Experiences of Antihomosexual Attitudes and Young Black Men Who Have Sex with Men in the South: A Need for Community-Based Interventions

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Abstract

Purpose: In 2012, Jackson, Mississippi, had the third highest incidence rate of human immunodeficiency virus (HIV) among young Black men who have sex with men (MSM). The goal of this qualitative study (the initial phase of an HIV prevention clinical trial) was to explore how cultural norms regarding antihomosexual attitudes interfere with the safe sex practices and relationship norms of young Black MSM in Mississippi.

Methods: Nine focus groups ($N=54$) were conducted with young Black MSM aged 18–29. Participants were recruited through medical providers at local sexually transmitted infection clinics and through community organizers at local LGBT outreach programs. The data were analyzed through the use of grounded theory, multiple coders for consistency and intercoder reliability, and a qualitative data analysis software.

Results: Three major themes were identified during the analysis: (1) resiliency and condom use, (2) inconsistent condom use among closeted young Black MSM, and (3) intimate partner violence (IPV) among closeted young Black MSM. Black MSM in Mississippi continue to be highly stigmatized within their social networks (i.e., families, sexual partners, and community).

Conclusions: The findings suggest that cultural and community norms regarding antihomosexual attitudes may be a barrier to the practices of safe sex and a contributing factor to IPV among young Black MSM. There is a need for tailored interventions that address these cultural norms and establish social and community support for young Black MSM in Mississippi.

Key words: African American/Black, condom use, intimate partner violence, MSM, resiliency.

Introduction

MORE THAN THREE decades after the first cases of human immunodeficiency virus (HIV), men who have sex with men (MSM) still have the highest rates of HIV.^{1,2} Men of this group represent ~2% of the U.S. population, but account for 72% of all new HIV infections among men aged 13–24 and 30% of new infections among all MSM.³ Young Black MSM have the highest burden of disease compared to other risk groups and present 36% of new infections among all MSM.^{1,4}

The majority of these cases were identified in the Southern region of the United States—a region with more prevalence and incidence of HIV than all other regions combined.⁵ In 2007, the Mississippi State Department of Health (MSDH) reported

an increase in the number of new HIV cases among Black MSM in Jackson, Mississippi.⁶ All of these cases were identified at one sexually transmitted infection (STI) clinic located in the central area. Findings from a 2-year Centers for Disease Control and Prevention (CDC) and MSDH study identified high rates of condomless anal sex among Black MSM aged 13–21.⁶

Based on the most recent surveillance data, Jackson, Mississippi, has the fourth highest HIV diagnosis rate of any metropolitan area.⁷ This city also has the third highest rate of HIV infection in the United States and the highest proportion of HIV diagnosis among men in the country: 48% of these infections are among Black MSM.^{8,9} A recent study found that Black MSM in Mississippi limit their sexual networks to other Black MSM, indicating a high seroprevalence

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in this subpopulation.¹⁰ Further evidence shows that higher rates of STIs and drug-resistant strains of HIV have been found in Black MSM.^{11,12} These risk factors increase the possibility of HIV acquisition and limit treatment options. Given the disparities of HIV among Black MSM and the limited explanation provided by sexual risk behavior,^{10,11,13,14} there is a need to address the social facilitators of HIV risk among Black MSM.

Negative beliefs about same-sex behavior (e.g., being a MSM is incongruent with being a strong Black man) persist in communities of color.¹⁵ The social expectations of traditional masculinity have established a false sense of manhood among men and a ritualistic need to ridicule homosexuals as a way of reinforcing one's own masculinity.^{16,17} In addition, Black men are often forced to deny their same-sex behavior or any form of homosexuality to avoid suspicion. For Black MSM, the response to disclosing their same-sex behavior could mean a loss of their male identity and respect within the community.

Previous evidence suggests that closeted MSM are more likely to engage in risky sexual behavior than men who are accepting of their same-sex behavior.^{18,19} Black MSM are more likely to identify as bisexual or nongay and report more sexual encounters with female partners than white MSM.²⁰ The decision not to identify as gay and having a lack of social support from their community could have an impact on the utilization of HIV prevention resources among young Black MSM.

