Social Stigma and HIV /AIDS in Black MSM

by

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A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
(Health Behavior and Health Education)
in The University of Michigan
2009

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Acknowledgements

Thank you to my full dissertation committee for providing support and mentorship. Thank you as well to those mentors who have provided encouragement, constructive feedback, and useful and rewarding research experiences throughout my graduate school experience. Thank you to Paul Anderson for compassionately listening to why I felt like I wanted to study public health, and thank you to Marcia Inhorn for encouraging me as I began my studies in public health. Thank you to Larry La Fountain-Stokes for providing useful comments and valuable resources. Thank you to David R. Williams for being an unwaveringly available, open-minded intellectual and warm and generous mentor, for advising me to study what I feel most passionate about, and for giving me the opportunity to become familiar with quantitative research methods. Thank you to Mark Padilla for helping me to find myself as a qualitative researcher, and who through his own work constantly reminds me about why I do what I do, and embodies the type of scholar I strive to become. Thank you to Edith Parker for being so consistently encouraging and approachable, while still offering critical feedback. Thank you to the courageous men who shared their stories. Thank you to the Rackham Graduate School, the National Institute for Mental Health, the department of Health Behavior and Health Education, and the Institute for Research on Women and Gender for providing the financial resources to allow me to pursue my doctoral degree. Thank you to all those friends, colleagues and family members whose insights have molded me in immeasurable ways. Thanks Danya, for being so brilliant, reading my work, sharing your own, and saying what you believe. Thanks Degaulle for sometimes knowing me better than I know myself. Thanks Aida, for being my best friend and role model. Thanks Lyd, for keeping it real, and not holding back. Thanks Debrai, for making me strong. Thanks Mom, for being my hero, and thanks Dad, for always doing your best. Nazret, Sammy, Selome, and Eli: thank you for giving me the honor and pleasure of getting to watch you continually become the wonderful human beings that you are.

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Chapter I

Introduction

Background/ Review of the Literature

Although increasingly perceived as an issue solely within developing nations, HIV/AIDS continues to be a major health problem within the United States (Mays, Cochran, and Zamudio, 2004, Karon, Fleming, Steketee and DeCock, 2001, Quan, Steketee, Valleroy, Weinstock, Karon and Janssen, 2002), where it remains the fifth leading cause of death for people twenty-five to forty four years old (Smith, 2000). Globally and within the United States in particular, social processes and seemingly intractable forms of structural violence continue to propel the spread of HIV/AIDS within the most marginalized segments of society (Parker, 2002, Parker, Easton, and Klein, 2003, Farmer, 1996, Farmer, Connors, Fox and Furin, 1996, Padilla, 2006).

As a unified group, MSM overall continue to account for the largest number of existing AIDS cases and new HIV infections in the U.S., despite overall declines in HIV/AIDS diagnoses and new infections (Mays et al., 2004, Blair, Fleming and Karon, 2002, Karon et al., 2001, Quan et al., 2002). Moreover, racial disparities in multiple HIV-related outcomes strongly persist among MSM. These stark racial differences within MSM have compelled researchers to look more closely at the dynamics of infection within African American/ Black MSM. Below I will review some of the major hypotheses that have been explored.

Higher rates of STIs could potentially explain elevated seroprevalence in Black MSM, since they increase HIV transmissibility. In a large longitudinal study (90-99) of MSM attending free STI clinics in New York City, researchers found that black MSM were more likely to be diagnosed with a new STI than their white counterparts (Torian, Hadi, Menzies, Murrill, Weisfuse, 2002). Similarly, studies of MSM conducted in Milwaukee and Atlanta have also found higher rates of gonorrhea and syphilis in Black

MSM as compared to other subgroups of MSM (Heckman et al., 1999; Landrum, Beck-Sague, and Kraus, 1988). In addition to site specific data, larger multi-site studies of major urban centers have also found a higher lifetime history of sexually transmitted diseases in Black MSM (CDC, 2001; Easterbrook, Chmiel, and Hoover, 1993; Valleroy, MacKellar, Secura, Behel, 2002). Thus, given the existing evidence, it is quite plausible that higher rates of background STIs may partially explain elevated seroprevalence in Black MSM (Millett, 2006).

The majority of studies exploring racial differences in testing for HIV find no differences between black and white MSM (Torian, 2002; Heckman et al., 1999; McKirnan et al., 1995; CDC, 2005). One study even reported slightly higher rates of having ever tested for HIV in black as compared to white MSM recruited at gay bars (Dao, Lehman, Wortley, Lansky, and Hecht, 1999). However, a study of black MSM 15 to 22 suggests that this group has low rates of *frequent* HIV testing (CDC, 2002). Furthermore, several studies suggest that seropositive Black MSM are more likely than white MSM to be unaware of their HIV status. This has been reported in a multi-site study of black MSM 15 to 22, 18 and older, and 15 to 29, as well as in an LA sample of MSM 23 to 29 (CDC 2002; CDC 2005; Bingham et al., 2003; MacKellar et al., 2005). This difference in knowledge of seropositivity could plausibly contribute to elevated rates of HIV insofar as knowledge of status in people living with HIV/AIDS (PLWHA) may influence them to avoid risky sexual contact with others.

Lower quality health care, and lower rates of highly active antiretroviral treatment (HAART) use are also theses that have been explored. In a study of MSM living in Baltimore/DC, Chicago, Pittsburgh and Los Angeles, researchers found that blacks and whites were equally likely to report having been hospitalized, having had outpatient visits, and having had ER visits in the past 6 months, controlling for HIV status, health insurance and SES (Zucconi et al., 1994). Similarly, in a study of 464 seropositive adult MSM living in New York and San Francisco researchers found no racial differences in the prevalence of reporting some access to HIV medical care, and having some form of health insurance (Halkitis et al., 2003). Moreover, in a Baltimore study of seropositive MSM (controlling for socio-economic status) researchers found no racial differences in having health insurance overall, and in having private vs public insurance, as well as in

the number of ER visits, and inpatient visits (Kass et al., 1998). However, in this Baltimore study, in analyses restricted to respondents with CD4 counts greater than 500, white men were far more likely than black MSM to have seen a physician in the past 6 months (Kass et al., 1998). This suggests better quality and continuity of care in white seropositive MSM as compared to their black counterparts. In further support of this claim, in a study of 464 seropositive adult MSM living in New York and San Francisco Black MSM were more likely to receive HIV care at public clinics (Halkitis et al., 2003). In short, disparities in quality of health care could plausibly contribute to racial disparities in HIV infection, and data on HAART access suggests the same. In a study of 464 seropositive adult MSM living in New York and San Francisco fewer Black MSM reported currently being on antiretroviral therapy, and reported lower levels of perceived access to HIV treatments, as compared to their white counterparts (Halkitis et al., 2003). Similarly, in a longitudinal study of 673 seropositive MSM living in Baltimore/DC, Chicago, Los Angeles and Pittsburgh, researchers found that Blacks were less likely than whites to be currently receiving antiretroviral treatment (Jacobson et al., 2001). In contrast, in a probability study of seropositive MSM living in Chicago, Los Angeles, New York, and San Francisco, researchers found that Black and Hispanic MSM with CD4 counts less than 500 were less likely than their white counterparts to report use of antiretroviral medications (Stall et al., 2001). Evidence concerning adherence to HAART is similarly mixed, with one cross-sectional study of New York and SF seropositives reporting no racial differences in rates of adherence (measured as having missed one or more doses of any of their HIV medications in the past month) and two other longitudinal studies using data from Los Angeles, Chicago, Baltimore and Pittsburgh finding that Blacks were less likely than non-AAs to report 100% adherence to ART medications, both at the start of the study, and over time (Halkitis et al., 2003; Kleeberger et al., 2001; Kleeberger 2004). However, the mechanisms underlying these disparities remain poorly understood.

