

HIV Prevention Research: Are We Meeting the Needs of African American Men Who Have Sex With Men?¹

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Two decades of HIV prevention efforts with men who have sex with men (MSM) have not eliminated the risk of new HIV infections in this vulnerable population. Indeed, current incidence rates in African American MSM are similar to those usually only seen in developing countries. A review of the existing literature suggests that the prevention research agenda for Black MSM could benefit from reframing conceptualization of risk as a function of individual properties to a broad consideration of social and interpersonal determinants. Studies that investigate dyadic and social-level influences on African American MSM's relationships are needed. This includes research explicating the diversity existing within the categorizations of Black MSM with respect to perceived identity (gay, bisexual, "men on the down low," "homo thugz"), constructions of masculinity, sexual scripts, sources of social support, and perceived norms and expectations. Recommendations are proposed for a research agenda focusing on linkages between interpersonal and social-structural determinants of HIV risk.

Keywords: *down low; MSM; African American; Black; homo thugz; HIV prevention; social determinants; inequality; mental health*

More than 2 decades after the first reports of the HIV/AIDS epidemic in the United States, men who have sex with men (MSM) still account for the

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largest number of cases of AIDS and a growing number of new cases of HIV infection (Blair, Fleming, & Karon, 2002; Catania et al., 2001; Centers for Disease Control and Prevention [CDC], 2002, 2003; Koblin et al., 2000; MacKeller et al., 2002; Stall, Hays, Waldo, Ekstrand, & McFarland, 2000; Valleroy et al., 2000). Studies in recent years find that the burden of AIDS and incidents of HIV infection have continued to shift from White men who have sex with men to younger men of color, particularly African American MSM (Bingham, et al., 2003; Blair, et al., 2002; Brooks, Rotheram-Borus, Bing, Ayala, & Henry, 2003; CDC, 2001, 2002; Karon, Fleming, Steketee, & De Cock, 2001; Koblin et al., 2000; Shehan, Freeman, & Kazda, 1999). These emerging data signal not only the changing face of the HIV/AIDS epidemic to one that is increasingly associated with racial/ethnic minorities, but the data also serve as a reminder of the ways that social inequality based on race, ethnicity, economic status, and sexual orientation in the United States is confounded with HIV transmission and infection (Cochran & Mays, 1987; Zierler & Krieger, 1997).

How successful we are in altering the current patterns and rates of HIV infection in African American MSM depends, in part, on the conceptual frameworks that we employ in our collection and interpretation of data as well as on our design and implementation of programs and policies (Zierler & Krieger, 1997). The purpose of this article is twofold. First, we will develop a rationale for reframing the conceptualization of risk of HIV infection in Black men who have sex with other men from an individualized perspective to a social and interpersonal paradigm drift (Trickett, 2002) that takes into account the multiple sources of influence on their behaviors and points of needed interventions (Cochran & Mays, 1993, 1994; Mays, 1992; Mays & Cochran, 1990b, 1990c, 1995, 1998; Mays & Jackson, 1991; Peplau, Cochran, & Mays, 1997). Factors that impact the relationships of African American men who have sex with men on a personal and individual level (i.e., choice of sexual partners, sources of information, emotional and social support) drive HIV-related behaviors. In addition, larger, macropublic relationships (power, privilege, and position in society) play a role in shaping the context and precursors for those behaviors. Patterns of both dyadic and social

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relationships have significant implications for the design of HIV-prevention approaches in this population.

Second, and equally important, we seek to focus the research agenda on questions to which answers may help us to reduce the burden of HIV disease among African American MSM. We suggest that research is needed to examine sources of influence, interpersonal factors, and contextual vulnerabilities that go beyond simply documenting traditional HIV-related disease parameters and individual risk behaviors. We begin by reviewing the racial disparities found in the epidemiology of HIV/AIDS in African American MSM. Our goal is to illuminate what it is that we now know and provide guidance for future directions for data collection.

RACIAL DISPARITY AND CASES OF AIDS IN AFRICAN AMERICAN MSM

In the examination of reported cases of AIDS from 1990 to 1999 (Blair et al., 2002), a number of significant findings emerge. Among males older than 13 years of age, MSM represented the largest proportion of AIDS cases. Temporal shifts in the proportional distribution of these cases are readily apparent. In 1990, racial/ethnic minority MSM accounted for 33% of the cases of diagnosed AIDS among men, but by 1999, this had increased to 54%. In particular, the proportion of African American MSM (between 1990 and 1999) increased from 19% to 34% of AIDS cases among men. Among Latinos, the increase was from 12% to 18%. In contrast, White MSM representation among AIDS cases actually decreased from a high of 67% to 46% (Blair et al., 2002). This shift in the epidemic is also seen in mortality statistics, which show that African American MSM had the lowest decline in death rates, particularly from 1996 through 1999 when highly active antiretroviral therapy (HAART) was responsible for steeply declining death rates in White MSM. Another indicator of the racial disparity in morbidity and mortality from HIV infection is survival time. African American MSM had shorter survival times following the clinical diagnosis of AIDS than what was observed among White and Latino MSM (Blair et al., 2002).

