sometimes talked about	1	0.6
Knows, openly talked about	43	27.6
Leaders of religious community		
Definitely does not know	95	60.1
Might know, never talked about	12	7.6
Probably knows, never talked about	4	2.5
Probably knows, rarely talked about	2	1.3
Knows, rarely talked about	2	1.3
Knows, openly talked about	43	27.2
Strangers, new acquaintances		
Definitely does not know	65	33.7
Might know, never talked about	14	7.3
Probably knows, never talked about	9	4.7
Probably knows, rarely talked about	4	2.1
Knows, rarely talked about	2	1.0

Table 4 Continued

Knows, sometimes talked about	11	5.7
Knows, openly talked about	88	45.6
Former straight/heterosexual friends		
Definitely does not know	57	29.2
Might know, never talked about	6	3.1
Probably knows, never talked about	7	3.6
Probably knows, rarely talked about	6	3.1
Knows, rarely talked about	9	4.6
Knows, sometimes talked about	17	8.7
Knows, openly talked about	93	47.7

Table 5

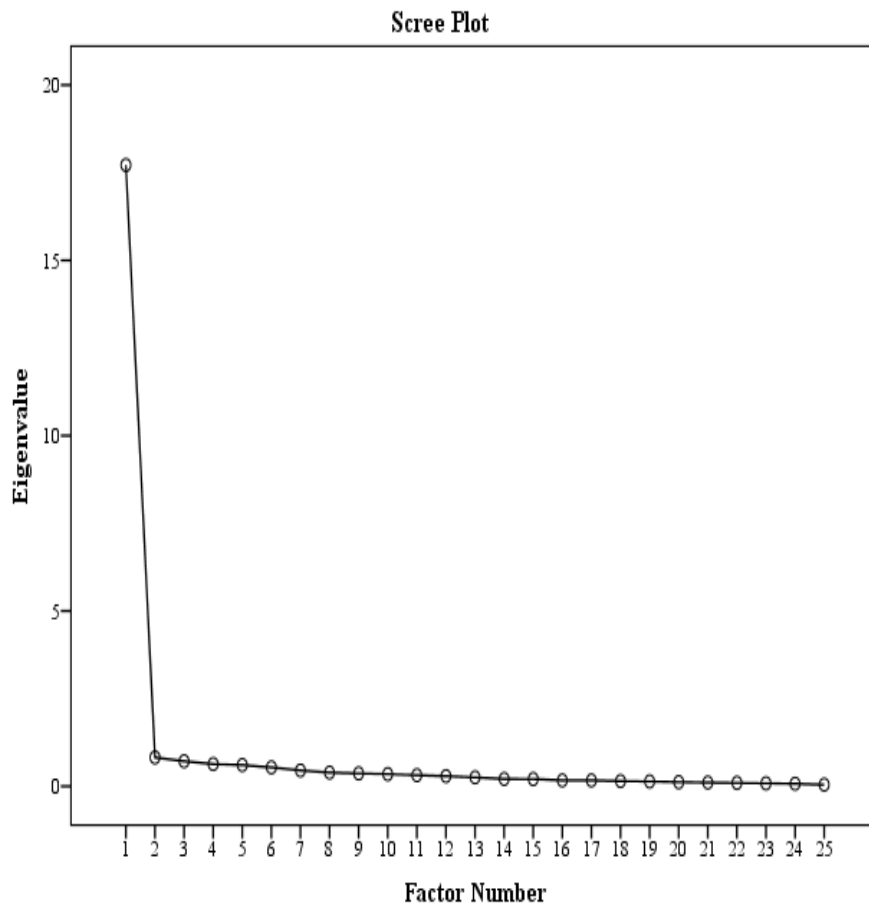
*Means and Standard Deviations of Outness Inventory*

Variable	<i>M</i>	<i>SD</i>
Outness scale	4.30	2.45

### **Exploratory Factor Analysis**

An exploratory factor analysis was conducted on the set of 27 questions related to Internalized Homophobia from the Internalized Homo-Negativity Inventory. A Varimax rotation was used, with a Maximum Likelihood method of extraction. Results suggested that only one factor existed in the internalized homophobia set of questions. The screen plot also

supported the conclusion. Since only one factor was suggested, no factor loadings were presented. The Internalized Homophobia score became the sum of the 27 questions from the Internalized Homo-Negativity Inventory. Cronbach alpha reliability was conducted for internalized homonegativity. The alpha value was .85, which suggests a good reliability for the subscale. Figure 1 presents the scree plot for the exploratory factor analysis.



*Figure 1.* Scree plot for Exploratory Factor Analysis on Internalized Homophobia Questions from the Internalized Homo-Negativity Inventory.

### Research Question 1

What is the relationship between age, relationship status, religiosity, and internalized homophobia in Black MSM?

To answer research question 1, a multiple linear regression was conducted on the independent variables age, relationship status, and religiosity to determine the relationship between the variables. The assumption of normality was assessed by viewing a Probability-Probability plot. The data was normally distributed and the assumption was met. The assumption of equality of variance was assessed with a residuals plot. The plot was randomly distributed about the origin, and thus the assumption was met.

The multiple regression with age, relationship status, and religiosity predicting internalized homophobia was significant, where  $F(3, 134) = 11.16, p < .001, R^2 = 0.40$ , indicating that the model of age, relationship status, and religiosity effectively predicted internalized homophobia. The model accounted for ( $R^2$ ) 40% of the variance in predicting internalized homophobia, where age ( $B = 2.13, p = .014$ ) and religiosity ( $B = 1.74, p = .032$ ) significantly contributed to the prediction of internalized homophobia. As age and religiosity increased, internalized homophobia also increased. Relationship status did not significantly predict internalized homophobia, where  $B = -2.93, p = .075$ . The null hypothesis – internalized homophobia in Black MSM does not have a relationship with age, relationship status, and religiosity – can be rejected. The results of the multiple regression are presented in Table 6.

Table 6

*Multiple Regression with Age, Relationship Status, Religiosity Predicting Internalized*

*Homophobia*

Model	<i>B</i>	<i>SE</i>	$\beta$	<i>t</i>	<i>p</i>
Age	2.13	0.86	<b>0.18</b>	2.48	.014
Relationship status	-2.93	1.63	-0.13	1.79	.075
Religiosity	1.74	0.81	0.15	2.16	.032

### Research Question 2

Is there a difference in internalized homophobia for HIV positive, HIV negative, and Unknown HIV status Black MSM?

To answer research question 2, a one-way ANOVA was conducted on the independent variable HIV status (positive, negative, or unknown) by the dependent variable internalized homophobia. The assumption of normality was assessed by examining skew and kurtosis. For skew, none of the values were outside of the absolute value of 2, and for kurtosis, none of the values were outside of the absolute value of 7; the assumption of normality was met. Levene's test for equality of variances was assessed with Levene's Test; the result of the test was significant, violating the assumption. A more stringent alpha level needs to be set for determining significance for the ANOVA test; an alpha value of .025 will be used to assess the ANOVA (Tabachnick and Fidell, 2007).

The results of the ANOVA for internalized homophobia was statistically significant for the alpha level .025,  $F(2, 193) = 96.08, p < .001$ , indicating there are differences in

internalized homophobia by HIV status. To further assess where the differences were, post hoc pairwise comparisons were conducted. Participants who were HIV positive ( $M = 88.98$ ,  $SD = 12.14$ ) or HIV unknown ( $M = 94.43$ ,  $SD = 6.51$ ) scored statistically higher than those who were HIV negative ( $M = 76.12$ ,  $SD = 7.59$ ) on internalized homophobia. The results of the ANOVA are presented in Table 7.

Table 7

*ANOVA on Internalized Homophobia by HIV Status*

	Positive		Negative		Unknown		$F(2, 193)$	$p$
	$M$	$SD$	$M$	$SD$	$M$	$SD$		
Internalized homophobia	88.98	12.14	76.12	7.59	94.43	6.51	96.08	.001

### Research Question 3

What is the relationship between internalized homophobia and HIV risk behaviors in Black MSM?