Another thesis that has been explicitly (and frequently) explored – and rarely supported-- is whether higher rates of HIV infection are explained by a greater prevalence of high-risk sexual behaviors (including unprotected anal intercourse, number of sexual partners, commercial sex) among Black MSM (Millett, Peterson, Wolitski, and

Stall, 2006; Stokes, Vanable, McKirnan, 1996 ;McKirnan, Doll, and Burzette, 1995). The vast majority of recent studies have found that black MSM are no more likely than whites to report unprotected anal sex (Denning and Campsmith, 2005; McKirnan, Vanable, Ostrow, and Hope, 2001; Solorio, Swendeman, Rotheram-Borus, 2003; Lemp, Hirozawa, Givertz, Nieri, Anderson, Lindegren, Janssen, and Katz, 1994;Mansergh, Marks, Colfax, Guzman, Rader, Buchbinder, 2002; MacKellar, Valleroy, Secura, 2005; MacKellar, Valleroy, Secura, 2005; Ruiz, Facer, and Richard, 1998). This is true among adult MSM overall (Denning and Campsmith, 2005;McKirnan et al., 2001;Mansergh et al., 2002) as well as young and very young MSM (Solorio et al., 2003; Lemp et al., 1994, MacKellar et al., 2005), those living in Chicago (McKirnan et al., 2001), the San Francisco Bay area (Lemp et al., 1994, Mansergh et al., 2002), as well as in multisite studies (MacKellar et al., 2005;Denning and Campsmith, 2005), among HIV-positive subsamples (Denning and Campsmith, 2005, Solorio et al., 2003; MacKellar et al., 2005) as well as among bisexually behaving subsamples (McKirnan et al., 1995). Several researchers have also found that in some samples, especially those focusing on MSM younger than 30, Black MSM have lower rates of unprotected anal intercourse (UAI) as compared to their white counterparts (Valleroy, MacKellar, Secura, and Behel, 2002;Peterson, Bakeman, Stokes, 2001;Bingham, Harawa, Johnson, Secura, MacKellar, and Valleroy, 2003; Harawa, Greenland, Bingham, et al., 2004). In contrast, data supporting the hypothesis that Blacks are more likely to report unprotected anal intercourse than other subgroups of MSM are few, collected in the late 1980s and early 1990s, and based upon much smaller sample sizes (Heckman, Kelly, Bogart, Kalichman, Rompa, 1999; Peterson, Coates, Catania, Middleton, Hilliard, and Hearst, 1992; Ekstrand and Coates, 1990).

Similarly, the existing research on number of male sexual partners overwhelmingly suggests that black MSM tend to have fewer such partners as compared to their white counterparts (Stokes, Vanable and McKirnan, 1996; Doll, 1990; Bingham et al., 2003). The existing literature on racial differences in participating in commercial sex are slightly more mixed. In a study of Chicago bisexually behaving MSM ages 18 to 30, researchers (McKirnan, Doll, Burzette, 1995) found that while Blacks were more likely to report having been paid for sex by another man, white respondents who reported

engaging in such encounters did so more often. Similarly, in a study of Milwaukee MSM, Heckman and colleagues (1999) found no racial differences in the prevalence of 3-month commercial sex, and in a study of MSM 15 to 22, drug using adult MSM, and multi-site studies of MSM, blacks were no more likely than whites to report sex with an exchange partner (Harawa, Greenland, and Bingham, 2004; Newman, Rhodes, Weiss, 2004; Rietmeijer, Wolitski, Fishbein, Corby, and Cohn, 1998). Overall the research overwhelmingly suggests that black MSM are not more likely than whites to engage in sexual risk behaviors (i.e have multiple sexual partners, practice unprotected anal sex, or participate in commercial sex). Thus the potential for this hypothesis to explain racial disparities in HIV infection is weak.

Given that substance abuse can impair cognitive functioning and thus negatively influence sexual decision-making, a plausible hypothesis is that higher rates of substance abuse and abuse could account for racial disparities in HIV infection among MSM. However, for the most part differences in alcohol and drug use and abuse appear to be unlikely to contribute markedly to racial differences in HIV infection among MSM. For example, in a study of 281 Chicago MSM, researchers found no ethnic differences in the frequency of alcohol intoxication, in a multi-site study of adult MSM Blacks were no more likely than whites to report alcohol-related physical and psychosocial problems, and in a study of Milwaukee MSM researchers found no racial differences in the prevalence of alcohol use prior to sex (McKirnan et al., 2001; Stall et al., 2001; Heckman et al., 1999). Similarly, in a cohort of younger SF MSM 18 to 29 researchers also found no differences in rates of heavy alcohol use (Greenwood et al., 2001). Moreover, a multi-site study of MSM 23 to 29 in urban centers found that Blacks were *less* likely to report ever having used alcohol (Valleroy et al., 2002). Similarly, in a study of 13 to 21 year old MSM researchers found that Blacks consumed less alcohol in the past three months, and had less severe substance use issues than their white counterparts (McNall et al., 1999). Only one study reviewed found higher rates of alcohol use in Black MSM, and this study was restricted to those with diagnosed with an alcohol abuse or dependence disorder who consumed alcohol in the past 30 days (Irwin et al., 2005).

Differential rates of drug use also appear unlikely to contribute markedly to racial disparities in rates of HIV infection. In a study of Milwaukee MSM, Blacks were less

likely to report drug use prior to sex (1999). Similarly, in a study of NYC MSM 15 to 29, Torian and colleagues found no racial differences in lifetime and 6-month drug exposures, and although the finding of lower drug use in AA MSM as compared to whites tends to recur in studies focusing on specific drugs, this varies depending on the drug under study (2002). The majority of studies find that black MSM are either less likely or equally likely to use injection drugs as their white counterparts, though two studies suggest otherwise. For example, in a study of young MSM 23 to 29 living in six urban centers, researchers found that Blacks were less likely to report having ever used injection drugs (Valleroy et al., 2002). This finding of lower injection drug use in black MSM as compared to whites was replicated in a study of Los Angeles MSM 23 to 29, and in a younger cohort of MSM 15 to 22 living in seven urban centers ((Bingham, Harawa, Johnson, Secura, MacKellar, and Valleroy, 2003; Harawa et al., 2004). In a study of 1290 Denver and Long Beach MSM recruited in high risk settings, researchers found no racial differences in injection drug use (Rietmeijer, Wolitski, Fishbein, Corby and Cohn, 1998). In contrast, two studies found greater injection drug use in Black MSM as compared to their white counterparts. Of these two studies, one focused solely on those older than 50, and the other focused on seropositive MSM (Siegel et al., 2004; Sullivan et al., 1998). The research strongly suggests that Black MSM are less likely or no more likely than whites to use amphetamines, barbiturates, heroin LSD, tranquilizers, nitrites, marijuana methaqualone (Harawa, Greenland, Bingham, 2004; Halkitis, Green, Mourgues, 2005;McKirnan et al., 2001; Sullivan, Nakashima, Purcell, Ward, 1998; McNall et al., 1999). However, data on crack use are more mixed. In a study of 281 Chicago gay and bisexual men, Blacks constituted a high proportion of those reporting crack cocaine use, and in a large multisite study of seropositive MSM, blacks were much more likely than nonblacks to use noninjection crack cocaine in the past 5 years. However, in a study of MSM aged 15 to 22 living in seven urban centers researchers found that blacks were less likely than whites to report having ever used crack cocaine (Harawa, Greenland, Bingham, 2004; McKirnan et al., 2001; Sullivan, Nakashima, Purcell, Ward, 1998). Altogether this research suggests that racial differences in drug use among MSM are unlikely to be a major contributor to wide racial disparities in rates of HIV infection.

