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What's in an identity label? Correlates of sociodemographics, psychosocial characteristics, and sexual behavior among African American men who have sex with men

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Abstract

African American men who have sex with men (AAMSM) are vastly overrepresented among people with HIV/AIDS. Using data from 595 AAMSM in Philadelphia, we explored differences in sociodemographics, psychosocial characteristics related to beliefs about ethnicity, sexuality and masculinity, and sexual behavior with men and women by self-reported sexual identity (gay, bisexual, down low, straight). Roughly equivalent numbers identified as gay (40.6%) and bisexual (41.3%), while fewer identified as straight (7.6%) or down low (10.5%), with significant differences in age, income, history of incarceration, HIV status, alcohol and drug problems, childhood sexual abuse, and connection to the gay community evident among these groups. Analysis of psychosocial characteristics theorized to be related to identity and sexual behavior indicated significant differences in masculinity, homophobia, and outness as MSM. Gay and straight men appeared to be poles on a continuum of frequency of sexual behavior, with bisexual and down low men being sometimes more similar to gay men and sometimes more similar to straight men. The percentage of men having total intercourse of any kind was highest among down low and lowest among gay men. Gay men had less intercourse with women, but more receptive anal intercourse with men than the other identities. There were no significant differences by identity in frequency of condomless insertive anal intercourse with men, but gay men had significantly more condomless receptive anal intercourse. There were significant differences by identity for condomless vaginal and anal intercourse with women. This study demonstrates the importance of exploring differences in types of sex behavior for AAMSM by considering sexual identity.

Keywords

African American Men; Men Who Have Sex with Men; HIV/AIDS; Sexual Identity; Sexual Orientation

INTRODUCTION AND BACKGROUND

African Americans are vastly overrepresented in HIV/AIDS epidemiology, with rates surpassing not only other racial and ethnic groups in the US but rates among populations in the world's most affected countries (World Health Organization, 2015). Although infections attributable to injection drug use are substantial, the largest proportion of the HIV/AIDS burden among African Americans rests among men who have sex with men (MSM). African Americans comprise only 14% of the US population and the generally accepted estimate of gay and bisexual men (inclusive of all races/ethnicities) in the US is 2% (Purcell et al., 2012). However, 44% of HIV diagnoses in 2010 in the US were among African Americans and AAMSM accounted for 72% of those diagnoses among African American men (Centers for Disease Control and Prevention [CDC], 2012). In Philadelphia, the site of this study, 63.3% of people living with HIV/AIDS are African American, of whom 29.8% are MSM (AIDS Activity Coordinating Office [AACO], 2014). Although incidence among women has been declining in recent years in the US and in Philadelphia (AACO, 2014; CDC, 2012), the link between AAMSM and African American heterosexual women is concerning. In molecular HIV surveillance data studies of HIV transmission networks, only 4% of MSM were linked to heterosexual women, however 29% of heterosexual women were linked to MSM. Older MSM and African American MSM were more likely to be linked to heterosexual women (Oster et al., 2015).

Despite the epidemiological disparities, AAMSM remain underserved in HIV prevention and treatment efforts. Although a handful of HIV prevention interventions have been demonstrated efficacious with MSM, startlingly few have been directed at AAMSM (Higa et al., 2013). In addition, research on risk and protective factors for HIV transmission has not clearly elucidated why AAMSM have elevated rates of HIV/AIDS compared with their White peers. Reviews by Millett et al. (2006, 2007) and Maulsby et al. (2014) suggest AAMSM do not have more risky sex or use drugs more than their White peers. It seems clear, though, that barriers to prevention and treatment services, higher levels of STIs, assortative mixing, higher rates of undiagnosed HIV and lower rates of HAART may contribute to higher rates among AAMSM (Millett et al., 2011). Especially concerning, AAMSM aged 13–24 accounted for 45% of all new diagnoses among AAMSM in 2010 (CDC, 2012).

The population of MSM is remarkably diverse, yet studies have tended to focus on comparing AAMSM with White MSM or exploring differences between AAMSMO (men who have sex with men only) and AAMSMW (men who have sex with men and women). Using a sample of nearly 600 AAMSM, this article takes as its primary goal differentiating AAMSM by four sexual identities (gay, bisexual, down low, and straight) in sexual behavior, sociodemographics as well as psychosocial characteristics theorized to influence or be influenced by sexual orientation self-identification and sexual behavior. Given the longstanding need to identify approaches for reducing the health disparities related to HIV/AIDS for AAMSM, this article focuses primarily on that health problem. However, findings may logically extend to other health disparities experienced by sexual minorities in addition to HIV/AIDS, including mental health, substance abuse, cardiovascular disease, and cancer

(Mayer, Bradford, Makadon, Stall, Goldhammer, & Landers, 2008; Blosnich, Farmer, Lee, Silenzio, & Bowen, 2014).