INCIDENCE AND PREVALENCE OF HIV INFECTIONS IN AFRICAN AMERICAN MSM

Currently, the incidence of HIV infection in young African American MSM is among the highest relative to other risk groups within the United States (CDC, 2001, 2002; Karon et al., 2001). A series of epidemiologic studies, published starting in 1999, indicates an alarming rate of HIV infec-

tion among African American men who have sex with men, particularly among young men under 25 years of age. In one study of 2,638 gay males between the ages of 13-19 who were tested at California state-funded testing sites between 1995 and 1997, African American MSM were 5.8 times more likely than their White counterparts to be HIV infected (Webb, Norman, & Truax, 1999). Behaviors found to be associated with elevated risk in this group included anal insertive sex, having sex with an HIV-infected partner, and receiving money for sex.

In the CDC's seven-city epidemiologic study of 3,492 young MSM aged 15 to 22 years old, African American MSM were almost six times more likely than their Whites counterparts to be infected (CDC, 2001). The prevalence rate of HIV infection for African American MSM was 14%, which is higher than all other groups of MSM regardless of ethnicity or race. A later phase of this same study conducted in six of the seven cities with older MSM (23 to 29 years of age) observed similar disparity in HIV infection rates. Of the 2,942 men surveyed, HIV prevalence was 7% among Whites, 14% among Latinos, and 32% among African Americans (CDC, 2001). In yet another CDC epidemiologic six-city study of men visiting sexually transmitted disease clinics for HIV testing, African American gay and bisexual men were two times more likely to be infected than White gay and bisexual men (CDC, 2002). An examination of blood samples in this study revealed that 11% of the infections in African Americans were recent (within the last 4 to 6 months). Comparable rates among Whites and Latinos were 6.5% and 7.7%, respectively.

Although findings of consistently higher rates of seroprevalence in African American MSM emerge from these studies, findings of differences in actual risk behaviors that can account for these higher HIV infection rates are not consistently found. Bingham et al. (2003) review this issue and find that there are studies finding higher, similar, and lower levels of unprotected anal sex by African American MSM as compared to White MSM (Easterbrook et al., 1993; Heckman, Kelly, Bogart, Kalichman, & Rompa, 1999; Lemp et al., 1994; Mays & Cochran, 1987, 1990b, 1993; Rotheram-Borus, Reid, & Rosario, 1994; Ruiz, Facer, & Sun, 1998). In the recent young men's studies cited above (CDC 2001, 2002, 2003), rates of risky sexual behavior by African American MSM as compared to their White counterparts were not higher despite the higher rates of seroprevalence (Bingham, Harawa, Ford, & Gatson, 1999). Bingham et al. (2003) argue that this lack of convergence in findings should lead us to look beyond individual-level behavioral-risk data. As an example, they examined partner characteristics in a Los Angeles County Young MSM study and concluded that the young African American MSM who were HIV infected tended to have older and predominantly Afri-

can American partners. Older men may be more likely to be HIV infected given their longer histories of risk exposure. African American men are also more likely to be HIV infected given the higher prevalence in this population. The risk in particular risk behaviors is greater when partners have a greater likelihood of infection. Prevention approaches for African American MSM would benefit from research that seeks understanding of the ways that relationships, as well as behaviors, of African American MSM affect their HIV risk. Indeed, Bingham et al. (2003) found that the sexual partner choices of young African American MSM were better predictors of the higher rates of seroprevalence than individual behavior histories.

Research focused on social and interpersonal factors is clearly needed. This type of research captures elements of behaviors that are a function of the individual in concert with others or their environment. As an example, an individual may be quite committed to using condoms, and this intention may be bolstered by use of condoms in past sexual interactions. Nevertheless, these intentions and typical behavioral scripts can be disrupted by powerful emotions, sexual attractions, or interpersonal power differentials (Gagnon & Simon, 1973). Men may falter, substituting an alternative, deferential script that allows one's partner to steer the course of the sexual experience even to include behaviors that the individual might not normally perform.

Psychological states raised within the context of interpersonal interactions can include fears of abandonment or isolation, feelings of inadequacy, perceived challenges to masculinity, loneliness, love (Greene, 1998; Mays, Chatters, Cochran, & Mackness, 1998; Mays, Nardi, Cochran, & Taylor, 2000), fears of isolation, discrimination, threat, and violence that accompany being a minority within a minority status (Mays & Cochran, 2001). These states can influence whether an individual will engage in safer sex practices.

Some men perceive less freedom or permission to be open about themselves in the world, and this, too, is both interpersonal in nature and important for HIV prevention. In the CDC six-cities study described above, African Americans were least likely to disclose their sexual orientation (CDC, 2003). Similar studies of nondisclosure have found that such behaviors are based on fears of isolation, discrimination, and verbal and physical threats (Kennamer, Honnold, Bradford, & Hendricks, 2000; Stokes & Peterson, 1998). One in three of the nondisclosing young men in the six-city study above reported having female sex partners; of the African American nondisclosers, one in five was infected with HBV, and one in seven was infected with HIV (CDC, 2003). Many of these young men also indicated that the majority of persons in their community disapproved of homosexuality (CDC, 2003).