Stigma

The role of social stigma in contributing to racial disparities in rates of HIV infection among white and black MSM has been in general under-explored. Although the literature on stigma as it relates to black MSM is in the early stages of development, there has been a great deal of theoretical investigation regarding this construct within the larger public health literature, and stigma and its key outcomes, prejudice and discrimination have been identified as key to the social production of health disparities more broadly (Stuber et al., 2008). Contemporary discussions regarding stigma are heavily influenced by Erving Goffman's text *Stigma: Notes on a Spoiled Identity* (1963), in which he characterizes stigma as a "deeply discrediting" attribute, which serves to justify the conscious and mindless de-humanization, discrimination against, and reduction of life chances of those who possess it (Goffman, 1963; Stuber et al. 2008; Link and Phelan, 2001). In this classic text Goffman explains that—although flexible and attribute-dependent-- the primary social function of stigma is to maintain social norms. Thus, in *Stigma* Goffman focuses on the social rules governing interactions between the stigmatized and those who do not possess the discrediting attribute – "normals"—which function primarily to reinforce and naturalize the "difference" in question, while simultaneously enabling polite yet distant communication between the two groups. Goffman speaks about these rules primarily from the perspective of the stigmatized, both those whose difference is immediately perceivable – the discredited, who must learn to manage social tension—and those whose difference is not perceivable—the discreditable-- who must learn to manage information regarding his/her difference. From Goffman's perspective, successful guidance of the rules presented to the stigmatized, including disclosure, conditional self-acceptance, and strategic 'passing' provides them with a sense of authenticity while simultaneously leaving unscathed the social meanings ascribed to their 'difference,' as well as their material consequences.

Extending the work of Goffman, Link and Phelan (2001; 2006) argue that stigma is present when the following four processes converge, within a system of power relations that enables and facilitates them: 1. Human differences are labeled, 2. Deeply

entrenched cultural beliefs attach negative stereotypes to labeled people, 3. Those who are labeled are categorized and clearly separated from "us", 4. Discrimination and status loss are experienced by the stigmatized, leading to poorer outcomes. The most discussed vehicle through which stigma operates is discrimination, which can be experienced both through individual, structural, and social psychological means. As Link and Phelan (2001) explain, individual discrimination, which is rationalized by a belief in the cultural stereotype assigned to stigmatized groups and people involves person to person acts of rejection and exclusion. In contrast, structural discrimination refers to "accumulated institutional practices" that work to disadvantage stigmatized groups, and can take place even in the absence of direct interpersonal forms of exclusion (Link and Phelan, 2001). Social psychological avenues through which stigma operates include the expectation of rejection that the stigmatized may learn and anticipate, which may influence their behaviors and the extent to which they seek support. Similarly, Link and Phelan discuss "stereotype threat" as another potential vector through which life chances are reduced for the stigmatized. Through this vector, being judged in accordance to the stereotype, or the threat of confirming the stereotype may negatively influence the behaviors of the stigmatized, even in the absence of direct acts of interpersonal discrimination.

Of the existing potential pathways between stigma and social disparities in health, discrimination is the most frequently cited. Providing one of the most explicit theories for how this operates, Link and Phelan (2006) describe several potential mechanisms, the first of which is stigma-induced stress. They argue that stigma may generate both stressful situations and limit the available tools with which to cope with stressful situations. An example which Link and Phelan illustrate is James' theory of John Henryism, the idea that high-effort coping in order both to maximize personal economic success and to disprove racial stereotypes of Blacks as "lazy" may bear severe health consequences, in the form of elevated rates of hypertension in Blacks. Similarly, the role of discrimination can operate more directly, through locating the stigmatized in security-threatening physical environments, for example, building treatment centers for those with mental illnesses in sub-standard buildings and isolated, high-crime areas (Link and Phelan, 2001). A final psychosocial route through which stigma can operate is through the erosion of traditional coping responses, like self-esteem (Link and Phelan, 2006).

However, authors are careful to note that stress is not the sole mechanism through which stigma can operate. For example, authors note that stigma can be a fundamental cause of disease to the extent to which it places the stigmatized at a persistently disadvantaged social position with respect to information, money, prestige and social connections, thus shaping patterns of exposure to health protective and risk factors (Link and Phelan, 2006).

In contrast to the majority of existing models of stigmatization, which focus primarily on the immediate outcomes of stigma, or the social psychological processes which directly link it to social disparities in health, Parker & Aggleton (2003) instead focus on the core relationship between stigma and social inequality, arguing that stigma plays a critical role in the reproduction of inequalities, and that it is deployed by individuals, communities and the state in order to reinforce social inequalities. Thus, Parker and Aggleton's (2003) focus is on the political economy of stigmatization, and the historically dynamic ways in which social inequalities attached to particular "differences" remain deeply entrenched over time, even in the presence of rapid and global economic transformations. Parker and Aggleton's (2003) view the role of power relations to thus be even more insidious than that of Link and Phelan (2001): rather than arguing that unequal power relations facilitate the exercise and deployment of stigma, they instead suggest that the maintenance of unequal power relations—social inequalities really—are fundamentally dependent on the exercise of stigma.