For purposes of HIV/AIDS surveillance, the epidemiological category of MSM emerged in public health practice in the 1980s and first appeared in publications in 1992 (Lifson, 1992). Theoretically, this category is based upon behavior rather than identity/orientation and incorporates various conceptualizations of sexuality for male same-sex sexual behavior. In part, this was to recognize and respect men wishing not to identify as gay. However, the continued use of this category has been subject to criticism within the broader gay and lesbian community as well as within public health. Some theorists have argued that the MSM categorization erodes empowerment within communities and by individuals to self-label, is reductive, and obscures social meanings (Young & Meyer, 2005). Alternatives to such categorization include the theory of intersectionality. The use of intersectionality deepens analyses by examining how multiple social statuses intersect at the level of an individual's experience often revealing patterns of interlocking systemic oppressions such as racism and heterosexism (Bowleg, 2012).

Public health classifications based on same-sex sexual behavior as well as self-identifications within the population of MSM are not consistent in the literature, but are often interpreted to differentiate men who primarily have sex with men or with both men and women. Some researchers differentiate between MSM and MSMW and describe the former as behaviorally homosexual and the latter as behaviorally bisexual. Others have classified men as MSMO (men who have sex with men only) or MSMW (men who have sex with men and with women) (e.g., Dyer et al., 2013, Latkin et al., 2011). This may be problematic given discordance with these classifications and the diversity of self-identities (Millett, Malebranche, Mason, & Spikes, 2005; Ross, Essien, Williams, & Fernandez-Esquer, 2003; Young & Meyer, 2005). For example, some men who self-identify as gay sometimes have sex with women and some men who self-identify as straight sometimes have sex with men. Classifying these groups of men as behaviorally bisexual versus homosexual can be useful in comparing between-groups sexual behavior and disease risk, but understanding within-group differences is important.

African American men self-identify their sexual orientation in a variety of ways (Battle, Cohen, Warrant, Fergusson, & Audam, 2002; Ford, Whetten, Hall, Kaufman, & Thrasher, 2007; Mays, Cochran, & Zamudio, 2004) and are more likely to identify using a label that signifies bisexuality than men of other races and ethnicities. Sexual identity is not a consistent predictor of condomless sex or number of sex partners (Millett et al., 2005). Few studies have specifically examined differences in sexual behavior among MSM using multiple categories of sexual identity and, to our knowledge, none has compared proportions of types of sex with men and with women among a large sample of AASMSM that includes multiple categories of self-identity. Determining how risk and protective factors for HIV infection and transmission may differ between men who identify as straight but have sex with men as well as with women and those who have sex with men only may illuminate targets for prevention. If there are differences in sexual behavior and associated risk and protective factors among MSM who identify as gay, bisexual or straight, intervention approaches can be tailored to address common as well as differing factors.

Research on MSM (regardless of race/ethnicity) using behavioral distinctions has documented differences between men who have sex only with other men (MSMO) and men who have sex with men and women (MSMW). Some studies have found MSMW are younger, more likely to be African American, more likely to identify as straight, have lower incomes, and less likely to have disclosed same-sex sexual behavior (O'Leary, Fisher, Purcell, Spikes, & Gomez, 2007; Wheeler, Lauby, Liu, Van Sluytman, & Murrill, 2008). However, other research studies focusing solely on African American MSM have found that, compared with AAMSMO, AAMSMW are older, less employed, poorer, less stably housed and more likely to have experienced incarceration (Dyer et al., 2013; Latkin et al., 2011). Wheeler et al. (2008) found MSMW were less likely to have engaged in condomless receptive anal intercourse, but more likely to have engaged in exchange sex for food, money or drugs and to have engaged in illicit drug use and alcohol use. In analyses of baseline data from the HIV Prevention Trials Network Brothers Study, AAMSMO had more frequent condomless receptive anal intercourse, but AAMSMW had more frequent condomless anal intercourse after drinking and were more likely to be paid money or drugs for sex (Dyer et al., 2013). Using the same data set, Harawa et al. (2014) examined types of female partners (primary-only, primary and non-primary, and non-primary-only) among MSMW using 10 categories of sexual identity. Men whose recent sexual activity with women was with primary-only had fewest male partners and were most likely to have primary male partners. More exploration of proportions of male and female partners among MSMW is clearly needed, particularly given the diversity of ways MSM self-identify.