Building on the work of Bingham et al. (2003), researchers who focus on partner choices might seek to identify the cultural proscriptions and psycho-

logical states that occur in the relationship interactions between older and younger African American MSM. Explorations of the men's sexual scripts (Gagnon & Simon, 1973) and how sexual scripts can be used or modified for risk reduction are needed. Questions in this interpersonal/social research approach could be as basic as the determination of what younger African American MSM seek in their relationships with older men, or whether power differentials based on culture and age result in risky dyadic behaviors (Adams & Kimmel, 1997; Cheng, 1999; Kurtz, 1999).

Perhaps now is the time to go beyond what we can learn from traditional public health surveillance and epidemiologic studies, with their focus on infection rates, risk behaviors, and attitudes of gay men aggregated by ethnic/racial and age strata. Instead, we might consider a focus on better understanding the social influences in interpersonal interactions of African American gay men, MSM, bisexuals, or any other variant of African American men who have sex with other men (e.g., brothers on the down low [Constantine-Simms, 2001; Denizet-Lewis, 2003; Hardy, 1997; Lee, 2001] or homo thugz [Hardy, 2001; Keyes, 2002; Trebay, 2000]). To date, much of the research on HIV risk and risk reduction on African American MSM has been epidemiologic in nature, with a focus on individual-level mediators of risk behaviors. Whereas at the individual level there have been several attempts at understanding the role of internal processes or mediators such as self-esteem (Peterson et al., 1996) or sexual/racial identity (Crawford, Allison, Zamboni, & Soto, 2002), a comprehensive focus on interpersonal factors (e.g., close and intimate relationships, neighborhood and community ties, sources of social support; Mays et al., 1998; Mays et al., 2000) or social constructs (e.g. definitions of Black MSM masculinities/sexuality, social inequalities, experiences of discrimination, and prejudice and Black MSM role expectations and norms; Cheng, 1999; Kurtz, 1999) has been slow to come. But this focus is the type of research domain that seems quite appropriate for exploration by mental health researchers (Peterson, 1998; Trickett, 2002). In general, over the course of the HIV epidemic, men have been studied from an essentialist perspective, as if the properties that we use to classify them for a particular study are stable, reliable, and valid (Kurtz, 1999). Although mainstream society tends to think of homosexuality as homogenous, it is more accurate perhaps to think of these diverse populations we are concerned with as representing homosexualities (Cheng, 1999). African American MSM consist of a diverse group not only in their socioeconomic status but also as a function of their ways of construing their relationships (Cheng, 1999). This translates into differences in the natures of their relationships, their environments, and their access to HIV-related prevention efforts. Research that can help identify how these differences foster higher risk environments, vulnerabilities, or

reduced access to supportive mechanisms for HIV-related risk protection is greatly needed if we are to decrease the rate of new infections in African American MSM. It is the experiences that these men have in their interpersonal and social relationships that form the cornerstones for understanding HIV-related risk-taking and/or protective behaviors (CDC, 2003; Cochran & Mays, 1994; Mays & Cochran, 2001).

There is an age-old debate in health promotion 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), and we argue that the time has come for focus on the population. The essence of HIV prevention in gay men is about influencing human behaviors, and those human behaviors are ultimately a function of the interpersonal and social context (Bonell et al., 2000). The determination of vulnerability to HIV infection as a function of context and social inequalities has evolved as essential in understanding women's risk for HIV infection (Zierler & Krieger, 1997). It is important that the prevention paradigm drift (Trickett, 2002) for African American MSM also move in this direction. Success of this direction with prevention work in the early 1990s that was focused on White gay men shows the importance of context and the interpersonal relationships of at-risk individuals in trying to influence individual behavior (Kegeles, Hays, & Coates, 1996; Kelly et al., 1991; Kelly et al., 1992; Latkin et al., 1995; Power, Jones, Kearns, Ward, & Perera, 1995; Treadway & Yoakam, 1992; Trickett, 2002). Similar comprehensive and culturally competent efforts have yet to widely appear for African American MSM.

GAPS IN THE EXISTING RESEARCH LITERATURE ON AFRICAN AMERICAN MSM

The scientific literature has firmly established that African American MSM should be a focus of HIV prevention. However, the connection between the risk of disease and the unique circumstances of African American MSM is in its infancy (Cochran & Mays, 1994; Crawford et al., 2002; Mays, 1992; Peplau et al., 1997; Stokes & Peterson, 1998). Most studies of HIV risk among MSM have recruited Black MSM as minority subjects within a general sampling frame. Questions that would capture information distinctly relevant to this group are not included in study instruments. As a consequence, much of their unique perspective on the world, which is integral to their behavioral decision-making, remains unknown.