The adoption of antihomosexual beliefs aligns with the construct of internalized homophobia²¹ and has been associated with sexual behavior among other MSM.²² For the purposes of this article, internalized homophobia is defined as upholding negative attitudes toward one's sexual orientation and includes "negative global attitudes toward homosexuality, discomfort with disclosure of sexual orientation to others, disconnectedness from other LGB individuals, and discomfort with same-sex sexual activity."^{22,23(p. 1020)} Research regarding the influences of antihomosexual attitudes and safe sex behavior among Black MSM is limited. The majority of this evidence has focused on nonminority MSM, and a need for research among Black MSM has been identified.^{23,24} Accordingly, the goal of this study was to explore how experiences with antihomosexual attitudes may interfere with safe sex practices and relationship norms of young Black MSM in Mississippi.

Methods

Participants

The participants ($N=54$) self-identified as a biological male, Black/African American, had penile–anal sex with a male partner in the past 90 days, and 18–29 years of age. Men were eligible regardless of a previous STI diagnosis or HIV serostatus.

Procedures

The original procedures and data analysis approach for this study have been published elsewhere.²⁵ Primary care physician and nurse practitioners at a local STI clinic as well as organizers from LGBT outreach programs in Jackson, Mississippi, recruited the participants. Clinical patients were asked if they were willing and able to participate in the focus group discus-

sion. After receiving healthcare services and expressing interest, the patients were referred to the study Project Director, informed of the focus group guidelines, screened based on the inclusion and exclusion criterion, and scheduled for participation in one of the nine focus group sessions.

Focus group discussions were facilitated in a quiet private room within the clinic to ensure participants' privacy and confidentiality. Written consent was obtained at the beginning of each focus group. One to two moderators conducted the focus groups. The focus groups were digitally recorded for transcription.²⁶ Groups ranged in size from 4 to 12 participants per session. The duration of each discussion generally lasted between 45 minutes and 1.5 hours.

Measures

The interview guide approach was selected to systematically elicit responses to each question. This approach provides the researchers and moderators with a series of outlined topics while providing flexibility for the moderator to sequence and phrase questions. Specifically, focus group participants were asked a range of questions about topics, including, but not limited to, their condom use "rules," condom and water-based lubricant preferences, their ability to use condoms correctly, their feelings about being asked to use condoms for anal and oral sex, and their willingness to discuss their STI and HIV serostatus with potential partners. The areas of inquiry for the focus groups were developed through preliminary discussions with the research team and community stakeholders, including leaders from local LGBT organizations and advocacy groups and doctors and nurses from the local STI clinic who focus primarily on the needs of MSM patients. A detailed outline of the interview guide for this study has been published elsewhere.²⁵

Data analysis

An internal contractor transcribed the digital recordings verbatim. All of the transcripts were uploaded into the qualitative data analysis software program, NVivo qualitative data analysis software, QSR International Pty Ltd, Australia, Version 9, 2010. The codes were analyzed using grounded theory. Coding was performed by two coders and was assessed for consistency and intercoder reliability. The calculated inter-rater agreement was in the 90th percentile range. Preliminary reviews of the data, by the primary coder, led to the initial group of codes, and each of these codes was used to categorize the focus group responses. The codes were revised and updated as needed during the coding process, which involved the interpretation of the data by the two coders and the interviewer. Overall, 73 codes were finalized and used by the data analysts to create patterns and identify themes in the data.^{25,26} The study protocol was approved by the Institutional Review Board of the University of Kentucky.

Results

Three major themes were identified during the analysis: (1) resiliency and condom use, (2) inconsistent condom use among closeted MSM, and (3) intimate partner violence (IPV) among closeted MSM. IPV is defined as "violence occurring between intimate partners and encompasses multiple domains of violent behavior."^{27(p. 168)}

Resiliency and condom use

Many of the men described the cultural norms of shame and guilt that are perpetuated in their community. When disclosing their same-sex behavior to their friends and family members, the men received denouncing and judgmental responses. The men were often stigmatized as being diseased and immoral. Despite these experiences, for men who disclosed their same-sex behavior, the antihomosexual attitudes of their family members were used as a motivation to use condoms.