Interest in identity among MSM ramped up with increased public health and community awareness of the "down low" identity, particularly spurred by the media frenzy surrounding newspaper features and a popular book in 2004 (Dodge & Sandfort, 2008; Sandfort & Dodge, 2008). Although the media attention focused on this as a new phenomenon, secrecy about sex between men and marital infidelity were clearly not new notions and had been expressed for generations in vernacular as "being on the down low." Described to be a subculture of secretive African American men who prize masculinity and reject effeminacy stereotypically associated with homosexuality and commonly perceived as deviant and predatory, men on the down low became a popular and maligned target of suspicion for a bridge from the HIV epidemic to African American women (Ford et al., 2007; Sandfort & Dodge, 2008). However, men on the down low are not necessarily any more sexually risky with men than their gay- or bisexual-identified peers (Dodge & Sandfort, 2008; Malebranche, 2008; Millett et al., 2005; Wolitski, Jones, Wasserman, & Smith, 2006). Nonetheless, African American men who identify as heterosexual denigrate down low men and other AAMSM as "switch hitters" and believe AAMSM are likely responsible for infecting women who subsequently infect heterosexual men (Bowleg et al., 2011). The crisis of HIV among African American men needs dedicated studies of risk and protective factors for HIV and other health disparities that focus on the continuum of sexual identity/orientation, including heterosexual men (Raj & Bowleg, 2012).

One explanation for differences in sexual behavior rests on the degree to which AAMSM integrate overlapping, intersecting and potentially conflicting notions of ethnic, sexual and masculine (ESM) identities (Bowleg, 2012; Bowleg et al., 2011; Icard, 1996; Wilson, 2008). In response to racism from the White gay community and homophobia within the Black

community, AAMSM may compartmentalize identities in response, which may be associated with elevated HIV risk behavior (Mays et al., 2004; Jeffries, Marks, Lauby, Murrill, & Millett, 2013). Identifying as gay is rarer among AAMSM than other MSM (Carlos et al., 2010; Magnus et al., 2010; O'Leary et al., 2007; Oster et al., 2011), but more AAMSM than other MSM are likely to identify as bisexual and to have sex with both men and women (Millett et al., 2005). Masculinity is highly valued in African American culture (Griffith, Gunter & Watkins, 2012; Han, Rutledge, Bond, Lauby, & LaPollo, 2014; Icard, 1986; Malebranche, 2003; Malebranche, Fields, Bryant & Harper, 2009; Icard, 1986; Mays et al., 2004). In response to pressures from family, community and church to reject homosexuality (Woodyard, Peterson, & Stokes, 2000; Ward, 2005) and to conform to ideals about masculinity, young AAMSM may experience psychological distress and elevated HIV risk behavior in attempting to conform (Fields et al., 2015; Kisler & Williams, 2012; LaPollo, Bond, & Lauby, 2014; Fischgrund, Halkitis, & Carroll, 2012).

Sexual behavior is clearly relevant to HIV risk. However, additional factors potentiate risk. Problems with alcohol or other drugs (Irwin et al., 2006; Dyer et al., 2013), depression (Reisner et al., 2009; Dyer et al., 2015), childhood sexual abuse (O'Leary, Purcell, Remien, & Gomez, 2003), and intimate partner violence (Hatcher, Colvin, Ndlovu, & Dworkin, 2014) are correlated with HIV risk behavior and being HIV-positive. An analysis of data from the present study showed that the number of these syndemic conditions men reported was related to the likelihood that they were HIV-positive (O'Leary et al., 2014). Differences in these psychosocial risk factors exist between MSMO and MSMW. For example, compared to AAMSMO, AAMSMW have higher psychosocial vulnerability, including internalized homophobia, lower social support, more depression and higher suicidality (Dyer et al., 2013, 2015). However, in a study comparing social networks of AAMSMO and AAMSMW, there were no differences in size of kinship networks or networks providing emotional and material support (Latkin et al., 2011).

In this article, we explore differences in sexual identity (gay, bisexual, straight, down low) in 1) sociodemographics such as age, HIV status, history of incarceration, and syndemic factors such as depression, childhood and intimate partner victimization, and drug and alcohol problems (O'Leary, Jemmott, Stevens, Rutledge, & Icard, 2014); 2) psychosocial characteristics related to beliefs about ethnicity, sexuality, and masculinity (ESM) that are postulated to influence sexual self-identity; and, 3) sexual behavior including proportions of types of intercourse and condomless intercourse. Better understanding differences in structural, psychosocial and behavior variables among AAMSM is important to tailor not only HIV prevention interventions, but may also be useful for health and social service practitioners providing mental health and substance abuse counseling.