Identity, masculinity, and sexuality. Despite the fact that we know that the experiences of Black males in America differ from those of White males, we know little about the experiences and feelings of African American MSM about being Black, same-gender loving, and living in American society (Adams & Kimmel, 1997; Cochran & Mays, 1988; Crawford et al., 2002). African American MSM have multiple group memberships, some of which are marginalized and some which are not (Cochran & Mays, 1988). These patterns of marginalization and nonmarginalized group memberships often influence interpersonal and social relations (Cheng, 1999). Definitions of identity, masculinity, manhood, and sexuality or experiences of power, privilege, and position are potential areas for research exploration in the design of HIV prevention efforts for African American MSM (Dube & Savin-Williams, 1999; Greene, 1994, 1998, 2003; Herek & Capitano, 1993; Icard, 1986; Loiacano, 1993; Stokes & Peterson, 1998). We know from an accumulation of studies that African American gay men and MSM are likely to experience prejudice, discrimination, or even threats of physical violence based both on their status as African Americans within the gay White community and as gay or MSM in the Black community. For some, this results in a compartmentalizing of identity to escape discrimination (Crawford et al., 2002; Mays, 1992; Mays et al., 1998; Cochran & Mays, 1994; Mays & Cochran, 1995; Peplau et al., 1997; Stokes & Peterson, 1998). This compartmentalization may be a factor in HIV-related risk taking. Crawford and colleagues (2002) have demonstrated that in African American gay men, those with better integrated racial-ethnic and sexuality identity are more likely than other men to engage in health protective behaviors.

Hegemonic masculinity is that which is defined by the cultural majority population. For the most part, masculine character in America is defined by White values (Cheng, 1999; Connell, 1995), but for Black men, it is nuanced by additional cultural values (Roberts, 1994). Their cultural sense is influenced by a legacy of denial and destruction of masculinity among African Americans (Baldwin, 1963; Cheng, 1999; Hunter & Davis, 1994; Oliver, 1984, 1989; Staples, 1982). Masculinity that differs from that of White male masculinity presents possibilities for marginalization in power, position, and societal privilege (Greene, 2003; Kurtz, 1999; Robinson & James, 2003). Particularly among those who are openly gay, daily behaviors are impacted by others' responses to African American gay men or MSM expression of their racial or sexual orientation identity.

As an example, in the African American community, there exist men who are described as being on the down low, bisexual, or homo thugz. These subgroups reflect the ways in which men respond to broad societal messages about Black male sexuality, gay identity, and their perceptions of the safety of

expressing a nonheterosexual orientation within Black culture. Although one may view the culture of homo thugz from the outside as comprising a group of tough young men who engage in gangster behavior, a more careful examination reveals a gangster image that functions protectively for young Black men (Keyes, 2002; Thomas, 1996). These men are well aware of the potential danger that exists as they move through communities where behavior that hints of sexual activity with other men is likely to result in trouble. Their specific style of dress and the association with hip-hop and its male crews or poses (the street terms for gangs) invoke yet another cultural shading to hegemonic definitions of masculinity (Cheng, 1999; Kurtz, 1999; Thomas, 1996, 1999; Trebay, 2000). The complexity of race and sexual orientation identity as contextualized by the multiple social networks and communities that African American MSM inhabit is greatly understudied. These men are minorities within a minority group and the effects of these complex identities on HIV risk taking are not yet fully grasped (Nagle, 1999; Thomas, 1996, 1999; Wise, 2001).

Sources of support. We know the valuable role that social support and disclosure of sexual orientation plays in keeping men HIV seronegative (Brotman, Ryan, Jalbert, & Rowe, 2002; Elizur & Mintzer, 2001). But we have only touched the surface of understanding how being a Black and gay man or MSM intertwines in accessing social support from family, friends, churches, and neighborhoods, where typically, behaviors or identities associated with a same-sex orientation are rejected (Mays et al., 1998; Peplau et al., 1997). How the fear of isolation and rejection from the Black community and the feeling of being a disappointment to family and friends because of a same-gender sexual orientation (Boykin, 1996; Robinson & James, 2003; Stokes & Peterson, 1998; Staples, 1982) enter into sexual risk-taking behaviors still remains an unanswered question. Equally understudied are the effects of racism, socioeconomic disadvantage, and Black-White differences in definitions and manifestations of masculinity and sexuality. These can serve to drive a wedge between African American MSM and others in their various communities based on both sexual orientation and race (Diaz, Ayala, Bein, Henne, & Marin, 2001; Kurtz, 1999; Staples, 1982; Stokes, Miller, & Mundhenk, 1998). The possible impact of social rejection should not be minimized. Social rejection has been shown to lead to problems with self-regulation and an increase in self-defeating behaviors that often increase the possibility of HIV risk taking (Cole, Kemeny, Taylor, & Visscher, 1996; Cole, Kemeny, Taylor, Visscher, & Fahey, 1996; Twenge, Catanese, & Baumeister, 2002).

Disclosure. Freedom to be oneself openly is born of privilege. For African American MSM, avoiding disclosure of their sexual orientation may well be sensible as studies of violence indicate that gay/bisexual men are the most likely targets to be victims of violence when compared to women and heterosexual men (Comstock, 1989; Levy, 1997). Among gay populations, gay men of color are most often the victims of such violence (Comstock, 1989; Levy, 1997). These men are also the least likely to be able to access expensive medical care and, instead, seek care through emergency rooms (Eisenman et al., 2003). African American MSM may find themselves in particular peril for openly acknowledging or manifesting outward signs of gayness. Although studies indicate a psychologically healthier state associated with being openly gay (Cole, Kemeny, Taylor, & Visscher, 1996; Cole, Kemeny, Taylor, Visscher, & Fahey, 1996; Miller & Cole, 1998), gay men of color may more often find such behavior perilous. In this context, the particular predominance of subgroups within the African American community, such as men who label themselves bisexual, on the down low, or homo thugz, is not so surprising (Mays & Cochran, 1995; Thomas, 1996, 1999). Feelings of self-hate and shame about minority sexual orientation have been shown to be associated with greater use or abuse of alcohol and drugs and to interfere with the practice of safer sex (Diaz, 1998, 1999; Diaz & Ayala, 1999; Stall et al., 2000; Stokes & Peterson, 1998; Zea, Reisen, & Diaz, 2003). These issues may be more prominent among African American MSM because of the strained relationships with the African American heterosexual and White gay communities.