To answer research question 3, a logistic regression was conducted to assess the relationship between internalized homophobia and HIV risk behavior while controlling for age, income, education level, relationship status, religiosity, and HIV status. The results of the Hosmer and Lemeshow test showed that the overall model had a good fit when  $\chi^2(8) = 5.71$ ,  $p = .680$ , suggesting that the age, income, education level, relationship status, religiosity, HIV status, and internalized homophobia accounted for (Nagelkerke  $R^2$ ) 36.5%

of the variance in risk. Internalized homophobia successfully predicted HIV risk behavior:  $B = 0.08$ ,  $p = .007$ ,  $OR = 1.08$ , suggesting that for every one point increase in internalized homophobia, the participants were 8% more likely to engage in HIV risk behavior; as internalized homophobia increased, the participant was more likely to engage in HIV risk behavior. The null hypothesis that internalized homophobia does not predict HIV risk behaviors can be rejected. Results of the logistic regression are presented in Table 8.

Table 8

*Logistic Regression with Internalized Homophobia, Age, Relationship status, Religiosity, and HIV Status predicting HIV risk behavior*

Source	<i>B</i>	<i>SE</i>	Wald	<i>p</i>	OR	95% CI
Internalized Homophobia	0.08	0.03	7.35	.007	1.08	[1.02, 1.14]
Age	-.60	0.34	3.05	.081	0.55	[0.28, 1.08]
Relationship status	-.78	0.51	2.34	.126	0.46	[0.17, 1.25]
Religiosity	0.08	0.21	0.15	.700	1.09	[0.72, 1.64]
HIV Status	-.09	0.40	0.05	.817	0.91	[0.41, 2.01]

#### **Research Question 4**

What is the relationship between internalized homophobia and sexual identity in Black MSM?

To answer research question 4, a point-biserial correlation was conducted to assess if there was a relationship between sexual identity and internalized homophobia. Sexual

identity was coded as 0 if the participant only thought of himself as straight or heterosexual (62, 30.7%) and 1 if the participant thought of himself as otherwise (140, 69.3%). The results of the correlation were significant,  $r_{pb} = .62, p < .001$ , suggesting that if the participant thought of himself as straight or homosexual only, he had larger internalized homophobia scores. Results of the correlation are presented in Table 9.

Table 9

*Point Biserial Correlation between Sexual Identity and Internalized Homophobia*

	Internalized Homophobia
Sexual Identity	.62**

*Note.* \*  $p < .05$ . \*\*  $p < .01$ .

**Research Question 5**

What is the relationship between internalized homophobia and mental health in Black MSM?

In order to answer research question 5, two Pearson correlations were conducted to assess if there was a relationship between internalized homophobia and depression and self-esteem. Depression was measured from the 12 questions of the Epidemiologic Studies Depression Questionnaire, which had possible responses ranging from 0 = rarely or none of the time to 3 = most or all of the time related to feeling depressed.

Self-esteem was measured from the 10 questions of the Rosenberg Self-Esteem survey, which had possible responses ranging from 1 = strongly disagree to 5 = strongly agree about questions related to self-esteem. Depression questions 1, 5, 7, and 9, as well as self-esteem questions 2, 5, 6, 8 and 9 were reverse-coded (See Appendix B).

Results of the Pearson correlations were significant for depression,  $r = .44, p < .001$ , suggesting that as internalized homophobia increased, so did depression. Results of the Pearson correlations were also significant for self-esteem,  $r = -.59, p < .001$ , suggesting that as internalized homophobia increased, self-esteem decreased. The null hypothesis that there is no relationship between internalized homophobia and mental health (measured by depression and self-esteem) can be rejected. Results of the correlations are presented in Table 10.

Table 10

*Pearson Correlations between Internalized Homophobia, Depression, and Self-Esteem*

	Internalized homophobia
Depression	.44**
Self-esteem	-.59**

Note. \*  $p < .05$ . \*\*  $p < .01$ .

## CHAPTER V

### DISCUSSION

#### **Review of the Rationale for the Present Study**

HIV is an ongoing epidemic in the United States, affecting all segments of Black America. Black MSM continue to experience the highest HIV transmission rates. This group is also the least likely to be aware of having a positive HIV status (CDC, 2005). In 2004, Williams, Wyatt, Resell, Peterson, and Asuan-O'Brien performed a qualitative study in order to understand what psychosocial issues may be influencing the lives of African American and Latino HIV positive MSM who do and do not identify as gay or bisexual. Their research found that cultural issues around having sex with men, having sex with women, sexual and racial stereotypes, church and religion, and living with HIV were linked to participants' sexual behaviors. The current study built on Williams and colleagues' work by exploring associations between internalized homophobia in Black communities, psychological well-being, and sexual risk practices.

Diaz and colleagues (2004, 2006) examined the intersections between socio-cultural factors, psychological health, and sexual risk behaviors among gay Latino men. The researchers found that the compounding experiences of racism, poverty, and homophobia predicted isolation, low self-esteem, depression, insomnia, anxiety, and suicidal ideation. They also found that the experiences of racism, poverty, and homophobia among this population predicted psychological distress that, in turn, promoted risky sexual behaviors. Diaz and colleagues' research highlights specific socio-cultural factors experienced by

Latino MSM associated with psychological well-being and sexual risk behaviors. This dissertation examined similar social-cultural factors among Black MSM.

Mays and colleagues (2004) issued a call for mental health professionals to play a role in providing support to African American MSM at risk for acquiring HIV or dealing with issues related to living with HIV. The researchers urged mental health researchers to examine how HIV risk is a function of contextual, cultural, and personal determinants in the lives of African American MSM. They provide several examples of potential risk determinants including isolation, perceived risk of disclosing matters involving sexual orientation or HIV status to others, feelings of inadequacy, stigma, challenges to masculinity, poverty, violence, and many others.

Overall, the current study attempted to respond to the call for mental health research examining associations between specific cultural factors, mental health functioning, and sexual risk behaviors among Black MSM. The impact of internalized homophobia and mental health on HIV risk behaviors was analyzed in this study. The current study was designed to provide data applicable to the ongoing HIV epidemic affecting Black MSM and to inform useful counseling interventions designed to address this epidemic.

### **Discussion and Implications of the Findings**

**Research Question 1:** What is the relationship between age, relationship status, religiosity and internalized homophobia in Black MSM?

The author hypothesized that there would be no significant relationship between age and internalized homophobia in Black MSM. In contrast, the author predicted that there would be a significant relationship between religiosity, relationship status, and internalized

homophobia. It was predicted that religiosity would have a positive relationship with internalized homophobia. Participants who reported being in a monogamous relationship with a male would report less internalized homophobia than men who reported not being in a relationship.

**Age and Internalized Homophobia:** Participants were asked to report their age as falling into one of these categories: 18-25, 26-35, 36-45, 46-55, 56-65, and over 65. The author postulated that because of their age, younger men in the sample would be in an earlier stage of dealing with same sex attraction, thus having higher internalized homophobia. The results did not support this assertion. The result of the linear regression revealed a positive relationship; as age increased, internalized homophobia increased. This finding is in opposition to the literature, which suggested that younger MSM, as compared to older MSM, would experience higher internalized homophobia. Because younger MSM are in the earlier stages of coming out and learning how to navigate a homophobic environment, it was believed that they would have higher internalized homophobia (Landa & Bybee, 2007). Data on the coming out process was not collected, limiting the ability to draw meaningful conclusions to explain results that were different than what was expected. It can be speculated, however, that the younger MSM in this study may have come out at an earlier age than the older participants. A study conducted by Drasin, Beals, Elliot, Lever, Klien and Schuster (2008) supported the idea that gay men are becoming aware of their same-sex attraction and coming out at earlier ages as compared to past generations. The authors asserted that the stigma associated with being gay and coming out does not currently present the level of risk it may have presented 20 or 30 years ago. The study conducted by Drasin

and colleagues (2008) consisted of primarily White participants (Drasin, Beals, Elliot, Lever, Klein & Schuster, 2008). Further research is needed to determine if these assertions hold true in Black communities.