METHOD

Baseline data collected May 2008 through March 2011 from 595 participants in a randomized controlled trial of an individual counseling HIV risk-reduction intervention for AAMSM in Philadelphia (Jemmott et al., 2014) are used to explore differences in sexual behavior among four sexual identity classifications. Eligible men were 18 years of age and older, self-identified as Black or African American, were born male, and reported having

anal intercourse with a man in the previous 90 days. Men who reported having anal intercourse with only one main male partner in the past 90 days or had participated in an HIV/STI risk-reduction intervention in the past 12 months were excluded.

Baseline data were collected via audio computer-assisted self-interviewing (ACASI), which provided audio and video presentation of the questions and response options on a laptop computer. Institutional review boards (IRB) at the University of Pennsylvania and Temple University reviewed and approved this study. The one CDC author was not engaged and this designation was approved by CDC in a project determination.

Measures

The assessment was pilot tested with a paper and pencil pilot version of the questionnaire with 217 men to ensure that the questions were clear and appropriate for the target population. The questionnaire was then programmed for ACASI and pre-tested with 16 men.

Sexual Identity—Participants self-reported sexual identity by choosing gay, straight, bisexual or being on the down low from a list following a lead “I consider myself sexually as...” In formative survey research prior to the research trial, we inquired about the meaning of the down low. Survey participants in general said that being on the down low inferred having sex with other men and perhaps with other women, but being secretive about same-sex sexual behavior. For this study, down low includes whatever individual meaning a participant ascribed to it.

Age—Participants reported their age in years.

Education—Participants indicated the highest grade of school completed, including no formal schooling, less than a high school diploma, a high school diploma or GED, some college or a 2-year degree, a 4-year degree, and post-graduate work. We dichotomized this variable as 0= equal to or less than a high school diploma and 1= more than a high school diploma.

Income—Participants reported total monthly income from all sources with seven categories ranging from less than \$400 to more than \$4,001 monthly. For these analyses, we dichotomized income as low if monthly income was \$850 or less.

Employment—Participants were asked “What is your employment status?” and chose from 0=Unemployed, 1=Part-time, 2=Full-time, 3=Retired. For these analyses we indicate whether participants are employed (including part-time or full-time) or not employed (unemployed or retired).

History of incarceration—A binary variable was used to assess incarceration history. Participants were asked “have you ever spent time in jail or prison” and if so, the amount of time incarcerated and length of time since last incarceration. Given the possibility for concerns about recall and specificity in responses, we dichotomized as ever or never.

Exchange of sex for drugs or money—Participants were asked how many days in the past 90 they had exchanged (as provider or recipient) sex for drugs or money. This was dichotomized as ever/never in the past 90 days.

Member of gay community—Participants were asked “Do you consider yourself to be a member of the local gay community?”

Where seek sex—Participants were asked how often in the last 90 days they had gone to each of six venues for meeting “new sex partners,” including gay bars, sex clubs/bathhouses, public cruising areas, private jack-off party/sex party, Internet, chat/party line.

HIV serostatus—Participants self-reported their HIV status by answering the question, “Has a nurse or doctor ever told you that you were HIV-positive?”

Syndemic factors—Referring to overlapping adversities affecting health, we measured alcohol and drug problems, depression, and experiences of childhood sexual abuse and intimate partner violence. The operationalizations of these variables are presented below. In addition, we created a composite Syndemic Index of the number of adversities experience by a participant, which could total 0 to 3. A score of 3 indicates 3 or more adversities (O’Leary et al., 2014).

Alcohol problems—Alcohol problems were assessed with the 4-item CAGE (Ewing, 1984). The respondent was coded as having a problem if he endorsed two or more items. The CAGE questionnaire is an extensively validated and widely used screener for problem drinking and alcoholism. It includes four yes/no questions about: 1) self-perceived need to Cut down on drinking, 2) feeling Annoyed that others are critical of his/her drinking, 3) feeling Guilty about drinking, and 4) needing a drink as an Eye-opener first thing in the morning.

Problems with drug use—Problems with drug use were assessed with the Texas Christian University Drug Screen II (Lowmaster, Morey, Baker, & Hopwood, 2010). This 11-item scale asked respondents which of a number of negative consequences of drug use they had experienced during the previous 90 days. Endorsed items were summed to create the scale score.