Contextual effects of trauma. Much of the scientific literature on African American gay men and MSM focuses narrowly on individual HIV risk behaviors. But as some of the studies previously cited indicate, the lives of some African American MSM, particularly those who seem to be most at risk, are more likely to include multiple traumas, such as physical abuse, gang involvement, substance abuse problems, incarcerations, and violent deaths of family members and friends. These men's prevention needs may not be successfully identified by research goals that stay at the level of counting the number of sexual partners, specific behavioral acts, or use of condoms.

MOVING TOWARD A MORE CULTURALLY SPECIFIC PREVENTION AGENDA

Existing community/scientist/federal government collaborative planning processes tend not to include representation from the most at-risk men in the

African American community. For gay men of much greater social privilege, the representation process that has developed over the years facilitates creating prevention projects that are directly targeted at both individual and community needs. But in the African American community, communication chasms created by wide disparities in education, employment, and culture really do result in distinctly different prevention needs, even among what may seem like a relatively homogenous group, that is, African American MSM. Men not open about their sexuality are not at the table to represent their interests when the community/federal/scientists collaborations are formed (Boykin, 1996; Denizet-Lewis, 2003; Johnson, 2001; Trebay, 2000). It is not clear that the current interventions that have been developed for gay men or MSM of color (Chesney et al., 2003; Koblin et al., 2003; Peterson, Coates, et al., 1996) fit the needs of these particular subgroups of men. To what extent this contributes to our inability in the field of public health to stem the HIV epidemic among African American MSM is an open question.

The act of living in American society as a Black man leaves little room to avoid an engagement with the inequalities that are attached to race and minority status (Hunter & Davis, 1994; Oliver, 1989). As is true with other societies, American society has a set of ideas and an ideology by which life is made understandable (Hunter & Davis, 1994; Oliver, 1984, 1989; Staples, 1982; Vander Zanden, 1986). American ideology directs individuals as to how to behave (as an American), how to define oneself (as an American), and how to make sense of experiences (in the American tradition) (Oliver, 1984, 1989; Vander Zanden, 1986). Ideology allows individuals to have a sense of the nature of their society, and it often serves as an intellectual foundation for group identity and solidarity (Oliver, 1984, 1989; Vander Zanden, 1986; Wildman, 1996). For Black men living in American society, what they are or should be and their definitions of manhood are measured against the status and privilege, both real and imagined, of White males (Boykin, 1996; Hunter & Davis, 1994). Much has been written about the marginalization of African American men in American society (Baldwin, 1963; Hunter & Davis, 1994; Oliver, 1984, 1989; Staples, 1982). For these men, making sense of being American and creating a sense of solidarity and group identity within the Black community and within the larger society is difficult (Wildman, 1996). Whether HIV risk taking is more closely associated with ethnic cultural values or gay cultural values is an open question, although there is evidence that the experiences that accompany the race, culture, and class status of African Americans may play a more prominent role in risk for HIV infection (O'Donnell et al., 2002). Marginalization arising from racism, poverty, and homophobia also add to the risk (Cochran & Mays, 1994; Diaz, 1998; Diaz et al., 2001; Marin, 2003; Stokes & Peterson, 1998; Zea et al., 2003).

Traditionally in America, manhood and masculinity are characterized by role attributes of competition, aggression, and success (Hunter & Davis, 1994; Spraggins, 1999; Wise, 2001) and are best summarized by the expectation that high-status men possess power, position, and privilege (Greene, 2003). In a parallel fashion, for some African American gay men, the perceived status, culture, and privilege of White gay men is also an important touchstone in defining what they expect for themselves (Boykin, 1996). Much also has been written in contemporary literature about the cool pose, the tough guy, the player, and now the homo thugz and brothers on the down low as if they are only stereotypes or affectations (Byrd & Guy-Sheftall, 2001; Majors & Billson, 1993; Smith, 2000). Yet, these roles manifest complex relationships among cultures, communities, and social inequalities. Power, position, and privilege shape both their roles and their behaviors (Greene, 2003). Being Black, male, and a man who has sex with other men in America is territory with few widely accepted role models, cultural proscriptions of behavior, or foundations of support (Boykin, 1996).