**Relationship Status and Internalized Homophobia:** Participants were asked if they were in a committed relationship. The author believed that being in a committed relationship would act as a protective factor against internalized homophobia. The results did not support this assertion; the current sample found no significant relationship between relationship status and internalized homophobia.

The literature suggested that internalized homophobia is lower in gay men in a legally recognized relationship (civil union or domestic partnership) than single or dating gay men (Riggle, Rostosky & Horne, 2010). The researchers asserted that legally recognized relationships offer a protective buffer against depression, stress, and internalized homophobia. It is unclear why the results from the current study were not consistent with the literature. This may be due to the methodology. When conducting the analysis, it was not taken into account whether the committed relationship was with a male or a female. Black MSM who are in a committed relationship with a female, but who also have male partners, may not have a protective buffer against internalized homophobia. In fact, that behavior may be a reaction to high levels of internalized homophobia. Future research analysis should take relationship status and partner type into account.

**Internalized Homophobia and Religiosity:** Participants were asked to describe their place of worship's stance on same sex relationships as "welcomes," "tolerates," "rejects," "or "I do not know." Participants were also asked to characterize their religious faith as "very

important,” “somewhat important,” “not very important,” or “not important at all.” The author predicted that religiosity would have a positive relationship with internalized homophobia. The results supported the author’s hypothesis that as religiosity increased, internalized homophobia also increased.

It has been widely documented that Black churches view homosexuality as a violation or a sin (Miller, 2002; Hicks 2000 & Fullilove & Fullilove, 1999). Despite these negative views about homosexuality from Black churches, when polled (Peterson & Stokes, 1998), the majority of homosexual African Americans reported that religion was important to them; the study also revealed that most of the respondents had not disclosed their orientation to anyone at their church. The findings from the current study were consistent with the Peterson and Stokes study. The results from the current study revealed that more than 80% of participants viewed religion as very or somewhat important; in addition, only 18% of participants reported that their church accepts same sex relationships. Also similar to the Peterson and Stokes study, participants in the current study were least likely to disclose their sexual orientation to their religious community members, with more than 70% of participants reporting that they had not disclosed.

To cope with the homophobic response from their religious community, some men feel they have to make a choice: suppress their sexual orientation and behavior to remain consistent with the biblical interpretations of their clergy, or reject the clergy's interpretation and risk being admonished by their religious community (Miller, 2000). The consequences of such choices can prompt a variety of coping responses, including diminished self-esteem, unsafe sexual practices, and drug use (Fullilove & Fullilove, 1999).

The results from the current study supported these findings. It can be speculated that the homophobic rhetoric espoused by the churches and attended by study participants may contribute to internalized homophobia, which has been shown to decrease mental health functioning and increase HIV risk behaviors. These findings display the powerful role of religion in Black communities. It is possible that the church's opposition to homosexuality is a major reason for negative attitudes within the communities at large. It is important for researchers to explore this further and find better ways to work with Black churches to enhance HIV prevention efforts.

**Research Question 2:** Is there a difference in internalized homophobia for HIV positive, HIV negative, and Unknown HIV status Black MSM?

It was hypothesized in research question 2 that internalized homophobia scores would vary according to HIV status. Specifically, it was hypothesized that HIV positive and unknown status Black MSM would have higher internalized homophobia compared with HIV negative MSM. The results of the one-way ANOVA supported the hypothesis; participants who were HIV positive scored significantly higher on internalized homophobia than those who were HIV negative. When revealing a positive HIV status, many MSM face stigma and homophobia from the public. They also suffer from shame and self-blame (Gossling, 2008). It is not surprising that internalized homophobia would be significantly higher for HIV positive men than for HIV negative men.

The analysis also revealed higher internalized homophobia scores for men who were unaware of their status (they had not been tested or they did not get the results of their test). A possible explanation for the elevated levels of internalized homophobia in these men may

be related to their risk behavior. The results of the current study revealed that these participants who were unaware of their HIV status reported multiple HIV risk behaviors. Ninety-three percent of participants who were unaware of their HIV status reported more than 5 male sexual partners in the prior 12 months; 88 % reported using condoms less than half of the time and 59% revealed that they were very concerned about contracting HIV within the coming 12 months. Also of note, 47% of these men who were unaware of their status reported sex with a female in the prior 12 months; 76 % reported multiple female sex partners; 85% reported using condoms less than half of the time, and 95% of participants who had female partners and were unaware of their HIV status reported that they were concerned that they would contract HIV within the coming 12 months.

Perhaps for these men who are unaware of their HIV status, knowingly engaging in HIV risk behavior may cause self-blame and anxiety over possibly having been exposed to HIV. This self blame and anxiety may be internalized, thus increasing internalized homophobia. By choosing not to know their status, these men may be attempting to avoid coping with the negative feelings and anxiety associated with a possible HIV diagnosis. Testing positive could potentially expose these individuals to the existing stigma and homophobia surrounding being labeled as HIV positive. In addition, avoiding an HIV test could help these Black MSM to avoid confronting their potentially risky sexual behavior, which may have put them at risk for HIV. This tactic may assist in avoiding confronting their internalized homophobic beliefs and their HIV risk behaviors, allowing the individual's sense of self to remain intact. There are no studies specifically conducted on this possible tactic among Black MSM regarding HIV testing. Studies have shown that HIV status

awareness has been associated not only with a reduction in HIV risk behaviors, but also a reduction in HIV transmission (Heckman & Kalichman, 2000). It is important to learn more about the testing behaviors of Black MSM in order to develop ways to increase HIV status awareness and HIV prevention methods.

**Research Question 3:** What is the relationship between internalized homophobia and HIV risk behaviors in Black MSM?

The author hypothesized that there is a positive relationship between Internalized Homophobia and HIV risk behaviors. The results of a logistical regression were consistent with the hypothesis. As internalized homophobia increased, the participants were more likely to engage in HIV risk behaviors. HIV risk behaviors were defined as inconsistent condom use *and* multiple sexual partnerships. The relationship to internalized homophobia remained statistically significant when demographics factors were entered as control variables.

The positive relationship revealed between internalized homophobia and HIV risk behaviors may be best explained by the Cognitive Escape Model of HIV risk behaviors proposed by McKirnan, Ostrow, and Hope (1996). They proposed that in reaction to the HIV crisis of the 1980s and 1990s and the resulting homophobia, many white gay and bisexual men may have been motivated to cognitively escape. They wanted to cognitively escape from homophobia, HIV awareness, and restrictive safer sex norms. The researchers asserted that automatic cognitive scripts encourage unsafe sexual behaviors by allowing gay men to temporarily avoid HIV anxiety, fatigue, and a sense of fatalism. McKirnan, Ostrow,

and Hope's (1996) model provides a useful framework with which to understand barriers to safer sex among gay and bisexual men.

Although the Cognitive Escape Model of HIV risk behaviors were primarily focused on White gay male culture, it may apply to Black MSM who are currently facing similar conditions. The high rates of HIV among Black MSM have been well documented and reported (CDC, 2002; CDC, 2003; CDC 2006; CDC, 2009). It has also been well documented that Black MSM have been overwhelmed and disheartened by these statistics, taking on a not *if* but *when* mentality in reference to HIV acquisition (Cochran, & Mays, 2000, Brown, 2005; & Graham et. Al, 2011). Sixty-eight percent of the participants in the current study indicated that they were very concerned or somewhat concerned that they would contract HIV in the coming 12 months, supporting the above assertion that many of these men view HIV acquisition as inevitable. The cognitive escape theory is an area for further research to understand the link between internalized homophobia and HIV risk behaviors among Black MSM.

**Research Question 4:** What is the relationship between internalized homophobia and sexual identity in Black MSM?

The author hypothesized that men who identify as heterosexual, or straight, will have higher levels of internalized homophobia than those who identify as homosexual, gay, or queer. The results were consistent with the hypothesis. Point-biserial correlation revealed significance, suggesting that if the participant thought of himself as straight or heterosexual, he had higher internalized homophobia scores.