Depression—The five-item Center for Epidemiologic Studies Depression Inventory (Radloff, 1977) was used. Participants reported severity of feelings on a four-point scale from 0 (not at all) to 4 (extremely). The five ratings were averaged and a binary variable created where 1 was assigned if average rating was greater than or equal to 1.00 and 0 was assigned if the average rating was less than 1.00.

Intimate partner violence (IPV)—IPV was assessed using three items from the Revised Conflict Tactics scale (Straus, Hamby, Boney-McCoy, & Sugarman, 1996) related to physical assault, assault with a weapon, or forced sex. Affirmative responses to any of the three items were coded as having experienced IPV.

Childhood sexual abuse (CSA)—The Wyatt Sex History Questionnaire (Wyatt, Lawrence, Vodounon, & Mickey, 1993) was adapted to assess CSA before the respondent was age 18 with six items. Example items include “Before you were 18, did anyone attempt to have sex with you against your will” and “Before you were 18, did anyone ever put their penis in your mouth or put their mouth on your penis?” CSA was coded as an affirmative response to any.

“Not Gay.”—We created a measure labeled in the assessment as “perceptions of gender” using a 5-point agreement scale. Based on formative research with the population, we included four questions related to African American men’s attitudes about sex behavior between men that may be stereotyped as “gay” behavior, including kissing, sexual positioning, drinking before sex, and whether sex with both men and women was a natural expression of Black sexuality. For the present study, we used two of the items to create the measure “Not Gay” that is based on notions that an African American man who 1) does not kiss another man or 2) always takes the insertive (top or active) position with another man is not gay. The alpha for the resulting measure was .79.

Outness—We assessed the degree to which participants disclosed they have sex with men to 1) friends, 2) family, and 3) co-workers. We asked true-false questions about whether “some of my friends/family members/co-workers, but not all, know I have sex with men” and “all of my friends/family/co-workers, know I have sex with men. To create a single-item variable, for each of the three groups we coded 0 if they responded false to both items about “some but not all” or “all,” 1 if they responded true to the item about “some but not all” but false to the item about “all” and 2 if they responded true to the item about “all.” We then computed *Outness* as a range of 0–6 by summing the score for the three groups.

Homophobia is the score from a modified version of the 20-item Heterosexuals’ Attitudes Toward Homosexuals (Larsen, Reed & Hoffman, 1980). Participants were asked to rate their agreement on a scale from 1 to 5 with 17 items about homosexuality. The HATH has been used by many researchers in the past three decades with most reports indicating good validity. We updated language that referred to “homosexuals” to “gays” and did not include three items (one about mistreatment and two that would be awkward for a sample of MSM to answer about themselves) in the assessment. The alpha for the resulting scale was .91.

Religiosity—Religiosity was assessed with a scale used in previous research (O’Leary, Jemmott, Jemmott, Bellamy, Ngwane, Icard, & Gueits, 2012). Respondents indicated how often they engage in specific religious activities, on a scale from 1 (never) to 5 (twice weekly or more). Items included, for example, “Go to church or worship services,” “Read the Bible or other religious works,” and “Listen to religious radio stations.” The mean of the sum of endorsed items became the religiosity score. Alpha = .87.

Black pride—Black pride was assessed with the Private Regard subscale of the *Multidimensional Inventory of Black Identity* (Sellers, Rowley, Chavous, Shelton, & Smith, 1997), a seven-item scale with responses from 1 (disagree strongly) to 5 (agree strongly). This Inventory assesses the significance of race for African Americans and how they interpret the meanings of being Black. Example items from the Private Regard subscale are

“I believe that because I am Black, I have many strengths” and “I feel good about Black people.” The mean of the seven items is the scale score. Alpha = .82.

Sexual Behavior and Risk Variables—Participants self-reported frequencies within the last 90 days of 1) insertive and condomless insertive anal intercourse with men, 2) receptive and condomless receptive anal intercourse with men, 3) vaginal and condomless vaginal intercourse, and 4) anal intercourse and condomless anal intercourse with women.

Data Analyses

We used descriptive statistics to summarize the participants at baseline on socio-demographics and psychosocial characteristics. To examine differences in sociodemographics and psychosocial characteristics among sexual identity groups we used chi square tests if the outcome was categorical and analysis of variance (ANOVA) if the outcome was continuous. If the omnibus F ratio from the ANOVA was statistically significant, we used Fisher's least significant difference (LSD) tests to conduct pairwise comparisons among sexual identity groups. ANOVA was used to analyze differences among identity groups in percentage of different types of intercourse acts (insertive anal intercourse with men, receptive anal intercourse with men, vaginal intercourse, and anal intercourse with women) and percentage of different types of condomless intercourse acts. The $p = .05$ two-tailed significance criterion was used and all analyses were conducted in SAS 9.3.