As preventionists, we have yet to effectively tap into the African American MSM's will to survive in the face of the social inequalities in America. Their will to survive, as well as race-consciousness and commitment to community empowerment, might be critical foundations in efficacious interventions in this population. Peterson and Diaz have underscored the importance of culture, community, race, and ethnicity to the prevention process for MSM (Diaz, 1998; Diaz et al., 2001; Peterson et al., 1996; Stokes & Peterson, 1998; Zea et al., 2003)

INCORPORATING CULTURE, SOCIAL AND INTERPERSONAL RELATIONSHIPS INTO HIV RISK REDUCTION

The link between interpersonal relationships, social networks, culture, and social inequality in HIV-related risk or protective behaviors was a lesson first learned by those who worked with injection drug users (IDUs) (Friedman, Des Jarlais, et al., 1990; Friedman, Quimby, Sufian, Abdul-Quader, & Des Jarlais, 1988; Friedman, Sufian, & Des Jarlais, 1990; Neaigus et al., 1994). Many IDUs were racial/ethnic minorities. Researchers honed in quickly on how race/ethnicity and cultural proscriptions in IDU networks, based on roles and gendered relationships, affected HIV risk (Friedman, Des Jarlais, et al., 1990; Friedman et al., 1988; Friedman, Sufian, & Des Jarlais, 1990; Neaigus et al., 1994). Gendered-role expectations were also found to

affect whether drug paraphernalia was shared, the order of sharing works, and who and how trading of sex for drugs and money occurred within intimate partnerships or among social networks of IDUs.

The field of HIV prevention developed some similar insights regarding heterosexual women in terms of how interpersonal relationships, social networks, culture, race/ethnicity, and social inequality could confer greater HIV-related risk to women as a function of their status as women and in their social interactions (Amaro, 1995; Mays & Cochran, 1988; Reid, 1992; Zierler & Krieger, 1997). Investigators identified the role of gender and sexual scripts, relationship power, violence, poverty, and economic and social inequalities in HIV risk for women (Amaro, 1995; Cochran & Mays, 1988; Pulerwitz, Amaro, De Jong, Gortmaker, & Rudd, 2002; Zierler & Krieger, 1997).

Although the study of interpersonal relationships of gay men is a relatively underdeveloped area in psychology (Peplau & Cochran, 1990), research has begun to examine how close and intimate relationships influence their sexual risk taking (Trussler, Perchal, & Barker, 2000). For example, in a recent study of gay men's interpersonal lives, researchers were able to identify a number of culturally constructed HIV vulnerabilities. These included the challenges of personal development over gay men's life course, the unspoken ground rules of gay relationships, and the relationship between gay culture, society, and local culture.

Relatively few studies, however, have looked directly at the interpersonal issues faced by gay men and MSM of color in their relationships (Cochran & Mays, 1988, 1994; Diaz, 1998; Diaz et al., 2001; Marin, 2003; Mays, 1992; Mays et al., 1998; Mays et al., 2000; Peplau et al., 1997; Stokes & Peterson, 1998; Zea et al., 2003). As in the work with injection drug users and heterosexual women, work in this area could provide telling insights into risk-reduction strategies for African American MSM.

THE IMPORTANCE OF AFRICAN AMERICAN MEN'S RELATIONSHIPS

The dynamics of HIV prevention among African American MSM are greatly influenced by the multiple social statuses and possibilities for marginalization that affect this population (Cochran & Mays, 1988, 1994; Diaz, 1998; Diaz et al., 2001; Marin, 2003; Mays, 1992; Stokes & Peterson, 1998; Zea et al., 2003). For example, in one of our studies exploring the friendship patterns of African American men who are openly gay, we observed distinct

differences in their friendship patterns from those found among White gay men (Mays et al., 2000). Both African American gay men and White gay men are most likely to have gay men as friends. These friends are generally of similar race. But unlike White gay men, African American gay men are also likely to have heterosexual women (of color) as friends as well. The valence of race/ethnicity as a source of support and the tendency to stay closer to the African American community emerged as central factors in their relationship choices.

What research has not yet revealed is the cost of the choices that these men make in constructing lives that straddle the borders of African American community life and gay community life or the stresses and strains of trying to maintain integration of the two communities. There are a host of issues that are salient here. One is the question of the emotional toll that results from commitment to maintaining a presence only in the African American community or an integrated presence also in the White gay community. In a study conducted several years ago, we observed that African American lesbians who attempted to do this paid an emotional price (Mays, Cochran, & Rhue, 1993). Those African American lesbians who were committed to only having same race partners had a harder time because of the difficulty in finding these relationships as the African American lesbian community tended to be less openly gay or accessible through gay/lesbian networks and organizations. Relationships with White women were impacted by racism, discrimination, and marginalization. Women who tried to maintain ties with both communities found it to be difficult. Those women who had more contact with the White lesbian community had higher levels of depressive distress (Cochran & Mays, 1994).

Exploring the nature of the intimate and close relationships of African American gay men and MSM may also be an avenue to begin to address the growing numbers of studies finding high rates of depressive distress in this population (Cochran & Mays, 1994; Myers, Javanbakht, Martinez, & Obediah, 2003; Peterson, Folkman, & Bakeman, 1996). As far back as 1994, we reported that African American gay and bisexual men had higher rates of depressive distress than those found in the literature for White gay men, heterosexual African American men, or Blacks in general (Cochran & Mays, 1994). Peterson et al. (1996) found that psychosocial resources and, most significantly, social supports were important in moderating the effects of a depressive mood in African American gay men. We know from a number of studies that positive interpersonal and intimate relationships are important to maintaining good mental health and can serve as a protective factor in the development of depression (Brown & Harris, 1978; Cowen, 1973). Therefore, we should not underestimate the importance that interventions designed

to enhance and strengthen the interpersonal, intimate, and social relationships may play in reducing HIV-related risk behaviors.