This dissertation is deeply informed by these inter-related theories of stigma, thus it builds on Parker and Aggleton's (2003) claim that stigma is linked to social inequalities, while seriously considering the particular role that discrimination may play in linking stigma to racial disparities in HIV/AIDS among MSM. However, as bearers of the marks of at least two forms of culturally entrenched stigmatizing attributes—blackness, and sexual non-normativity— a thoughtful exploration of the role of the explicit role of stigma is clearly warranted. To this end, my first dissertation paper accomplishes two critical goals. Firstly, guided by the belief that in order to constructively and conceptually build forth from the existing literature we must first clearly understand the critical forms of knowledge that currently exist, paper one of the dissertation consists of an exhaustive illustration of the ways in which racial and sexual

forms of stigma are conceptualized within the applied public health literature on stigma and HIV risk and vulnerability in Black MSM. Secondly, in this paper I provide a critique of this specific applied literature, in light of existing theoretical approaches to stigma generally, as well as in light of the existing theoretical literature on intersectionality, which asserts that racial and sexual forms of stigma are mutually constitutive and fundamentally intertwined, rather than discrete (Ford et al., 2007). Building forth from a key critique of paper one, which is that the existing applied public health racial and sexual stigma literature does not properly consider the mutually constitutive nature of both racial and sexual forms of stigma, and instead tends to adopt a universal (white) gay subject position, paper two uses a multi-site probability sample of U.S. MSM to accomplish the following goals. First, it explores levels of perceived racial stigma and affiliation with the gay community in an ethnically diverse sample of MSM, and second, it empirically tests racial differences in these measures. Finding notable ethnic differences in feelings of affiliation and perceptions of racial stigma among MSM, these findings provide data critical for contextualizing existing empirical evidence regarding the relationship between stigma and HIV risk among MSM. This paper concludes that the failure to find meaningful relationships between stigma and HIV risk in Black MSM may be explained by the racially neutral ways in which psychosocial protective factors have been theorized. Moving forth, paper three is a qualitative analysis of the illness narratives of older adult black MSM who have been living with HIV/AIDS since before the advent of highly active antiretroviral therapies, and focuses specifically on the ways in which stigma related to HIV, non-normative sexuality, and race are described, experienced and resisted.

Chapter II

A qualitative analysis of current models of social stigma and HIV risk and vulnerability in African/American Black sexual minority men

There are striking racial disparities in HIV prevalence, incidence, and disease progression among sexual minority men in the United States (Millett et al., 2006; Blair et al., 2002; CDC, 2005). HIV prevalence among black sexual minority men is estimated at 46%, far surpassing that of other racial/ethnic groups, and rivaling prevalence rates in the most resource poor settings globally (CDC, 2005; Catania et al., 2001). In response, there has been tremendous growth within the applied public health literature, with several scholars both exploring the potential causes of this domestic health disaster, and suggesting productive future research directions. For example, in a critique of data-sparse epidemiologic emphasis on the "down low" (DL) -- "straight-appearing" bisexually-behaving closeted gay men-- as a potential cause of racial disparities in HIV/AIDS, Ford and colleagues argue that historically-entrenched social constructions of black male sexuality as predatory have supported excessive focus on behavioral factors, minimizing the role of structural and social determinants (Ford, Whetten, Hall, Kaufman and Thrasher, 2007). Similarly, in a comprehensive empirical review of existing HIV prevention research on Black sexual minority men Mays and colleagues posit that what is required is a shift from individual-level proximate determinants of HIV risk to social and interpersonal factors, with renewed focus on the role of social power and privilege (Mays, Cochran, and Zamudio, 2004). Supporting this focus away from behavioral factors is evaluative and meta-analytic research illustrating the failure of individual risk behaviors to empirically account for existing black - white racial disparities in rates of infection among sexual minority men, and instead pointing to the more plausible role of factors such as higher background levels of STDs, lower levels of knowledge of HIV

status, and the importance of heightened focus on factors like social stigma (Millett, Flores, Peterson, and Bakeman, 2007; Millett, Peterson, Wolitski and Stall, 2006). Other leading researchers similarly cite the need for direct focus on social stigma as a potential underlying cause of factors more proximately associated with black - white racial disparities in HIV/AIDS among sexual minority men, including healthcare utilization and HIV testing (Malebranche, Peterson, Fullilove, and Stackhouse 2004; Wilson and Moore, 2009).

Although the study of stigma and HIV risk in Black sexual minority men is at present in its early stages, a focus on social stigma is strongly supported by the wider social determinants literature, in which researchers have identified social stigma as both a potential fundamental cause of health disparities, and a requirement for the perpetuation of social inequalities more broadly (Stuber et al., 2008; Link and Phelan 2001; Parker and Aggleton, 2003). Moreover, the existing domestic and global public health literature suggests that there is a strong relationship between stigma and HIV-risk and vulnerability among sexual minority men (Diaz, 2004; Diaz, 2001; Padilla, Castellanos, Guilamo-Ramos, Reyes, Marte and Soriano, 2008; Meyer, 2003; Frye, 2006; Wilson and Yoshikawa, 2004). However, focused analysis on the direct and explicit relationship between experiences of social stigma and HIV vulnerability among sexual minority men of color has tended to focus either on Latinos in the U.S. or abroad, or on Asian Americans, with researchers finding that social stigma is directly associated with psychologic symptoms in U.S. Latino sexual minority men, that experiences and responses to social stigma in Asian and Pacific Islander sexual minority men may strongly influence HIV vulnerability, and that sexual stigma and structural inequalities powerfully constrain Dominican male sex workers' attempts to maintain their own sexual health as well as that of their sexual partners (Diaz, Ayala, Bein, Henne and Marin, 2001; Wilson et al., 2004; Padilla et al., 2008). Although the same level of *direct* empirical attention to the explicit role of social stigma and HIV vulnerability is not yet present in the existing applied public health literature focusing on Black sexual minority men, there has indeed been considerable attention to assessing *indirect* ways in which social stigma may influence HIV risk and vulnerability in this population. Millett and colleagues (2006) provide a brief empirical review of this subset of the general applied

public health literature on black - white racial disparities in HIV/AIDS among sexual minority men, which focuses primarily on psychosocial identity-related factors which may protect against the influence of social stigma. Specifically, this subset of the applied public health literature examines racial differences in sexual self-identification and its related psychosocial factors in an attempt to comparatively examine the extent to which black and white sexual minority men exhibit attempts to mitigate the influence of social stigma in their lives. Within this body of research, there have been some fairly counter-intuitive empirical findings, given that in the wake of tremendous advancements in the civil rights of sexual minorities in the United States, it is reasonable to expect that embracing and claiming one's gay identity would be universally health-promoting. However, Hart found no relationship between sexual identity and unprotected anal intercourse for black men who have sex with men (2004). Similarly, Wheeler and Lauby (2008) found that disclosure of same-sex behavior was unrelated to unprotected receptive anal intercourse in behaviorally bisexual and behaviorally homosexual black men. And, in an even more perplexing fashion, some researchers have found that sexual identity was related to greater sexual risk, such that black MSM who identify as gay may be more likely to report unprotected receptive anal intercourse than their straight and bisexual identifying counterparts (Mutchler et al., 2008, Crawford et al., 2002, Wheeler et al., 2008).