Studies have shown that Black MSM experience pressure to hide their homosexual behavior and identify as heterosexual (Cohen & Jones, 1999; Icard 1986; Lewis 2003). To avoid the homophobia projected by Black communities and the culture of homophobia in the U.S. in general, Brown (2005) asserted that these men assume a homophobic mentality by keeping their sexual behavior and sexual identity separate. The results of the current study support this finding. It is possible that the participants in the current study cope with the homophobia espoused by their communities by internalizing it and potentially putting on a façade. This can result in the loss of his identity and perhaps the refusal to identify oneself as being gay (Brown, 2005).

It can also be surmised that these men are at higher risk for contracting HIV due to the findings from research question 3, which suggests that men with higher internalized homophobia are more likely to engage in HIV risk behavior. Ninety-eight percent of respondents who had male partners but identified as straight or heterosexual reported multiple partners; 89% of these men revealed condom use less than half of the time. Interestingly, 63% of participants who identified as heterosexual or straight reported sex with a female; 77% of these respondents reported multiple partners; and 79% reported condom use less than half of the time. Wilson, Kastrinakis, D'Angelo & Getson (1998) found that African American MSM who do not disclose their sexual orientation and view themselves as heterosexual (i.e., non-disclosures) have a higher prevalence of HIV infection, nearly three times higher than non-disclosing MSM of all other races combined. These findings have implications for HIV prevention because prevention messages aimed at gay men may not be effective with a population that does not identify as gay or homosexual.

**Research Question 5:** What is the relationship between internalized homophobia and mental health in Black MSM?

The author postulated that there is a negative relationship between internalized homophobia and mental health as measured by levels of depression and self-esteem; as mental health functioning decreased, internalized homophobia would increase. Two Pearson correlations were conducted to assess whether a relationship between internalized homophobia, depression, and self-esteem exists. The results of the analysis supported the hypothesis, revealing significance for depression, suggesting that as internalized homophobia increased, so did depression. Results for self-esteem were also significant and supported the hypothesis, suggesting that as internalized homophobia increased, self-esteem decreased.

These results are not surprising, as studies suggested that many Black MSM have reported sometimes feeling that their black selves and their sexual orientation compete; in other words, they feel that they have to choose to be black or be a sexual minority. These men do not feel they can be both at the same time (Crawford et al. 2002). It is logical that this type of dissonance would lead to low self-esteem and depression, fueling internalized homophobia. Many of the participants may feel torn between fidelity to black communities in general and the black sexual minority communities of which they also belong.

These findings expand previous literature (Cochran & Mays, 2000; Consolacion, Russell, & Sue, 2004) which suggested a link between a homosexual identity and psychological functioning. The results of the current study suggested that it is not homosexuality alone, but rather, the internal discomfort with one's homosexuality (internalized homophobia) that is linked to poor mental health functioning. It is likely that

the more Black MSM are able to work through their internalized homophobia, the more likely they are to experience less depression, exhibit higher self-esteem, and safeguard their health. An enhanced understanding of this mental health process among Black MSM will aid mental health practitioners, researchers, and educators in improving quality of care, increasing acceptability of services, and designing targeted prevention efforts.

This study adds to the dearth of research on the mental health challenges facing Black MSM. These findings highlight the need for mental health professionals to join in the prevention efforts aimed at this population. Furthermore, mental health researchers are needed to assist in the development of acceptable intervention strategies targeted at this group to adequately and compassionately address their mental health needs.

### **Implication for Counselors**

The results of this research study have several implications for counselors providing therapy for Black MSM. This study found that high-internalized homophobia predicted a tendency to engage in HIV risk behaviors. It is likely that many of the participants may have had at some point in their lives a diagnosable mental disorder (e.g., depression, anxiety, PTSD), as over half of the participants had previously been referred to a mental health professional. The results revealed that 51.3 % of the participants had visited a mental health practitioner, but only 35% had their needs met and 41 % were not open to visiting a counselor again in the future. These findings highlight the need for mental health professionals to be properly trained to gain the skills and sensitivity needed to meet the needs of this population. Understanding Black MSM's experiences and the impact of internalized

homophobia on potentially self-destructive behavior is important for counselors to consider in their conceptualizations, interventions, and treatment planning.

To begin the therapeutic relationship, counselors must gain an understanding of the client's perspectives without the assumption that the client is homosexual, bisexual, or heterosexual. Each person will present differently. By focusing on sexual orientation or identity labels prematurely during therapy, the therapist may increase rather than decrease internalized homophobia for some Black MSM. Therefore, it is imperative that mental health providers work to learn the clients' points of view and personal sexual identity labels and use language that appropriately reflects this understanding. Men within this population self identify across the continuum of sexual orientation identities and represent a wide spectrum of outness. Not identifying exclusively as gay or bisexual does not necessarily mean he is in denial of his true sexual orientation; nor does relative outness. Education on the concepts of internalized homophobia, outness, and identity development could be an important aspect of the therapeutic process.

Exploring internalized homophobia with these men in therapy may be integral in helping them develop a better sense of self and ultimately help them reduce their HIV risk behaviors. According to the literature, risk behaviors among this population may be part of an elaborate defense mechanism aimed at reducing or avoiding internalized homophobia (Wilson et.al, 1994). Therapists should work to help the client identify, understand, and become educated about HIV risk behaviors and prevention methods. A goal of therapy with these men is to develop a safe, non-judgmental therapeutic alliance, seek understanding of HIV risk behaviors, and assist the client in working through his internalized homophobia.

This therapeutic process can effect change in HIV risk behaviors by assisting the client in developing a stronger sense of self. In addition to working with clients to reduce HIV risk behaviors, counselors who work with Black MSM who do not frequently test for HIV, in spite of the presence of risk behaviors, should consider the impact of internalized homophobia in influencing the decision not to test. As discussed above, therapists who assist clients in reducing internalized homophobia may help these individuals take more proactive approach to their sexual health. Establishment of support for these men is important as they explore their sexual identity and sexual risk. In addition to one-on-one therapy, counselors could institute support groups. Individuals can benefit from receiving input from others, for example, in a group setting, who accept and understand their thoughts and situations (Halkitis, Gomez, & Wolitski, 2005). These groups would offer men a safe place to express their thoughts and feelings to others who share similar issues.

All of the therapeutic strategies suggested above require therapists to be knowledgeable and develop understanding regarding Black men who choose to engage in sexual activities with other men. Counselors who understand the socio-contextual factors that influence the lives of Black MSM will have an essential framework by which to meet the needs of these men and to help improve their lives. Counselors identifying and challenging their own assumptions and biases regarding this population are also necessary processes in becoming effective helpers. In order to work effectively with this highly stigmatized population, counselors must approach the therapeutic relationship with openness to the client's experiences and be free from judgment or moralistic assessment. Sensitivity and understanding will greatly assist the therapist in establishing strong, beneficial

therapeutic relationships. Table 11 provides recommendations for counselors working with Black MSM.

Table 11

*Recommendations for working with Black MSM*

<b>Inappropriate Counselor Behavior</b>	<b>Appropriate Counselor Behavior</b>
1. Expressing moralistic beliefs or judgments about sexual behavior and sexual orientation.	Expressing openness, empathy, and understanding.
2. Inflexible counseling style not tailored to the multi-faceted needs of Black men who have sex with men (MSM).	Adaptive counseling style attentive and attuned to the dynamic needs of Black MSM.
3. Dismissing client experiences related to sexual behavior and sexual orientation.	Seeking to understand the unique experiences and perspectives of the client.
4. Attempting to change sexual behavior and sexual orientation.	Establishing an environment of safety and comfort for clients to be themselves.
5. Using judgmental and invalidating language or identity labels related to sexual behavior and sexual orientation.	Mirroring and modeling language used by client.
6. Operating as if the client shares your belief and value systems (i.e., pushing one's assumptions on clients) about sexual behavior and sexual orientation.	Collaborating with the client to understand their belief and value systems in order to work honestly, openly, and effectively with them.
7. Leaving personal belief and value systems unexamined and unchallenged related to sexual behavior and sexual orientation.	Critically identifying and challenging personal beliefs and value systems (e.g., assumptions and biases) regarding sexual behavior and sexual orientation.
8. Rationalizing and intellectualizing homophobic beliefs and practices.	Acknowledging the homophobic views of the larger society.
9. Being uncomfortable with discussing sex and sexual feelings in therapy, particularly same-sex sexual behaviors.	Developing competence and comfort in discussing sex and sexual feeling in therapy, particularly same-sex sexual behaviors. Admitting to not having answers and/or being ignorant of an issue.