The perception that those who suffer from depression or depressive distress are more likely to forego sex may be an erroneous assumption. Recent research indicates that the relationship between depression and sexual behavior in gay men is more complex than initially imagined (Bancroft, Janssen, Strong, & Vukadinovic, 2003). There is a segment of gay men who respond to negative mood states such as depression with an increase in sexual activity. It appears that this activity may be in the service of fulfilling a need for physical intimacy and self-validation.

THE EFFECTS OF SOCIAL AND ECONOMIC DISADVANTAGES

In their Bay Area study, Peterson et al. (1992) found that of the 250 African American MSM, more than half reported engaging in unprotected anal intercourse; this is a startling high rate. The men most likely to engage in this high risk behavior were poor, engaged in sex for money or drugs, and had little support for engaging in lower risk sexual behaviors. Findings of both high rates of risky sexual behavior and lower rates of HIV testing in MSM who are poor and less likely to disclose their sexual orientation is a pattern found in other studies (Marin, 2003; Mays & Cochran, 1990a, 1993; Peterson et al., 1992). Removing social and economic disadvantages should be a clear target for HIV prevention activities in a social prevention framework (Peterson, 1998; Trickett, 2002; Zierler & Krieger, 1997).

In moving from an individual focus to a social/interpersonal focus of HIV prevention, we can enhance communities through bolstering economic development, improving work opportunities, developing skills, improving access to affordable education, and creating greater tolerance for diversity (Peterson, 1998; Trickett, 2002). These community-level enhancements, if they are to be effective, should not be targeted merely at the men themselves but also at the development of community-based infrastructures that can deliver the needed resources.

But to develop effective community-level interventions, we will need to reverse the general patterns of services delivery. For example, the results of a five-city study of the prevention needs of gay men of color ($N = 285$) found high rates of sexually transmitted infections (STI), particularly among African American MSM residing in Chicago, New York, and Los Angeles (Gerald et al., 1993). Despite a high prevalence of cases of STI and AIDS among

MSM of color, the report also found that expenditures for HIV-related services targeted specifically to MSM in these five cities ranged from a low of 1% to 13% of the AIDS/HIV budgets. Often, this resulted in specific programs for gay and bisexual men of color being small and underfunded. The chances of discovering and developing model HIV prevention programs that are culturally specific are severely diminished when there are so little resources to serve the diversity of subgroups within the African American MSM population.

EXPRESSIONS OF VARIATIONS IN AFRICAN AMERICAN MSM IDENTITIES

When the epidemic first began, scientists sought to understand HIV disease by using traditional epidemiologic and surveillance procedures (Mays, 1992). To stop the epidemic, we needed to somehow find the behaviors that increased the likelihood of transmission and classify those individuals most likely to engage in these behaviors. This need to categorize people is still, in view of the diversity of African American men who have sex with men (gay men, MSM, homo thugz, and men on the down low), a weakness in how we approach prevention (Mays et al., 1992). We classify people with labels that make sense either from a disease-transmission standpoint or from a sampling and recruitment need. We put people into discrete categories so that we can package programs for them. When programs do not work, we may blame the person rather than blame the categorization process (Mays, Ponce, Cochran, & Washington, 2003).

Sometimes we even try to fit people into our finely articulated categories even though many African American gay men, MSM, or brothers on the down low cannot connect with or recognize themselves in those boxes. Here, prevention efforts tend to fail. For traditional public health disease eradication to be successful, we need to find ways to meet our needs for categorization while interfacing with individuals in ways that resonate with their own experiences.

A reality for many African American men who are gay, bisexual, MSM, or on the down low is their experience of a dynamic, evolving, and interactive nature of their race, their maleness, their sexuality, their social class, and other intertwining social statuses. This makes categorization difficult. Yet, in our best attempts at prevention, we need informed categories that can provide a way to outreach, organize, and evaluate activities that engage and address the interactive nature of their complex identities. There is a race-based con-

sciousness about maleness; it is a Black maleness. It may be a Black maleness that is associated with Southern culture, an urban flavor, or a culture of poverty or middle-class experiences. No one model of prevention will be sufficient to address the entire community of African American men who have sex with men. Unfortunately, HIV prevention of the last 2 decades has treated African American gay men as gay men who are Black or gay men in the Black community, an additive model that negates the complex experiences of African American gay and bisexual men, MSM, and down low men.

The perceived contradictions of Black men's identities in American society create difficulties for researchers because our work is facilitated by the use of simple, mutually exclusive categories or labels. In an anonymous piece written by a Jamaican gay man, he says, if the Black church were to remove every homosexual from its ranks there would be no more choir, half the pastors would vanish, and some of the sisters would not be getting it as regularly as they currently do. This is a model of male homosexuality that inherently includes heterosexual sexual behavior. This model is not prominent in the White gay community. Understanding that the African American MSM expressions of homosexuality may be different from the essentialist binary identity models of the White gay community will help us to generate more useful categorizations for prevention work with African American MSM.