Although this fairly contentious body of applied public health literature focuses primarily on indirect assessments of and coping responses to social stigma, it remains a critical site for qualitative analysis for two main reasons: 1. of the existing applied research, it most explicitly attempts to empirically engage how racial and sexual stigma and inequalities may influence the spread of HIV/AIDS among black sexual minority men, and 2. as an applied literature, it has the unique ability to fairly quickly and directly impact public health intervention development and policy. Thus, it represents a critical conceptual springboard from which to further develop a body of research devoted to issues of social stigma and social inequality as relates to HIV in black sexual minority men. Building upon the existing research, and following the general procedure employed by Millett and colleagues in their review of this literature (2006), the purpose of this qualitative study is to describe the literature on the relationship between sexual identity

and its related psychosocial constructs and HIV risk and vulnerability in black sexual minority men, focusing not on evaluating the empirical results of the literature, which others have already done (see Millett et al., 2006), but rather on understanding the major ways in which race, racial stigma and inequality, sexuality, sexual stigma and inequality are conceptualized. Thus, the premise of this study is that the ways in which key constructs are conceptualized ultimately form the boundaries within which the problem of social stigma and HIV in Black sexual minority men can be addressed and understood. Identical to the literature addressed in Millett and colleagues' (2006) study[1], the specific object of analysis in this study is the HIV-related applied public health stigma literature which addresses: 1. black-white differences in sexual identity among sexual minority men, 2. black-white differences in sexual identity disclosure among sexual minority men, 3. the relationship between HIV risk and sexual identity among Black sexual minority men 4. The relationship between HIV risk and sexual identity disclosure in Black sexual minority men.

Method

In order to accurately identify the qualitative data to be analyzed, I performed a literature search using Medline, Sociological Abstracts, and PsycInfo. The parameters of my search were: "Black or Black or Afro American" AND "white or racial disparities" [2] AND "homosexual or bisexual or men who have sex with men or MSM or gay or same gender loving or non-gay identified or down-low or sexual identity or sexual orientation" AND "HIV." In addition, I triangulated my literature search by following the citations of other published studies, including Millett and colleagues' 2006 seminal assessment of the major findings of this literature. I limited my search by selecting only peer-reviewed

[1] This study and that of Millett and colleagues is not identical in that all of the articles reviewed are the same. Rather, it is identical in that it undertakes the same general process of article selection employed by Millett and colleagues, focusing on those articles which examine 1. black-white differences in sexual identity among sexual minority men, 2. black-white differences in sexual identity disclosure among sexual minority men, 3. the relationship between HIV risk and sexual identity among black sexual minority men and 4. The relationship between HIV risk and sexual identity disclosure in black sexual minority men.

[2] "White or racial disparities" served to ensure the inclusion of studies that consider the role of social stigma in an ethnically comparative fashion.

articles based in the United States, which were published between January 1990 and October 2008. Furthermore, I limited my analysis to empirical studies which analyzed either quantitative or qualitative data. Lastly, consistent with Millett (2006), articles were limited to those which explicitly assessed 1.black: white differences in sexual identity among MSM 2. black: white differences in sexual identity disclosure among MSM 3. The relationship between sexual identity and HIV risk in black sexual minority men, and 4. The relationship between sexual identity disclosure and HIV risk in black sexual minority men. In total, 38 articles were selected for inclusion in this review.

The first step of analysis involved identifying and abstracting "conceptualization statements" regarding how race, sexuality, racial stigma and inequality and sexual stigma and inequality are conceptualized within each article. I define a "conceptualization statement" to be a generalized statement about what the construct reflects. In some cases, article authors endorse several, sometimes overlapping and conflicting conceptualization statements. Thus, the purpose of this article is not to critique one particular article or even the literature as a whole, but rather to examine recurring conceptualization statements, in order to develop a clear and global sense of *how* existing scholars in the area think about race, racial stigma and inequality, sexuality, and sexual stigma and inequality. The second analytic step involved typing out verbatim from each article all "conceptualization statements" regarding race, sexuality, racial stigma and inequality and sexual stigma and inequality, thereby constructing a smaller qualitative data-set to be analyzed. The final step of data analysis involved the systematic process of manually coding the resultant qualitative data-set, using both microscopic analytic and descriptive coding techniques (Strauss and Corbin, 1998). In summary, the data were coded according to major themes in how each key construct is conceptualized, as well as by major trends in modes of conceptualizing the specific mechanisms which link each construct to HIV risk and vulnerability. In the results section of this paper, I describe major trends in the ways in which each construct is conceptualized and linked to HIV risk and vulnerability, and in the discussion section of this paper, I more critically assess major conceptualizations circulating within this burgeoning applied public health literature, in light of the already existing theoretically rich and highly nuanced broader social science literature which focuses on both intersectionality and the connections

between social stigma and social inequalities (see Williams et al., 2008; Link et al., 2001; Parker and Aggleton, 2003; Padilla et al., 2008; Padilla, 2007; Cohen, 2005; Cohen, 1999; Ferguson, 2005; Ferguson, 2004; Eng, 2005; Johnson, 2005; Duggan, 2002; Manalansan,1997; Manalansan, 2003; Johnson, 2005; De Cena, 2008; Collins, 2005; Bowleg, 2008).

Results

Race

Consistent with much of the epidemiologic research on race and health, within this literature, black race/ethnicity is typically conceptualized as reflecting either an independent variable, or risk group (Torian et al., 2001, Chu et al., 1992, Hart et al., 2004, Doll et al., 1992, Rietmeijer 1998, Ross et al., 2002, McKirnan et al., 1995, McKirnan et al., 2001, Crawford et al., 2002, Goldbaum et al., 1998, Chng et al., 2000, Purcell et al., 2005, Stokes et al., 1996, Peterson et al., 1992, CDC, 2003, Mason et al., 1997, Bernstein et al., 2008, Essien et al., 2005, Halkitis et al., 2008, Warren et al., 2008, Wohl et al., 2002, Wolitski et al. 2006, Rhodes et al., 2006, Mutchler et al., 2008, Lauby et al., 2008, Solorio et al., 2003, Martinez and Hosek, 2005, Wheeler et al., 2008). In these studies, researchers often cite disproportionately high rates of HIV infection among black MSM, and seek to identify behavioral, psychosocial, or socioeconomic correlates of risk behavior in this group. However, as is common in much epidemiologic research, race as a social phenomenon or as a social process is not explicitly discussed.[3] Rather, race is understood to be fairly self-explanatory, the property of individuals. Although researchers certainly do not suggest that race is a biologic or genetic construct, within the literature, race figures as a personal, private attribute.

Although the overall trend is for race to be described as belonging to individuals, in other instances far more complex relationships are described. For example, some researchers explicitly discuss the ways in which cultural values may vary across different race/ethnicity groups (Simoni et al., 1997). For example, on page 591 of their study, Simoni and colleagues (1997) state that Blacks may be distinct from whites as a result of "cultural values that emphasize sparing loved ones emotional distress or that stigmatize

[3] see Schulz and colleagues, 2006 for a critical discussion of this limitation within the broader racial disparities in health literature.

homosexuality and AIDS." Other researchers suggest that behavioral studies or interventions need to be developed in more culturally competent ways (Kennamer et al., 2000, Warren et al., 2008, Ostrow et al., 1991, Wheeler et al., 2008). In other words, race also figures prominently in terms of its potential to reflect cultural variation. Moreover, although in general researchers tend to frame race as either a risk factor or as potentially indicative of cultural differences, in a small handful of more structurally-oriented pieces, race is indeed directly theorized in terms of its relationship to socioeconomic inequality, thus race is seen to act as proxy for fewer economic resources (Ostrow et al., 1991, Siegel et al., 2004).