Table 11 continued

<p><b>10.</b> Pathologizing client behavior related to sex and sexual orientation.</p>	<p>Seeking to understand client’s behavior related to sex and sexual orientation. Provide support by staying flexible and open to learning.</p>
<p><b>11.</b> Compartmentalizing race, gender, sexual orientation, and sexual behavior.</p>	<p>Conceptualizing the intersections of race, gender, sexual orientation, and sexual behavior embedded in larger social, economic, cultural, and political contexts.</p>
<p><b>Suggested Counseling Techniques</b></p>	
<p><b>1.</b> Goals of therapy with Black Men Who Have Sex With Men (BSM) is to develop a safe, non-judgmental therapeutic alliance, facilitate understanding of HIV risk behaviors and prevention methods, and assist the client in working through internalized homophobia.</p>	
<p><b>2.</b> Establishment of support for Black MSM is important as they explore their sexual identity and sexual risk. The therapeutic process can effect change in HIV risk behaviors by assisting the client in building self-esteem and developing self efficacy in order to become more actively involved in his sexual health. .</p>	
<p><b>3.</b> Black MSM can benefit from receiving input from other Black MSM who are dealing with similar circumstances. Support groups would offer Black MSM a safe place to express their thoughts and feelings to others who share similar issues.</p>	
<p><b>4.</b> Understanding the experiences of Black MSMs and the role of internalized homophobia in potentially self-destructive behavior is important for counselors to consider in their conceptualizations, interventions, and treatment planning. Counselors should also consider issues related to the social, economic, spiritual, cultural, and political contexts in the lives of Black MSM.</p>	

The wealth of knowledge that counselors possess concerning psychosocial issues is critical in dissecting the complex prevention needs of Black MSM. It is important that counselors gain the additional knowledge needed to work successfully with clients struggling with these complex issues, thus joining the fight in battling this epidemic.

## **Limitations**

Because the instruments that were used in the study were anonymous self-report measures, the researcher assumed that the participants responded in a trustworthy manner, and that the results will accurately represent mental health, internalized homophobia, demographic characteristics, and HIV risk behaviors as defined by the specific instruments.

The study had potential limitations, which may have affected the outcomes and could have affected the validity of the results.

1. The study was limited to Black men who were willing to complete the surveys.
2. Due to homophobia and other factors, many Black MSM may have been unwilling to participate in the study because of fear of exposure; therefore, the results may not be representative of the larger population.
3. The sample was conducted utilizing a convenience, snowball recruitment method that may limit generalizability.
4. The sample was recruited from specific Internet sites; it is possible that Black MSM who did not access the targeted Web sites were less likely to be recruited, and therefore the results may not be representative of all groups of Black MSM.
5. It is difficult to estimate the size of the Black MSM population because MSM may be unwilling to disclose their sexual behaviors due to internalized homophobia or the desire to avoid being labeled as gay. It is difficult to know if MSM who agree to participate in studies are different from the men who do not, which creates a potential for a selection bias.

6. The data analysis did not account for relationship status and partner type; this may have influenced the inconsistent results revealed between relationship status and internalized homophobia.

### **Future Research**

Future research in this area should address the issue of sampling. As discussed in the limitations, sampling among Black MSM is challenging due to the sensitive nature of same-sex behaviors in Black communities. Future researchers should work to develop novel ways of sampling this population. Recruitment strategies should be developed to enhance the benefits and minimize the disadvantages of internet recruitment. Future research should also explore methods for using social media to combat the homophobia present in Black communities. Social media could be used to address this problem through research aimed at influencing public opinion, empowering Black MSM communities, and preventing gay and lesbian individuals from internalizing anti-homosexual sentiments.

As discussed, a few studies with primarily white participants have suggested that the stigma associated with being gay and coming out does not currently present the level of risk it may have presented 20 or 30 years ago. Further research is needed to determine if these assertions are applicable to Black MSM. In addition, research efforts should focus on the coming out process for this group and the impact this process has on how Black MSM label their sexual identity. Understanding how these factors (i.e., stigma, the coming out process, and sexual identity) intersect to impact HIV testing and HIV prevention are areas for future research.

The powerful role of religion in Black communities was underscored by the study results, highlighting the importance of incorporating Churches in prevention efforts. The results suggest that it is possible that the church's opposition to homosexuality is a major factor influencing internalized homophobia among Black MSM. It is important for researchers to explore this further and find better ways to work with Black churches to enhance HIV prevention efforts.

Taken collectively, the results of the present study implicate internalized homophobia as one potential barrier to HIV prevention efforts. A link between internalized homophobia and poor mental health functioning was also identified, highlighting the need for mental health professionals to join in the prevention efforts aimed at this population. Mental health researchers are needed to assist in the development of acceptable intervention strategies targeted at this group to adequately and compassionately address their mental health needs.

Building on the results from this study, future researchers should include a qualitative component to add depth to the quantitative results. A qualitative component would add context to the quantitative finding, providing further insight into the lived experiences of this population. This would further assist counselors in working with and designing culturally appropriate therapeutic interventions for Black MSM. Sixty-five percent of participants reported that their needs were not met by their mental health professional; a qualitative inquiry would help future researchers to examine the counseling experiences of Black MSM. This would inform practitioners about the most effective counseling practices for Black MSM. In addition, researchers should explore the diversity

among Black MSM with regard to sexual identity, HIV status, age, religion, and other relevant variable and how these elements impact the therapeutic process.

In order to further inform best counseling practices, future research building on the current study's findings should focus on both the negative as well as the positive lived experiences of this population. There is limited qualitative data on the relationship between internalized homophobia, trauma (such as childhood sexual abuse, racism, verbal and physical abuse), and HIV risk behaviors. Follow up qualitative research should also explore the often overlooked aspects of resiliency among Black MSM as discussed in chapter 2. Mays, Cochran & Zamudio (2004) have identified resiliency as a critical area for future research among Black MSM. It would be helpful for counselors to understand how aspects that influence resiliency, such as natural supports, protective factors, affirmation, and social support (Consolacion, Russell, & Sue, 2004; CDC, 2003; Mays & Cochran, 2001) could be utilized to help buffer the negative and often homophobic experiences of Black MSM. Future research should work to uncover these homophobic experiences, when and how they start, how they may change over time, and how these factors affect mental health and how it may become internalized. This would help counselors to design and improve interventions and therapeutic counseling practices that would enhance resiliency and buffer against the negative experiences of homophobia.

Researchers who seek to develop and implement interventions should consider the impact of internalized homophobia and mental health functioning. Given that the results of this study suggest that internalized homophobia is related to both poor mental health functioning (i.e., measured by self-esteem and depression) and HIV risk behavior, HIV

prevention specialists and mental health professionals should work together to develop programs designed specifically to reduce internalized homophobia. This partnership could help to thwart the negative effects of internalized homophobia among Black MSM.

### **Conclusions**

The current study added to the limited data on the prevention needs of Black MSM. Overall, the results suggest that HIV prevention efforts may not be as effective among Black men experiencing internalized homophobia, which may influence these men to engage in HIV risk behaviors. It is possible that the high prevalence of HIV infection among Black MSM is due to the high levels of homophobia in Black communities. The findings from this study suggests that these men are less inclined to identify as gay or do not disclose their sexuality to others, leading to increased risk behaviors. Counselors should be aware that rather than addressing labels and sexual identity, which may serve to increase internalized homophobia, it may be better to focus on the specific behavior and not the sex of the partner. Although there is little empirical research in this area, conclusions from the current study and data from the 2009 CDC study suggest that homophobia may be the root of HIV transmission, as those with high internalized homophobia (non-disclosers) were more likely to not know they were infected (CDC, 2009). Thus, homophobia may be influencing the risk behaviors of Black MSM, ultimately putting Black communities at risk. When working with this population, or attempting to conduct research with this population, it is important for clinicians and researchers to have an understanding and sensitivity of the participant's feelings and actual experiences of social rejection due to homophobia. It is also important to understand how homophobia influences internalized homophobia and its effect on HIV risk

behaviors. Internalized homophobia is an area that will continue to demand extensive research and awareness by counseling researchers and practitioners because of its far reaching implications in the lives of Black MSM.