Ken: When people see or relate homosexuality or gay males, they always relate it to them having an STD or mainly HIV and I wouldn't like to be a statistic so it make me want to always protect myself and also it is a gay males parent's worse fear, especially a mom, for the child to contract HIV. When alot of people tell their momma they be so scared like oh my child's gonna die or gonna get AIDS ... that also makes me wanna make sure.

Torren: When I first told my momma, the first thing she told me was that I was gonna die from HIV or you're going to be put on the side of the road, somebody is gonna beat you up so of course when she told me that it scared me. And I knew for a fact that I wasn't going to deviate from men so that made me want to put it (condoms) on even more.

BJ: I agree, I don't think it would deter you from wanting (to) have safer sex, I think it would make you protect yourself more because of the stereotype that they list homosexuals to have so I think that with us being based on the stereotype that may not be true but it still makes you want to use condoms more being the fact that you don't want to be placed in that bracket as others.

Inconsistent condom use and closeted MSM

The participants described how many young Black MSM chose to adopt these antihomosexual attitudes. It was influenced by a lack of support from their community and their inability to accept or publically acknowledge their sexual orientation. Men who adopted these "self-hating" ideals were said to be less likely to use condoms and more likely to meet partners through an anonymous setting. In this community, men who adopted these behaviors and principles were labeled as a subgroup of MSM known as "Trade" partners.

Keith: We call that trade and it matters how mature you are because trade don't want to do it with condoms, because they feel like if they put a condom on that's still like DL (down low) but we call it trade.

Brandon: There are people that meet up in the parks and in the restrooms or you meet them online and they are like self-hating gays. So they just want to have sex and get it over with so they can just go home and they really can't deal with what they're doing so they just want to have sex. Either they're not really thinking about using a condom or they're trying to meet up, they don't want to take the time out they just want to drop their pants, get it over with and go about their business.

Keith(2): So to them if they put a condom on that means they will feel maybe guilty because they are having sex with another man. In they mind they bi-sexual so this is just a little extra activity for them. In Jackson, alot of girls (effeminate MSM) they won't do it with condoms with the trade.

Intimate partner violence

IPV was a dominant characteristic of relationships among this subgroup of MSM. Sexual encounters and relationships with a "Trade" partner involved the policing of sexual and intimate behavior through threats of abuse or violence. The variation in violence ranged from emotional abuse to physical mutilation, and in rare cases, murder.

Rudeness: DL leads to death, bodies being found, toes cut off, HIV ... anything (is) possible so why even put yourself in that situation.

Michael: Trade boys will not only kill you with maybe diseases or stuff like that they will ... just kill you kill you. The boys that say they are trade most of them (when) they can't get what they can get out of you (when) you say no they expose you to their friends and their friends most of the time the trade boys have straight friends they don't mess with gay people at all and they will oh he tried to talk to me, they will just come and kill you.

Many of the participants discussed how relationship dynamics would often change when the sexual orientation of a "Trade" partner could be exposed to his peers or family members. The men explained how "Trade" partners were not only violent with them but also with MSM who publically identify as gay or bisexual. These sentiments were echoed throughout many of the focus groups and were accompanied by details of personal or observed experiences.

Rudeness: I've been put in a situation like that when me and a guy was dating for about 7 months. He lived a total different life. There was no gays around them, if he seen them he would try to run them over, shoot at them, and it got to me because if you will do that to them when I'm not around do you think of me the same way. And it got to the point where once people would put two and two together it came to life, then it was more of oh well, he had to put on this role of bitch I'm gonna kill you or now you about to come up missing ...

Michael: I've known one to get killed, a trans to get killed because she was messing with a trade and he just he flipped on her. He changed the script, he was messing with her but none of his friends knew it and they was like this trans try to holla at me this boy trying to be a girl try to holla at me and they killed her. They killed, actually shot her.