Sexuality

Similar to race/ethnicity, sexuality tends to be theorized in discrete and individualistic terms. The most common way in which sexuality is theorized is in relationship to the gender of those with whom an individual engages in sexual acts. Thus, self-identified men are classified as belonging to the behavioral risk group "men who have sex with men" or "men who have sex with men and women" if they report intra-gender or both intra and inter-gender sexual contact, although, of note, studies differ in terms of the time period during which such acts must have occurred (Torian et al., 2001, Chu et al., 1992, Montgomery et al., 2003, Hart et al., 2004, Rietmeijer et al., 1998, Goldbaum et al., 1998, CDC, 2003, Simoni et al., 1997, Mason et al., 1997, Warren et al., 2008). Typically "men who have sex with men" are classified as representing a high risk group for HIV infection, although the specific sex acts which characterize their "at risk" classification are often left unstated. Another way in which sexuality has been conceptualized is as a self-assessed identity or label; a social category which individuals either personally select or with which they personally identify, typically including some of the following options: homosexual, heterosexual, bisexual, gay, straight, or DL (Hart, 2004, Montgomery et al., 2003, McKirnan et al., 1995, Stokes et al., 1996, Essien et al., 2005, Wolitski et al., 2006, Rhodes et al., 2006, Lauby et al., 2008, Solorio et al., 2003 Martinez and Hosek, 2005, Harawa et al., 2008). A second, and far more complex way in which sexuality has been conceptualized is as "sexual orientation", or as a combination of sexual fantasies and behaviors (Peterson et al., 1992; Mutchler, 2008; Martinez and

Hosek, 2005). For example, on page 738 of their study Mutchler and colleagues (2008) describe their use of a sexual orientation measure which asks "participants to rate their sexual feelings, sexual activities, romantic feelings, and use of pornographic or erotic materials on a 7-point scale with labels for exclusively hetero, equally hetero and homo, and exclusively homosexual." It is important to note both that studies often conceptualize sexuality in more than one way, and that in some cases, researchers assess concordance, or the extent to which either behavior, self-identity or sexual desires are in alignment (Montgomery et al., 2003, Ross et al., 2002, Pathela et al., 2006). Social psychological models of sexuality tend to theorize same-sex desire as a characteristic which resides within individuals, and often posit that there are developmental stages through which those who experience same-sex desire can healthily claim their desire as a social identity (Crawford et al., 2002, Chng et al., 2000, Rosario et al., 2004, Harawa et al., 2008). Although in general sexuality is understood to be static in time, some authors do in fact suggest that we must consider the dynamic nature of sexual desire, identity and behavior, and that these may change over the life course (Rhodes et al., 2006; Ross et al., 2002). Although in general there is much more variation in the ways in which sexuality is theorized, relative to race/ethnicity, some features common to these different models of sexuality include that it is private; the property of individuals. And, although race and sexuality are theorized to be distinct and discrete concepts, some authors do in fact suggest that the interpretation of sexual desire and sexual acts may differ across cultures, clearly demonstrating an awareness of the dynamic nature of these constructs (Doll, 1992, Stokes et al. 1997, Martinez and Hosek, 2005; Pathela, 2006).

In addition to directly theorizing sexuality, researchers have importantly sought to identify psychosocial protective factors related to sexual stigma that may protect against HIV risk and vulnerability. One factor which has been theorized to be protective is claiming a gay self-identity. Gay self-identity has been theorized to be critical to protecting against HIV risk insofar as it may reflect having overcome the self-hatred, low self-esteem or internalized homophobia (CDC, 2003; Wolitski 2006) often experienced by sexual minorities as a result of possessing a sort of "stigmatizing attribute" (Goffman, 1963). In other words, within this applied public health literature, labeling oneself as gay is often perceived to reflect that one has personally accepted and is comfortable with

one's same-sex desire. For example, in psychological models "coming out" to oneself through identifying as gay is theorized as an adaptive psychological process through which individuals become more comfortable and accepting of their gay identity (Rosario et al., 2004). Although the process of coming out may be influenced by one's social environment, the process is generally theorized to occur within individuals, and is in this sense a fundamentally private, internal process.

The disclosure of same-sex desire, orientation, or behavior has also been described as a stigma mitigating psychosocial factor, although disclosure is also typically linked to the health of sexual partners (Dodge et al., 2008). Secondly, "coming out" to physicians has also been theorized to be important, in order that individuals can receive proper health screening (Bernstein, 2008). A third way in which sexual identity disclosure has been described is in terms of its potential link to effective HIV/AIDS political organizing (Kennamer, 2000). For example, on page 520 of their study Kennamer and colleagues contextualize their study in stating a key assumption—that "to the degree that Blacks are not 'out' and are not organized, then they are unable to participate to the same degree as white gay and bisexual men in the fight against HIV/AIDS." These acts of personal revelation are taken to reflect the decisions of individual actors, and are cast as necessary to preserving either one's own health, the health of others, or the collective health of sexual minority communities. The personal benefits of disclosing one's sexual behavior are also described in psychological terms, such that those who disclose to others their same-sex behavior are understood to have moved towards transcending internalized homophobia (Dodge et al., 2008). In contrast, opting to not disclose one's same-sex sexual behavior has been described as "concealment" (Siegel, 2004), suggesting that sexual desire is visible, in its natural state. Similarly, those who choose not to disclose are described as "confining themselves" to secrecy (Simoni et al., 1997), suggesting that the space of public acknowledgment may be a safer space.

Beyond the psychological comfort theorized to be reflected in personally claiming a gay identity, claiming a gay identity is also theorized as a protective factor through access to the multiple health promotion messages targeted towards the gay community. In other words, those who identify as gay are understood to be more likely to participate in

the identifiable gay community, which is critical in terms of health because identifiable gay communities are often the target of health promotion planning (Martinez and Hosek, 2005; Siegel et al., 2008; CDC, 2003; Rietmeijer, 1998). By extension, those not engaged with the identifiable gay community are theorized to be less likely to receive the benefits of educational materials geared to protect sexual health (Stokes et al., 1997, Martinez and Hosek, 2005, Goldbaum, 1998). Gay communities in general are not deemed healthy, rather those so deemed are those which are visible and affiliated with venues providing health education materials or messages. A second theorized linking factor between gay identity and health is that those who gay-identify are theorized to be more likely to respond to health promotion materials that are designed for gay populations, both because they will be less likely to fear association with such materials (since reading these materials may inadvertently socially mark them as gay) and because these materials are more likely to be relevant to their gay sexual-cultural context (McKirnan et al., 1995, Goldbaum et al., 1998, Montgomery et al., 2003). A third reason that gay identity is theorized to be protective against HIV risk is that those who identify as gay and participate in gay culture may have access to healthy sexual norms present within the gay community (Doll, 1992, Chng et al., 2000). A fourth route through which claiming a gay identity is deemed protective is that it may increase the likelihood that individuals correctly perceive themselves as 'at risk' of HIV infection, since the disease is often associated with sexual minorities (Wohl et al., 2002, Rietmeijer, 1998, Chu et al., 1992, Doll, 1992). The final route through which claiming a gay identity is deemed protective is that those who do not identify as gay are theorized to be less trusting of HIV/AIDS information coming from official sources such as the CDC (Bernstein et al., 2003). Similar to the ways in which race and sexuality are discussed, sexuality-related psychosocial factors are also theorized to be characteristics which belong to individuals, which individuals can freely choose to adopt. However, in general, those associated with the gay community "visible" to public health officials are theorized to be at lower potential sexual risk.