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## APPENDICES

## Appendix A

### IRB CONSENT FORM FOR RESEARCH



North Carolina State  
University is a land-grant  
university and a constituent  
institution of the University of  
North Carolina

**Office of Research and  
Innovation**  
Division of Research  
Administration

Campus Box 7514  
Raleigh, North Carolina 27695-7514  
919.515.2444 (phone)  
919.515.7721 (fax)

From: Carol Mickelson, IRB Coordinator  
North Carolina State University  
Institutional Review Board

Date: December 22, 2011

Title: The effects of internalized homophobia in Black Men who have Sex with Men on  
HIV risk behaviors.

IRB#: 2431

Dear Ms. Oluwakemi Amola,

The research proposal named above has received administrative review and has been approved as exempt from the policy as outlined in the Code of Federal Regulations (Exemption: 46.101. b.2). Provided that the only participation of the subjects is as described in the proposal narrative, this project is exempt from further review.

NOTE:

1. This committee complies with requirements found in Title 45 part 46 of The Code of Federal Regulations. For NCSU projects, the Assurance Number is: FWA00003429.
2. Any changes to the research must be submitted and approved by the IRB prior to implementation.
3. If any unanticipated problems occur, they must be reported to the IRB office within 5 business days.

Please forward a copy of this letter to your faculty sponsor, if applicable. Thank you.

Sincerely,

A handwritten signature in black ink that reads "Carol Mickelson". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Carol Mickelson NC State IRB

## **APPENDIX B**

### **SURVEY**

**North Carolina State University**

**Consent to Participate in a Research Study**

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**IRB Study**

**Consent Form Version Date: Version 1.0, October 25, 2011**

**Title of Study: Men’s Attitudes on Sexual Health and Risk Behaviors**

**Principal Investigator: Kemi Amola**

**North Carolina State University: Counselor Education Department**

**Dissertation Committee: Marc Grimmett, PH.D – Committee Chair,**

Angela Smith, PH.D

Pamela Martin, PH.D

Sylvia Nassar-McMillan, PH.D

Jessica T. DeCuir-Gunby, PH.D

---

#### **What are some general things you should know about research studies?**

You are being asked to take part in a research study. Joining the study is voluntary.

You may refuse to join, you may stop the survey at any time and you may skip any questions you do not feel comfortable answering.

Deciding not to be in the study or stopping the study before it is done will not affect your relationship with the researcher, or North Carolina State University.

Details about this study are discussed below. It is important that you understand this information so that you can make an informed choice about proceeding through the survey.

**What is the purpose of this study?**

The purpose of this study is to understand men's views on sexual health in order to better understand risk behaviors. This knowledge will help inform researchers in designing interventions.

**How long will your part in this study last?**

It will take you about 15-20 minutes to complete the survey

**What will happen if you take part in the study?**

If you choose to complete this study, you will be asked a variety of questions including questions about your sexual practices, mood and demographic information such as your age, race, and income. Although some questions are sensitive, the researcher hopes you will be as honest as possible when completing the questionnaire.

**Who should Participate in the Study?**

Males over the age of 18 are eligible to participate in the study.

**What are the possible benefits from being in this study?**

You may receive no direct benefit from this study, but we are hoping to obtain new knowledge that may help other people in the future.

**What are the possible risks or discomforts involved with being in this study?**

Some of the questions in the survey ask about sensitive topics, which may cause you to feel uncomfortable. You do not need to answer any questions that you do not feel comfortable.

It is recommended that you complete the survey in a private location, clear, and close your browser when the survey is complete.

**How will your privacy be protected?**

The survey is anonymous you will not be asked to provide any identifying information; therefore you will not be personally linked to the answers you provide.

The web-survey uses data encryption technology to encode responses, there is also firewall technology to further protect data from unauthorized access.

**What should I know about internet research?**

As an online participant in this research, there is always a risk of intrusion, loss of data, identification, or other misuse of data by outside agents. Though these risks may be minimized by the researcher, it is important to understand they exist.

It is important to note that internet communications may be insecure and confidentiality cannot be guaranteed due to the technology itself. However, steps have been taken with the use of this online survey site to protect your privacy.

**What if you want to stop before you complete survey?**

You can stop the survey at any time or skip any questions, without penalty.

**Will you receive anything for being in this study?**

You may not receive anything for completing the survey. At the end of the survey, participants who complete the survey will be given the option to enter a drawing for a \$100.00 visa check card. If you choose to enter the drawing, you will follow a link to another survey that will collect your contact information. There will be no link from your answers to your contact information. The information will be kept by Qualtrics secure technology. The researcher will only see the information for the winning participants in order to mail the gift card. All identifying information will be deleted after the winner is selected.

**Who is sponsoring this study?**

This research is being conducted as part of a Dissertation in the Counselor Education Department at the North Carolina State University.

**What if you have questions about this study?**

You have the right to ask, and have answered, any questions you may have about this survey. If you have questions, you can contact Kemi Amola at Kemi@unc.edu or you can contact North Carolina State's Internal Review Board, Carol Mickelson 919- 575-7515. If you would like to speak to someone after taking the survey you can contact the Counselor Education department at North Carolina State 919-515-2244. If you would like to speak to someone about sexual health, you can call the National CDC Hotline 1-800-232-4636.

**Participant's Agreement:**

**Lease Remember No Identifying Information Connecting You to Your Survey**

**Responses will be Collected.**

Yes, I have read this consent form, I am over the age of 18 and I agree to take part in this survey.

No, I do not wish to participate in the survey at this time.

What is your gender?

Male

Female

How old are you?

Under 18

•  18-25

•  26-34

•  35-54

•  55-64

•  65 or over

Please be as honest as possible all of your answers are completely anonymous.

Are you currently in a committed relationship? By committed we mean a romantic or intimate relationship.

- Yes
- No
- Not Sure

Is that relationship monogamous? By monogamous we mean you are not having oral sex (sex in the mouth) vaginal sex (sex in the vagina), or anal sex (sex in the butt) with anyone else.

- Yes
- No
- Not Sure

Is that partner male or female?

- Male
- Female

In the past 12 months have you had oral sex (sex in the mouth) vaginal sex (sex in the vagina), or anal sex (sex in the butt) with a female?

- Yes
- No

In the past 12 months how many different **female** sexual partners have, you had vaginal sex (sex in the vagina) with?

- 0
- 1
- 2-5
- 6-9
- 10-13
- 14-20
- Over 20

In general, how often do you use condoms when having **vaginal** sex (sex in the vagina) with a primary partner? By primary partner, we mean an intimate or romantic partner.

- Always
- More than Half of the time
- Half of the time
- Less than half of the time
- Never
- N/A

In general, how often do you use condoms when having vaginal sex (sex in the vagina) with a partner who is **NOT** a primary, intimate, romantic partner?

- Always

- More than half of the time
- Half of the time
- Less than half of the time
- Never
- N/A

In the past 12 months how many different **female** sexual partner(s) have you had **anal** sex (sex in the butt) with?

- 0
- 1
- 2-5
- 6-9
- 10-13
- 14-20
- over 20

In general, how often do you use condoms when having **anal** sex (sex in the butt) with a primary **female** partner? By primary partner, we mean an intimate or romantic partner.

- Always

- More than Half of the time
- Half of the time
- Less than half of the time
- Never
- N/A

In general, how often do you use condoms when having **anal** sex (sex in the butt) with a **female** partner who is **NOT** a primary intimate or romantic partner?

- Always
- More than half of the time
- Half of the time
- Less than half of the time
- Never
- N/A

In the past 12 months, have you had oral sex (sex in the mouth) anal sex (sex in the butt) with a **male** where you were either the giver or receiver?