RESULTS

Differences by Sexual Identity in Sociodemographic Characteristics

As detailed in Table 1, of the 593 participants who indicated sexual identity, there were roughly equivalent numbers of men who identified as gay (40.6%) and bisexual (41.3%) while far fewer identified as straight (7.6%) or on the down low (10.5%). The participants ranged in age from 18 to 69 years (mean = 41.64) with significant differences by sexual identity with those identifying as gay being youngest. In general, the participants were poor and unemployed. More than half had been incarcerated and there were significant differences by sexual identity with a lower percentage of gay men reporting history of incarceration. Almost 30% (29.5%) of the participants said they had been diagnosed HIV+ and there were statistically significant differences by sexual identity: 41.9% of gay men said they were positive as did 11.4% of straight, 23.2% of bisexual, and 19.0% of down low men. Few of the straight (8.9%) and down low (14.5%) men considered themselves members of the gay community compared with those identified as bisexual (20.8%) or gay (58.1%). There were few statistically significant differences by identity for where participants indicated they sought sexual partners. There were not statistically significant differences in the Syndemic Index. However, there were statistically significant differences in alcohol and drug problems by sexual identity with gay men reporting the fewest problems. There were significant differences by identity in the percentages of men who reported having experienced childhood sexual abuse, but not intimate partner violence. Nearly 60% (59.8%) of gay men reported experiencing childhood sexual abuse compared to 42.9% of bisexual, 43.6% of down low, and 31.1% of straight men ($p < .0001$).

Differences by Identity in Ethnic-Sexual-Masculine (ESM) Variables

As described in Table 2, there were significant differences for ESM measures conceptualized as reflecting sexual identity and masculinity, but not for those aligned with ethnicity. The means for the sexual and masculine attitudes fell along a continuum from gay to bisexual to down low to straight.

Scores on the Not Gay measure significantly differed among the sexual identities with gay men (1.55) and bisexual men (1.88) scoring lower than down low (2.13) and straight (2.42) men. The same pattern was observed in the opposite direction for the variable measuring Outness. There were also differences among the sexual identities in Homophobia with gay lower than the other sexual identities, and straight men's scores higher than the other sexual identities and bisexual men and down low men in the middle, not differing from each other. Means on scales conceptualized to align with ethnicity – Black Pride and Religiosity – were not statistically different by sexual identity. The three masculinity and sexuality variables were correlated with one another in expected directions. Also, the ethnicity variables (Black Pride and Religiosity) were significantly correlated with one another. Interestingly, having Black Pride was associated with lower homophobia, but not with being out. Religiosity was not significantly correlated with the three masculinity and sexuality measures.

Differences in Sexual Behavior by Sexual Identity

Mean total number of intercourse (insertive and receptive anal with men, vaginal and anal with women) within the past three months was highest among down low and lowest among gay men. Down low men reported an average of 18.19 (sd 25.25) intercourse acts, straight men 15.36 (sd 17.01), bisexual 13.67 (sd 18.88), and gay 11.16 (sd 14.82). As reported in Table 3, percentage of various types of intercourse varied by sexual identity. A much greater percentage of gay men's intercourse was receptive anal intercourse (45.8%) compared with bisexual (13.4%), down low (18.4%), and straight men (3.4%). A much smaller percentage of gay men's intercourse was with women. For instance, 2.4% of gay men's intercourse was vaginal intercourse compared with 33.7% for bisexual, 30.9% for down low, and 48.6% for straight men.

To examine risky sexual behavior, we computed mean total reported condomless intercourse (insertive and receptive anal with men, vaginal and anal with women) within the past three months and compared percentages engaged in each type of intercourse by sexual identity. Mean total condomless intercourse was highest among down low and lowest among gay men. Down low men reported an average of 7.06 (sd 16.31) condomless intercourse acts, straight men 6.89 (sd 12.66), bisexual men 4.70 (sd 13.16), and gay men 2.85 (sd 7.74). As noted in Table 4, there were statistically significant differences for each behavior, except condomless insertive anal sex with men. There was no distinguishable order by sexual identity except that gay men reported much less condomless intercourse with women than the men of the other three identities.