Racial Stigma and Inequality

Although race and racial stigma inequality are in general far less explicitly theorized within this literature than are sexuality and sexual stigma and inequality, some researchers do explicitly address racism. When explicitly discussed, racism is described as interpersonal discrimination, social or sexual exclusion, or sexual objectification (Crawford et al., 2002, Chng et al., 2000, Mason et al., 1997, Warren et al., 2008). A small number of researchers have alluded to the notion that racism involves political power (Simoni et al., 1997, Harawa et al., 2008). However, in those instances where racism is explicitly discussed, it is typically theorized in relationship to its presence within gay communities and gay-identified venues (Crawford et al., 2002, Chng et al., 2000, Kennamer et al., 2000, Rosario et al., 2004, Warren et al., 2008, Ostrow et al., 1991, Harawa et al., 2008). In other words, racism is most often explicitly discussed insofar as it is perpetrated by white gays, or by the mainstream "identifiable" or "white" gay community. For example, on page sixty of their study Ostrow and colleagues (1991) state that black MSM can face "alienation and isolation, often stemming from real or perceived racism in the traditional white gay organizations." In this way racism is taken to be a cultural attribute of the gay community. Although alternative ways in which racism may operate are in some instances implied, they remain far less central.

Sexual Stigma and Inequality

Sexual stigma is a far more commonly discussed concept within this literature, and is typically described as "homophobia." Some researchers describe homophobia as pressure to have an opposite-sex partner, as rejection, lack of tolerance for, and negative attitudes toward same-sex behavior, as rejection of same-sex behavior as not masculine, as stigmatization of homosexuality, lack of tolerance for homosexuality, or as the silencing of homosexuals (Montgomery et al., 2003, Doll et al. 1992, Chng et al., 2000, Ross et al., 1992,McKirnan et al., 1995, Crawford et al., 2002, Stokes et al., 1996, Kennamer et al., 2000). Similar to racism, homophobia is typically theorized in relation to its presence in the black community (Ross et al., 2002, McKirnan et al., 1995, Stokes et al., 1997, Stokes et al., 1996, Kennamer et al., 2000, Simoni et al., 1997, Mason et al., 1997, Rosario et al., 2004, Warren et al., 2008, Siegel et al., 2008, Mutchler et al., 2008)

where particularly "high" levels of homophobia are theorized to exist. Some researchers also suggest that homophobia may be a part of black culture (Kennamer et al., 2000). For example, on page 523 Kennamer and colleagues (2000) contextualize their own study by stating that "homophobia is a major part of Black culture." Researchers also often suggest that high levels of homophobia in the black community may be a consequence of conservative religious beliefs (Crawford et al., 2002), or a result of racism, and the felt need to maintain respectability (Kennamer et al., 2000). Although uncommon within the literature, one researcher alludes to the notion that homophobia may be a more institutionally-rooted phenomenon, given that discrimination based on sexual orientation may be legal in some contexts (Simoni et al., 1997). In general, sexual stigma and inequality are taken to be cultural attributes of the black community, although in some instances researchers recognize that stigma associated with same-sex desire exists in contexts outside of the black community as well, in which case the experience of homophobia is theorized to be present for all sexual minorities, although black sexual minorities may have less ability to do mitigate the effects of homophobia, given that, as racialized minorities, they are already disempowered (Kennamer et al., 2000). Thus, in cases where homophobia is spoken about as existing outside of the black community, the experience of homophobia is itself racially neutral.

Racial and Sexual Stigma and Inequality in the Lives of Black Sexual Minority Men

In general, racial and sexual stigma and social inequalities are theorized to be discrete constructs. However, in some instances, researchers acknowledge that they are constructs that merge in the lives of black sexual minority men. One way in which these constructs are theorized to merge is in creating a social context in which black sexual minority men must grapple with simultaneous exposure to two distinct forms of discrimination—interpersonal racial discrimination and interpersonal homophobic discrimination (Crawford 2002, Kennamer et al. 2000, Stokes 1998, Mason 1997, Williams 2008, Mutchler 2008, Siegel 2004, Martinez and Hosek 2005). Crawford and colleagues (2002) describe this predicament in terms of its potential to create overall higher levels of stress, Kennamer and colleagues (2000) describe it as a dual minority status, Mason and colleagues (1997) describe it as "double jeopardy" (p. 156), Mutchler

and co-authors (2008) describe it as "multiple levels" of stigma, and Martinez and Hosek (2005) describe it as a process of "dual alienation". The perspective of simultaneous exposure to two forms of discrimination is a fairly neutral fashion in which describe the experience of confronting both racial and sexual inequality. However, researchers also sometimes make claims about whether racial or sexual forms of stigma and inequality are ultimately *more* harmful, in terms of increasing HIV risk and vulnerability.

For example, Chng and colleagues (2000) suggest that there may be fundamental conflicts between ethnic minority cultures and gay culture, and that these cultural conflicts may become particularly salient "as MSM of color assimilate into the mainstream gay culture, theorizing ultimately that ethnic minority MSM who are highly affiliated with their ethnic identity may "isolate themselves from the gay community" (p.336) and limit their access to safer sex norms and affirming gay social networks. From this perspective, Chng and colleagues suggest that ethnic cultures may be fundamentally more damaging to sexual health. On the other hand, in positing cultural clashes between gay and ethnic cultures, other researchers suggest that gay culture may ultimately be more damaging. For example, in the absence of racism-driven differences in sexual behaviors, Solorio and colleagues (2003) suggest that gay/bisexual culture may be more powerful in driving risk. In contrast to much of the existing research, which ultimately suggests that race and sexuality are discrete constructs, as are homophobia and racism, Harawa and colleagues (2008) offer a unique proposition, stating that among Black MSM "sexuality and sexual expression are linked to their history of race-based oppression" (p. 760). In making this statement the authors suggest that the link between sexual and racial oppression in the United States may fundamentally change the context in which racialized sexual minorities construct self-identities. In the next section of this paper, I will provide some critical comments on existing ways in which race, sexuality and racial and sexual stigma and inequality are theorized within the existing applied public health stigma literature, building on existing theories of stigmatization as a social process. Then I will build forth from Harawa's (2008) unique proposition, in light of social science theories on racial and sexual oppression as intertwined social processes, and suggest how applying this theoretical proposition may improve our current

understanding of the lives of Black sexual minority men, as well as how to better respond to black: white racial disparities in HIV/AIDS.