Discussion

There were notable differences within this sample. Although young Black MSM of Mississippi habitually experience social stigma from members of their community, the impact of these encounters varied based on disclosure status. Young Black MSM who did not disclose their same-sex behavior to their social network were described as being more likely to engage in condomless sex, having internalizing antihomosexual attitudes, and being (at times) violent. These emotions were directed toward their male sexual partners and other gay members of the community. Cultural norms of this community that support and perpetuate antihomosexual beliefs have cultivated negative stereotypes and induced a level of self-hating beliefs that has ultimately influenced the safe sex practices of this population.

Young Black MSM who disclosed their same-sex behavior to their social network reported a desire to engage in

safer sex practices (e.g., frequent testing and condom use) as an adaptive response to the negative stereotypes and application of their knowledge about HIV risk in their community. For young Black MSM in Mississippi (a state with one of the highest rates of HIV incidence in the country),²⁸ disclosure could be a protective buffer against HIV and STI acquisition. There is a need for research to understand the social and structural context of their resiliency. Findings from this study and future research could be used to inform the development of sexual health interventions for young Black MSM.

MSM who receive social support from their community and are open about their sexual orientation are more likely to engage in safe sex practices.²² Young Black MSM are less likely to be involved in supportive social networks, resulting in limited resources that are specific to their needs. Involvement in supportive networks can expose young Black MSM to more HIV education and prevention messages, thereby reinforcing their knowledge and support to maintain safe sex behaviors. Further qualitative and quantitative research is also needed to better understand cultural norms and willingness of this community to support young Black MSM. Indeed, the accounts of these men suggest a need to develop community-based interventions that establish supportive social networks for young Black MSM in Mississippi.

In this community, the fear, shame, and guilt associated with their sexual orientation are so powerful that the possibility of disclosure leads to physical, sexual, and psychological violence in their partnerships. Men who experience stigmatization and discrimination, which is associated with heteronormativity, are at an increased risk for experiencing²⁹ or demonstrating IPV. IPV, especially psychological and physical IPV, has increased in MSM partnerships.²⁷

Research focused on IPV among young Black MSM is limited.²⁷ This study is one of the first to report the experiences of IPV among young Black MSM in the South.²⁴ The descriptions of IPV suggest a need for social support and organizations that specifically address IPV among same-sex partners. Further research is needed to establish an appropriate level of support and to inform the development of IPV and sexual health interventions for young Black MSM.

Limitations

This study includes noteworthy limitations. The results are not generalizable to all young Black MSM because of sample size and recruiting methods. Measurement of outness and social support was not collected. This information would have allowed the researchers to examine the source of their resiliency. A notable theme absent from the data was gender norms and their effect on the relationships of young Black MSM. Future studies should examine the influence of masculine identity and its role in the relationship dynamics and safe sex practices of young Black MSM. Variation in the definition of internalized homophobia has been identified as a significant limitation in research of this capacity.²⁶ In an effort to address this limitation, the definition provided in the most recent literature review of sexual risk behavior among Black MSM was utilized for this study.²⁴

Conclusion

Social determinants of health continue to be powerful health predictors in this population. Efforts to reduce HIV in-

cidence are essential to address social stressors that perpetuate disproportionate outcomes of HIV among young Black MSM. The findings of this study identified a population that, despite experiences with antihomosexual attitudes, has positive attitudes toward condom use and HIV prevention such as HIV testing.²⁵ The social norms of the local community conflict with these beliefs, implying the influence of external and cultural factors that should be considered in future research. Given the potential benefits of providing social, cultural, and community support as a strategy to decrease the prevalence of HIV and IPV, public health scientists should consider collaborative efforts as an approach to developing tailored interventions for young Black MSM in Mississippi. These collaborations should include members of the LGBT community, LGBT organizations, and clinicians with a focus in LGBT and sexual healthcare.

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Author Disclosure Statement

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