- Yes
- No

In the past 12 months how many different **male** sexual partner(s) have you had **anal** sex (sex in the butt) with where you were either the giver or receiver.

- 0
- 1
- 2-5
- 6-9
- 10-13
- 14-20
- More than 20

In general, how often do you use condoms when having **anal** sex (sex in the butt) with a primary **male** partner where you are either the giver or receiver? By primary partner, we mean an intimate or romantic partner.

- Always
- More than Half of the time
- Half of the time
- Less than half of the time

- Never
- N/A

In general, how often do you use condoms when having **anal** sex (sex in the butt) with a **male** partner who is **NOT** a primary intimate or romantic partner where you are either the giver or receiver?

- Always
  - More than Half of the time
  - Half of the time
  - Less than half of the time
  - Never
  - N/A

Please be as honest as possible all of your answers are completely anonymous.

Have you ever been tested for HIV?

- Yes
- No
- Unsure

What was the result of your most recent HIV test?

- Positive

- Negative
- Indeterminate
- Did not get results

What was the approximate date of your most recent test month and year?

How concerned are you that you will contract HIV in the next year?

- Very concerned
- Somewhat concerned
- Not very concerned
- Not concerned at all

Please be as honest as possible, all of your answers are completely anonymous.

Using the scale below, please give your honest rating about the degree to which you agree or disagree with each statement.

I believe being homo/bi-sexual is an important part of me

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree

- Moderately Agree
- Strongly Agree

I believe it is OK for men to be attracted to other men in an emotional way, but it's not OK for them to have sex with each other.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree
- Moderately Agree
- Strongly Agree

When I think of my *homo/bi-sexuality*, I feel depressed.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree
- Moderately Agree
- Strongly Agree

I believe that it is morally wrong for men to have sex with other men.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree
- Moderately Agree
- Strongly Agree

I feel ashamed of my homo/bi-sexuality

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree
- Moderately Agree
- Strongly Agree

I am thankful for my sexual orientation.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree

- Slightly Agree
- Moderately Agree
- Strongly Agree

When I think about my attraction towards men, I feel unhappy.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree
- Moderately Agree
- Strongly Agree

I believe that more sexual minority men should be shown in TV shows, movies, and commercials.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree
- Moderately Agree
- Strongly Agree

I see my homo/bi-sexuality as a gift.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree
- Moderately Agree
- Strongly Agree

When people around me talk about homosexuality, I get nervous.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree
- Moderately Agree
- Strongly Agree

I wish I could control my feelings of attraction toward other men.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree

- Slightly Agree
- Moderately Agree
- Strongly Agree

In general, I believe that homo/bi-sexuality is as fulfilling as heterosexuality

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree
- Moderately Agree
- Strongly Agree

I am disturbed when people can tell I'm not heterosexual.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree
- Moderately Agree
- Strongly Agree

In general, I believe that sexual minority men are more immoral than straight men.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree
- Moderately Agree
- Strongly Agree

Sometimes I get upset when I think about being attracted to men.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree
- Moderately Agree
- Strongly Agree

In my opinion, homo/bi-sexuality is harmful to the order of society.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree

- Slightly Agree
- Moderately Agree
- Strongly Agree

Sometimes I feel that I might be better off dead than homo/bi-sexual.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree
- Moderately Agree
- Strongly Agree

I sometimes resent my sexual orientation.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree
- Moderately Agree
- Strongly Agree

I believe it is morally wrong for men to be attracted to each other

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree
- Moderately Agree
- Strongly Agree

I sometimes feel that my homo/bi-sexuality is embarrassing.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree
- Moderately Agree
- Strongly Agree

I am proud to be homo/bi-sexual.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree

- Slightly Agree
- Moderately Agree
- Strongly Agree

I believe that public schools should teach that homo/bi-sexuality is normal.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree
- Moderately Agree
- Strongly Agree

I believe it is unfair that I am attracted to men instead of women only.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree
- Moderately Agree
- Strongly Agree

I feel ashamed when I see or am around sexual minority men who are obviously

homo/bi-sexual or who are acting gay.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree
- Moderately Agree
- Strongly Agree

I believe homo/bi-sexual men are weak.

- Strongly Disagree
- Moderately Disagree
- Slightly Disagree
- Slightly Agree
- Moderately Agree
- Strongly Agree

Please be as honest as possible all of your answers are completely anonymous.

Use the following rating scale to indicate how open you are about your sexual orientation to the people listed below.

Mother

- Person definitely does NOT know about your sexual activity with other men
- Person might know about your sexual activity with other men, but is NEVER talked about
- Person probably knows about your sexual activity with other men, but it is NEVER talked about
- Person probably knows about your sexual activity with other men, but it is RARELY talked about
- Person definitely knows about your sexual activity with other men, but it is RARELY talked about
- Person definitely knows about your sexual activity with other men, and it is SOMETIMES talked about
- Person definitely knows about your sexual activity with other men, and it is OPENLY talked about
- Not applicable to your situation: there is no such person or group in your life

Father

- Person definitely does NOT know about your sexual activity with other

men

- Person might know about your sexual activity with other men, but is NEVER talked about
- Person probably knows about your sexual activity with other men, but it is NEVER talked about
- Person probably knows about your sexual activity with other men, but it is RARELY talked about
- Person definitely knows about your sexual activity with other men, but it is RARELY talked about
- Person definitely knows about your sexual activity with other men, and it is SOMETIMES talked about
- Person definitely knows about your sexual activity with other men, and it is OPENLY talked about
- Not applicable to your situation: there is no such person or group in your life

Siblings (sisters, brothers)

- Person definitely does NOT know about your sexual activity with other men
- Person might know about your sexual activity with other men, but is

NEVER talked about

- Person probably knows about your sexual activity with other men, but it is NEVER talked about
- Person probably knows about your sexual activity with other men, but it is RARELY talked about
- Person definitely knows about your sexual activity with other men, but it is RARELY talked about
- Person definitely knows about your sexual activity with other men, and it is SOMETIMES talked about
- Person definitely knows about your sexual activity with other men, and it is OPENLY talked about
- Not applicable to your situation: there is no such person or group in your life

Extended family/relatives

- Person definitely does NOT know about your sexual activity with other men
- Person might know about your sexual activity with other men, but is NEVER talked about
- Person probably knows about your sexual activity with other men, but it is

NEVER talked about

- Person probably knows about your sexual activity with other men, but it is

RARELY talked about

- Person definitely knows about your sexual activity with other men, but it is RARELY talked about

- Person definitely knows about your sexual activity with other men, and it is SOMETIMES talked about

- Person definitely knows about your sexual activity with other men, and it is OPENLY talked about

- Not applicable to your situation: there is no such person or group in your life

My new straight/heterosexual friends

- Person definitely does NOT know about your sexual activity with other men

- Person might know about your sexual activity with other men, but is NEVER talked about

- Person probably knows about your sexual activity with other men, but it is NEVER talked about

- Person probably knows about your sexual activity with other men, but it is

RARELY talked about

- Person definitely knows about your sexual activity with other men, but it is RARELY talked about
- Person definitely knows about your sexual activity with other men, and it is SOMETIMES talked about
- Person definitely knows about your sexual activity with other men, and it is OPENLY talked about
- Not applicable to your situation: there is no such person or group in your life

My work peers

- Person definitely does NOT know about your sexual activity with other men
- Person might know about your sexual activity with other men, but is NEVER talked about
- Person probably knows about your sexual activity with other men, but it is NEVER talked about
- Person probably knows about your sexual activity with other men, but it is RARELY talked about
- Person definitely knows about your sexual activity with other men, but it

is RARELY talked about

- Person definitely knows about your sexual activity with other men, and it is SOMETIMES talked about
- Person definitely knows about your sexual activity with other men, and it is OPENLY talked about
- Not applicable to your situation: there is no such person or group in your life

My work supervisor (s)