DISCUSSION

We found significant differences by sexual identity in sociodemographics, sexual behavior, and psychosocial characteristics related to HIV risk. Low income was reported most often by men identifying as straight and down low. Incarceration rates are higher among African American men than any other group in the US (Harawa & Adimora, 2008). There is an elevated lifetime incarceration history among AAMSM and a strong relationship to syndemic factors such as childhood maltreatment (Brewer et al., 2014). Similar to Brewer and colleagues' findings there were differences by identity. Brewer et al. found straight men more likely to have incarceration histories. In the present study, a considerably higher percentage of down low men reported having ever having been incarcerated than any other group. This may reflect two possibilities: they were having sex for money (reported by more down low men), leading to incarceration for prostitution, and continued following incarceration because they could not find employment; or had enjoyable experiences having sex with men while incarcerated and continued the behavior afterwards.

More men identifying as gay were HIV-positive, and were much more likely to consider themselves members of the local gay community. Gay men were more employed, younger, and reported less sex than men of the other identities. Not surprisingly, gay men reported the lowest levels of "Not Gay" and homophobia, and the highest levels of outness. Neither Black pride nor religiosity differentiated the groups.

Consistent with other studies of substance abuse among AAMSM (e.g., Dyer et al., 2013), gay men reported fewer alcohol and drug problems. This may indicate that men who are out suffer less distress than those who are not, and this is reflected in lower levels of "self-medicating" with substances. Addressing drug and alcohol use among AAMSM is an important concern in and of itself. Tailoring HIV prevention intervention content about drug and alcohol use by sexual identity may be important as AAMSMW may be more likely to have condomless anal intercourse with other men and to trade drugs and sex (Dyer et al., 2013).

There were significant differences in sexual behavior among men by sexual identity. Overwhelmingly, self-identified gays were most likely to practice condomless receptive anal sex. This behavior puts them most at risk for HIV infection. However, they were the least likely to have sex with women. Men in the other categories were less likely to have condomless receptive anal sex. It is not clear whether gay self-identification leads to more opportunities to engage in receptive intercourse, whether a preference for receptive sex leads to the adoption of a gay identity, or both. Men identifying as straight, bisexual, or down low were, however, considerably more likely to have condomless sex with women, including high rates of condomless anal sex, a very high-risk behavior. Their relatively low rate of receptive anal sex with men militates against their being infected and transmitting the virus.

There has been considerable speculation as to whether bisexually active men may serve as a sexual HIV bridge to women (Millett et al., 2005; O'Leary & Jones, 2006). The results reported here are relevant to this question. Although a higher percentage of gay-identified men engaged in condomless insertive and receptive anal sex with men, few reported

condomless sex with women and therefore are unlikely to serve as HIV bridges despite their high levels of HIV-positivity. However, straight men, a large percentage of whom reported condomless sex, both vaginal and anal, with women, seldom had condomless receptive anal sex with men, a fact reflected in their relatively low rates of HIV-positivity. Again, this is consonant with a low probability of transmission to women. Both of the intermediate groups, the bisexuals and down lows, report non-trivial percentages of receptive anal sex with men, and frequently engaged in condomless sex with women—including anal sex, a much riskier transmission-related behavior than vaginal sex. Thus, attention should be focused on men who identify as bisexual or down low in prevention efforts to protect women from becoming infected by MSM. In addition, integrating types of female partners (primary-only, primary and non-primary, or non-primary-only as did Harawa et al. 2014) would be useful in future analyses using multiple categories of sexual identity.

Limitations

These data are cross-sectional, rendering causal influence highly problematic. Data were self-reported, but gathered via ACASI, which is thought to reduce potential bias associated with self-report. Also, as reported in Jemmott et al. (2014), the effects of social desirability were low in the randomized controlled trial. There remains substantial variation in interpreting the meaning of down low, so comparing our results directly to other research studies is difficult. Our convenience sample may not be reflective of the population of AAMSM. While our measure of “Not Gay” is novel and harmonizes with cultural interpretations of masculinity related to same-sexual behavior, there are scales of masculinity that would be useful to incorporate in future studies. Finally, since the time of the origin of the parent study, a variety of new measures of anti-gay bias have been developed that may provide additional explanatory value about internalized homophobia.

Conclusions

This study indicates the need for public health specialists to attend to sexual identity rather than subsuming men under the acronym “MSM.” Although all of the men in our study did report having sex with other men, their behaviors and demographics differed significantly among men of different sexual identities. The implications of such differences focused primarily on HIV/AIDS in this article. However, examining differences in sociodemographic and psychosocial characteristics among AAMSM should be explored for other health disparities experienced by sexual minorities such as substance abuse, mental health, cancer, and cardiovascular disease.