Perceived contradictions seem to lie at the heart of homo thugz experience. This is a population that is seldom mentioned in published prevention efforts, but those who work in the African American community are well aware of their existence. As described by Trebay (2000), these are young African American men who sport do-rags, Fubu jackets, platinum and gold necklaces, Timberlands or neonerd Wallabies, sideway knotted bandannas, and army fatigue trousers that hang off the hips. These young men are easily mistaken for thugs or gangstas, hence the term homo thugz. Scholar Cheryl Keyes (2002), in her book on rap and hip-hop music, discusses the relationship among gay men/MSM, HIV, and the rap/hip-hop communities, giving us insight to the longevity that this subgroup has had within the hip-hop community. Novelist James Earl Hardy (1997, 2001) also writes about the phenomenon of homo thugz, defying the perception that they just recently emerged on the scene. The rap and hip-hop world of the homo thugz, with its crews and posses, has been characterized as appealing to a sense of male-with-male attraction (Thomas, 1999; Trebay, 2000). The contradiction for some is the mistaken expectation that homosexuality is incompatible with the gangsta/thugz experience. In reality, the portrayal is yet another variation on hegemonic masculinity; it is young Black men expressing their masculinity through a specific portrayal of masculinity in the gangster image.

Perceived contradictions in recognizing homosexuality seem to be present in hearing the stories of men on the down low teaching other men how to maintain their sexual relationships with women and to keep these women satisfied. These relationships with women serve a number of purposes (Denizet-Lewis, 2003). They offer protection to those on the down low. Maintaining a sense of masculinity and the ability to traverse the Black community as a masculine Black male is an important survival tool. This is particularly true when men lack social and economic resources to otherwise insulate themselves from antigay violence. Maintaining this heterosexual relationship is then a mixture of protection and sexual pleasure. In some instances, these women also provide financial resources as well as serving as a safe haven. To label these men bisexual as an identity is to describe a very different population than what is found in the White community.

AN AGENDA FOR MENTAL HEALTH INTERVENTIONS

At this junction, there is a critical need for data that can help guide the development of evidence-based prevention for African American MSM in their diversity. Below, we suggest several recommendations for both researchers and governmental agencies, such the National Institutes of Health (NIH), which serves as the government's mechanism for funding of investigator-initiated research, and the CDC, which is entrusted with the planning and execution by the Department of Health and Human Services for the HIV/AIDS prevention agenda. We chose to focus many of our recommendations at the federal level in our call for data because of the already existing funding mechanisms and because, to some extent, gathering data in hidden populations embedded in a larger community is best done through household surveys that are administered nationally by federal agencies in which sexual orientation is not a selection factor. We recommend the following:

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 and their possible role in the development of risk reduction.
 - A. Although this research should document and differentiate the types of subgroups within the African American population of men who have sex with men (i.e., bisexuals, men on the down low, and homo thugz), the 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 rates of HIV testing and appropriate disclosure of HIV status.

- B. 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 are needed to identify, if available, best practice mental health interventions 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 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.
4. To encourage this work, we suggest that CDC and the NIH use a variety of mechanisms at their disposal. These possibly include the following:
 - 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 attendance by local prevention-planning council members who can help CDC and NIH prioritize objectives and strategies to incorporate into new requests for proposals; and

- 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 conducted by the National Center for Health Statistics and NIH, such as the National Health Interview Survey or the National Household Survey of Drug Abuse, to provide overall health data on African American men who have sex with men.

If instituted, the above recommendations would provide a strategy for obtaining critically needed insights into the diversity of the subgroups of African American MSM, for understanding how these groups vary in their risk environments, and for identifying the support they need for maintaining an HIV seronegative status. Research agendas that seek to reveal the intimate and often coded behaviors of a marginalized, stigmatized group require researchers to develop both an appreciation for the behaviors uncovered and a commitment to develop appropriate, effective, and sensitive interventions. When studies are reported that merely serve to demonize men for their absence of disclosure or for their bisexual sexual activities, then points of intervention with this population remain invisible as our true understanding of these men's lives is opaque. If we are to stem the HIV epidemic among African American MSM, we must design research that consciously includes an agenda to address social-structural barriers that contribute to HIV infection. Although this may seem like a daunting task that is outside the realm of psychology and public health, it is not. Researchers who investigate the social-structural environments of African American MSM that are necessary for the maintenance of safe HIV-related behaviors will find themselves in complex collaborations with political, social, and economic community-based organizations, justice systems, faith-based coalitions, politicians, and others. All of these constituencies are key to the prevention efforts aimed at establishing norms, values, and policies that will reduce HIV risk. It is only in full collaboration with these groups and an expanded research focus that we will finally develop the prevention programs that can eradicate this disease.

NOTE

1. The terms gay, bisexual, MSM, and on the down low are not used interchangeably in this article. A growing body of oral testimony and scientific research indicates that although these men may reside within the same communities, there are significant differences in identity and

consciousness among these subpopulations that are important factors to consider when designing prevention programs. We have, therefore, purposely accentuated their distinctiveness to encourage discussion about our focus on prevention needs. On the other hand, we use the terms African American and Black interchangeably because it is unclear that data collected heretofore in this population has separated Black (which could include individuals from Africa or the Caribbean) from individuals whose origin is of African descent via the slavery experience of pre-Civil War America.

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