- Person definitely does NOT know about your sexual activity with other men
- Person might know about your sexual activity with other men, but is NEVER talked about
- Person probably knows about your sexual activity with other men, but it is NEVER talked about
- Person probably knows about your sexual activity with other men, but it is RARELY talked about
- Person definitely knows about your sexual activity with other men, but it is RARELY talked about
- Person definitely knows about your sexual activity with other men, and it

is **SOMETIMES** talked about

- Person definitely knows about your sexual activity with other men, and it is **OPENLY** talked about
- Not applicable to your situation: there is no such person or group in your life

Members of my religious community (e.g. church, temple)

- Person definitely does **NOT** know about your sexual activity with other men
- Person might know about your sexual activity with other men, but is **NEVER** talked about
- Person probably knows about your sexual activity with other men, but it is **NEVER** talked about
- Person probably knows about your sexual activity with other men, but it is **RARELY** talked about
- Person definitely knows about your sexual activity with other men, but it is **RARELY** talked about
- Person definitely knows about your sexual activity with other men, and it is **SOMETIMES** talked about
- Person definitely knows about your sexual activity with other men, and it

is OPENLY talked about

- Not applicable to your situation: there is no such person or group in your life

Leaders of my religious community (e.g. pastor, bishop, temple leader)

- Person definitely does NOT know about your sexual activity with other men
- Person might know about your sexual activity with other men, but is NEVER talked about
- Person probably knows about your sexual activity with other men, but it is NEVER talked about
- Person probably knows about your sexual activity with other men, but it is RARELY talked about
- Person definitely knows about your sexual activity with other men, but it is RARELY talked about
- Person definitely knows about your sexual activity with other men, and it is SOMETIMES talked about
- Person definitely knows about your sexual activity with other men, and it is OPENLY talked about
- Not applicable to your situation: there is no such person or group in your

life

Strangers, new acquaintances

- Person definitely does NOT know about your sexual activity with other men
- Person might know about your sexual activity with other men, but is NEVER talked about
- Person probably knows about your sexual activity with other men, but it is NEVER talked about
- Person probably knows about your sexual activity with other men, but it is RARELY talked about
- Person definitely knows about your sexual activity with other men, but it is RARELY talked about
- Person definitely knows about your sexual activity with other men, and it is SOMETIMES talked about
- Person definitely knows about your sexual activity with other men, and it is OPENLY talked about
- Not applicable to your situation: there is no such person or group in your life

My former straight/heterosexual friends

- Person definitely does NOT know about your sexual activity with other men
- Person might know about your sexual activity with other men, but is NEVER talked about
- Person probably knows about your sexual activity with other men, but it is NEVER talked about
- Person probably knows about your sexual activity with other men, but it is RARELY talked about
- Person definitely knows about your sexual activity with other men, but it is RARELY talked about
- Person definitely knows about your sexual activity with other men, and it is SOMETIMES talked about
- Person definitely knows about your sexual activity with other men, and it is OPENLY talked about
- Not applicable to your situation: there is no such person or group in your life

Please be as honest as possible all of your answers are anonymous.

Please read each statement carefully, and then pick out the response in each group that best describes the way you have been feeling during the past 7 days.

**I felt that I was just as good as other people.**

- Rarely or none of the time (less than 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

**I had trouble keeping my mind on what I was doing.**

- Rarely or none of the time (less than 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

**I felt depressed.**

- Rarely or none of the time (less than 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

**I felt that everything I did was an effort.**

- Rarely or none of the time (less than 1 day)
- Some or a little of the time (1 – 2 days)

- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

**I felt hopeful about the future.**

- Rarely or none of the time (less than 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

**My sleep was restless**

- Rarely or none of the time (less than 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

**I was happy.**

- Rarely or none of the time (less than 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

**People were unfriendly.**

- Rarely or none of the time (less than 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

**I enjoyed life.**

- Rarely or none of the time (less than 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

**I had crying spells.**

- Rarely or none of the time (less than 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

**I felt that people disliked me.**

- Rarely or none of the time (less than 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)

- Most or all of the time (5 – 7 days)

**I could not get “going.”**

- Rarely or none of the time (less than 1 day)
- Some or a little of the time (1 – 2 days)
- Occasionally or a moderate amount of the time (3 – 4 days)
- Most or all of the time (5 – 7 days)

Please be as honest as possible all of your answers are completely anonymous.

Below is a statement dealing with your general feelings about yourself. Using the scale below, indicate your agreement with each item. Please be open and honest in your responding.

On the whole I am satisfied with myself I feel that I'm a person of worth, at least on equal plane with others

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

I feel that I have a number of good qualities.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

All in All, I am inclined to feel that I am a failure.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

I am able to do things as well as most other people.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

I feel I do not have much to be proud of.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

On the whole I am satisfied with myself

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

I take a positive attitude toward myself.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

I wish I could have more respect for myself

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

I certainly feel useless at times

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

At times, I think I am no good at all.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

What is your race?

- Asian
- African American/ Black
- Caucasian/White
- Hispanic
- Native American
- Pacific Islander
- Other

Do you live in the United States?

- Yes
- No

What country do you live in?

In which state do you currently live in?

How would you describe the area in which you live?

- Rural/Country
- Small Town
- Suburban

- Urban/City

Where did you grow up, by grow up we mean the place you consider to be your hometown?

How would you describe your hometown?

- Rural/Country
- Small Town
- Suburban
- Urban/City

What is the highest level of education you have completed?

- Less than High School
- High School / GED
- Some College
- 2-year College Degree
- 4-year College Degree
- Masters Degree
- Doctoral Degree
- Professional Degree (JD, MD)

What is your annual income range?

- Under 9,000
- 10,000- 19,000
- 20,000 – 29,000
- 30,000- 39,000
- 40,000-49,000
- 50,000-59,000
- 60,000- 69,000
- Over 70,000

Have you ever visited a mental health practitioner (psychologist, psychiatrist, counselor, etc) for counseling or therapy?

- Yes
- No

Are you open to receiving mental health services if you needed it?

- Yes
- No

Did the mental health services meet your needs?

- Yes

- No

Would you seek mental health services again in the future, if you needed it?

- Yes
- No

What is your religious affiliation?

- Christianity (please specify, example Baptist)
- Islam (please Specify)
- Buddhism (please specify)
- Hinduism (please specify)
- Judaism (please specify)
- None
- Other

In the past six months, how many times have you attended a religious service?

- 0
- 1
- 2-5
- 6-9
- 10-13

- 14 or more

How important is your religious faith to you?

- Very important
- Somewhat important
- Not very important
- Not important at all

Which best describes your place of worship's view on same sex relationships?

- Welcomes
- Tolerates
- Rejects
- I don't know

Please be as honest as possible all of your answers are completely anonymous.

Please select the responses that describes how you view your sexual identity

- Heterosexual
- Straight
- Bisexual
- Gay
- Same Gender Loving

- Homosexual
- Queer
- Other



## APPENDIX D

### REQUEST TO ALTER OUTNESS SCALE

November 1, 2011

Dear Kemi,

Thank you for your interest in the Outness Inventory. The scale was published in a scientific journal for use in the public domain. You do not need to contact any of the authors for permission to use this scale in noncommercial research. You may *not* use the scale for commercial purposes without permission.

Feel free to make changes to the wording of the questionnaire to meet the needs of your study population. Adding items (or even removing items) may also be advisable depending on the population you are surveying. For example, if you know that your population includes many individuals from blended families, then you may want to include stepparent items. Decisions about which subscale such items should go in can be made using common sense (e.g., “stepmother” should probably go into Out to Family) or statistical analyses (e.g., factor analyses, examination of item-total correlations).

It is important to note that the rating scale is, in part, what makes the OI a unique and sensitive measure of outness. We discourage users from making any substantive changes to the rating scale.

If you have questions or concerns about the scale, feel free to contact me using the contact information below. Best wishes with your research!

Sincerely,

Jon Mohr

Jonathan Mohr  
Assistant Professor  
Department of Psychology  
Biology-Psychology Building  
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College Park, MD 20742-4411  
Office phone: 301-405-5907  
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Email: [jmohr@umd.edu](mailto:jmohr@umd.edu)