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Figure 1.
Percentage (%) of types of sex by sexual identity (N=593)

Figure 2.
Percentage of men engaged in condomless intercourse by sexual identity (N=593)

Table 1

Sample characteristics by sexual identity (N=593)

	All (n=593)	Gay (n=241)	Bisexual (n=245)	Down Low (n=62)	Straight (n=45)	p
Age	41.6 (10.72)	38.9 (11.59)	43.3 (9.72)	42.8 (9.81)	45.4 (9.14)	<.0001
> High School	48.4	53.9	42.9	48.4	48.9	.1125
Low Income	72.7	65.1	75.5	82.3	84.4	.0031
Employed	30.7	32.4	30.2	30.7	24.4	.7601
Ever Incarcerated	51.8	37.7	60.4	69.4	57.8	<.0001
Exchange Sex for Drugs/Money	20.4	14.1	23.3	29.0	26.7	.0115
Ever Tested for HIV	96.0	97.1	95.1	93.6	97.8	.4617
Recent HIV Test	69.2	69.7	67.4	69.0	75.0	.7723
HIV-Positive	29.5	41.9	23.2	19.0	11.4	<.0001
Member Gay Community	34.4	58.1	20.8	14.5	8.9	<.0001
Where Seek Sex						
Gay Bar	31.2	34.0	31.4	32.3	13.3	.0544
Bathhouse	21.3	22.0	22.0	24.2	8.9	.2035
Cruising	37.4	34.4	40.00	43.6	31.1	.3382
Sex Party	12.7	10.4	15.5	12.9	8.9	.3176
Internet	25.5	28.6	23.3	27.4	17.8	.3309
Chatline	32.2	37.3	27.4	38.7	22.2	.0318
Alcohol Problems	26.6	19.9	31.0	32.3	31.1	.0240
Drug Problems	16.7	11.2	17.1	29.0	26.7	.0016
Depression	20.6	23.7	18.0	22.6	15.6	.3521
Childhood Sexual Abuse	48.9	59.8	42.9	43.6	31.1	<.0001
Intimate Partner Violence	37.1	39.0	35.5	38.7	33.3	.8055
Syndemic Index	1.55 (1.066)	1.59 (1.00)	1.49 (1.10)	1.76 (1.10)	1.42 (1.14)	.2547

Age and Syndemic Index are presented as mean (standard deviation). All other measures are percentages.

Percentages for Recent HIV Test within the past 6 months are drawn from 568 participants who had ever been HIV tested.

Table 2

Differences in mean Ethnic-Sexual Masculine (ESM) attitudes about homosexuality, outness, Black pride and religiosity by sexual identity (N=593)

	Gay (n=241)	Bisexual (n=245)	Down Low (n=62)	Straight (n=45)	p
"Not Gay"	1.55 (0.66) ^{2,3,4}	1.88 (0.84) ^{1,3,4}	2.13 (0.91) ^{1,2}	2.42 (1.05) ^{1,2}	<.0001
Homophobia	1.72 (0.55) ^{2,3,4}	2.18 (0.66) ^{1,4}	2.34 (0.55) ^{1,4}	2.75 (0.61) ^{1,2,3}	<.0001
Outness	3.34 (1.74) ^{2,3,4}	1.62 (1.42) ^{1,3,4}	1.06 (1.27) ^{1,2}	1.04 (1.54) ^{1,2}	<.0001
Black Pride	4.24 (0.64)	4.18 (0.65)	4.19 (0.57)	4.07 (0.77)	.3734
Religiosity	2.87 (1.03)	2.92 (1.05)	2.85 (1.11)	2.89 (1.06)	.9511

¹ Gay

² Bisexual

³ Down Low

⁴ Straight

Table 3

Percentage (%) of types of sex by sexual identity (N=593)

	Gay (n=241)	Bisexual (n=245)	Down Low (n=62)	Straight (n=45)	p
Insertive Anal Intercourse with Men	51.0	44.5	45.3	38.9	.0899
Receptive Anal Intercourse with Men	45.8	13.4	18.4	3.4	<.0001
Vaginal Intercourse	2.4	33.7	30.9	48.6	<.0001
Anal Intercourse with Women	1.4	9.1	5.3	10.3	<.0001

Table 4

Percentage of men engaged in condomless intercourse by sexual identity (N=593)

	Gay (n=241)	Bisexual (n=245)	Down Low (n=62)	Straight (n=45)	p
Sex with Men					
Condomless Insertive Anal	26.1	29.0	33.9	22.2	.5059
Condomless Receptive Anal	23.7	9.0	12.9	2.2	<.0001
Sex with Women					
Condomless Vaginal	2.1	24.9	32.3	48.9	<.0001
Condomless Anal	5.4	35.9	27.4	35.6	<.0001