Discussion

The existing applied public health stigma literature on Black sexual minority men is strong in many ways, particularly in that it uniquely and explicitly works to understand how multiple rather than simply singular forms of stigma may contribute to black: white disparities in HIV/AIDS. Furthermore, researchers employ dynamic and nuanced approaches to conceptualizing how stigma may become embodied, with some researchers even beginning to explicitly focus on cultural and interpersonal determinants of risk and vulnerability, clearly moving beyond frameworks which focus solely on proximate determinants of risk. However, one major limitation of the existing applied literature is the tendency to characterize sexual and racial forms of stigma and inequality in an individualistic fashion, focusing mostly on the homophobic or racist attitudes of particular individuals or groups of individuals. In other words, within this existing applied literature, racial and sexual forms of stigmatization remain fundamentally de-politicized. Thus, I argue that we must be far more explicit and comprehensive in defining racial and sexual inequality. To this end, a clear and comprehensive definition of racism provided by Krieger and colleagues follows: racism is "an oppressive system of racial relations, justified by ideology, in which one racial group benefits from dominating another and defines itself and others through this domination" (1993). This comprehensive definition of racism is critical foremost because it emphasizes that racism is a dynamic social process, which is perpetuated through policies, and ideologies, which in turn justify and support the attitudes and behaviors of individuals. However, the key point is that racial inequality does not solely exist as it is manifested in the interactions between individuals. On the contrary, racism structures the entire world of social interactions, not solely or primarily those which occur within the identifiable gay community. Similarly, I argue that homophobic attitudes do not fully reflect the totality of sexual inequality. Cohen (2005) offers a comprehensive definition of sexual

inequality, "hetero-normativity," characterizing it as "those localized practices and centralized institutions that legitimize and privilege heterosexuality and heterosexual relationships as fundamental and 'natural' within society" (24). Similarly, this comprehensive definition of hetero-normativity is critical because it draws attention to the ways in which the de-valuation of same-sex desires and relationships is supported through laws, institutions, and social ideologies, which in turn legitimate the stigmatizing attitudes of particular groups of people. Although gains have been made in the rights of sexual minorities, in a hetero-normative society, to experience same-sex desire remains stigmatized, and acting on or publicly claiming one's same-sex desire remains a fundamentally politicized act, in that it exists outside the boundaries of normative heterosexuality. Evidence for the continued relevance of sexual inequality includes the lack of federal protection for workplace discrimination based on sexual or gender identity (HRC, 2009). However, these forms of stigma and inequality are in fact contested and battles are being waged in order to displace them.

The primarily cultural mode of characterizing racial and sexual inequality as existing primarily in the acts of members of the gay and black community may be symptomatic of larger trends in the study of sexual and racial stigma and inequality. As legal scholars such as Urvashi Vaid have argued, with notable gay and black political leaders, it may sometimes appear that sexual and racial inequalities remain a thing of the past (2008). And, in fact, in a post-segregation world in which gay marriages have become legal in certain states, circumstances have in fact have truly improved for certain subsets of the LGBT and black communities (Vaid, 2008). However, the subjugation of many people of color, sexual minorities, and sexual minorities of color continues unabated, despite several symbolic and real gains (Vaid, 2008). For example, scholars have noted the ways in which racial inequalities in mortality and life expectancy in 1998 were similar to those in 1945 (Levine, Foster, Fullilove, Fullilove, Briggs, Hull, Husaini and Hennekens, 2001). Similarly, although there have certainly been increased benefits accorded to same-sex relationships in general, many researchers have argued that in the process of gay "normalization," certain racialized homosexualities remain fundamentally cast as unredeemable, illegitimate, pre-modern, or "unliberated" vis-à-vis "homo-

normative" gay identity formations (Duggan, 2004; Decena, 2008; Manalansan, 1997, Ferguson, 2005).

Another major limitation of the existing applied public health stigma literature is the tendency to theorize race and sexuality as fundamentally *discrete* and individual attributes. And, although some researchers do in fact note that there may be cultural differences in the expression of same-sex desire, these differences are spoken about in relative, neutral ways, rather than in relationship to power (see Doll,1992; Martinez and Hosek,2005). In contrast, scholars and activists of intersectionality have long spoken about the *interlocking* nature of social inequalities (Cohen, 2005; Ferguson, 2005; Collins, 2000; Lorde, 1984). One key tenet of this work is the concept of "racialized sexuality." In other words, in a racialized society, one's experience of sexual desire, behavior and identification is a racialized -- not color-blind-- process, for both sexual minorities and heterosexuals. This point is key because it troubles the notion that the personal experience of sexual desire and behavior is politically neutral, and generalizable across race. In fact, as several scholars point out, in a racialized society, the sexual desires and practices of certain groups of even black heterosexuals are also rendered "other" relative to normative forms of sexuality (Cohen, 2005). This notion is critical to the ways in which we conceptualize both the experience of homophobic acts, and the potentially health-protective properties of sexual identity disclosure, or sexual identification in general. If the sexual desires of racialized sexual minority men are always already marked as suspect, this "marked status" must influence how they perceive and experience the "choices" available in terms of sexual identity and its disclosure, as well as the degree to which these potential choices are experienced as protective and affirming. This mode of thinking about racism and homophobia in the lives of black sexual minority men is fundamentally different from those which focus mostly on black homophobia or white gay racism, their simultaneity, or even those which consider the institutional manifestations of hetero-normativity or racism. This is the case because this intersectional perspective travels underneath sexual behaviors and identities in order to understand the racialized political context in which desiring bodies are rooted.

Another key feature of stigma and social inequality, which several others have noted is that in order to develop effective policy and intervention responses, and in fact in

order to fully understand the lives of those who are stigmatized (including the ways in which they resist inequality), we must place stigmatization in relationship to the large-scale social processes through which it operates (Parker and Aggleton, 2003; Padilla 2007; Padilla et al., 2008). Thus, as a social process, stigmatization is not simply self-sustaining, rather, stigmatization processes operate and are perpetuated in relation to particular political economic configurations (Parker and Aggleton, 2003; Padilla, 2007; Padilla et al., 2008). To properly theorize this process requires an interdisciplinary approach. To begin this hopefully ongoing interdisciplinary engagement, below I describe one existing model of how social inequalities may operate in the contemporary post-civil rights era, which Cohen (1999) terms "advanced marginalization." Cohen describes this historical moment as involving the reduction of many forms of direct institutional subordination, and the prominence of larger ideological narratives about the removal of social inequalities (1999). However, she asserts that these social advancements are fundamentally cast as dependent upon the ability of marginalized groups to embody codes of culturally and sexually normative behavior (Cohen, 1999). According to this model, rather than operating solely through explicit forms of segregation or censure, marginalized groups are granted greater social mobility, although this greater mobility is partially contingent on their success in regulating and policing intra-group difference (Hall, 1994; Ferguson, 2005; Cohen, 1999). Authors have discussed the ways in which this operates within both the Black community, through the internal policing of sexual "others" (Cohen, 2005; Cohen,1999; Ferguson, 2005) , as well as how it occurs within the gay community, through the internal regulation of poor, gender-non-conformist, and racialized sexual minorities (Duggan, 2004; Vaid, 2008, Murphy, Ruiz and Serlin, 1997; Manalansan, 2005). This political economic framework is necessary for putting acts of racial and sexual discrimination in relationship to the processes through which social inequalities linked to "difference" are reproduced. Thus, we must be cognizant of these larger forces when developing or conceptualizing ways to act upon or transform the social environment in which black sexual minority men experience racial or homophobic discrimination. In this context, generalized interventions to authentically shift the attitudes of those in the white gay community, or those in the black community may understandably be unsuccessful, given that the continued mobility

or "liberation" accorded these groups may be constructed and indeed felt to *require* the exclusion of "others." More importantly, such culture-based interventions will neither fundamentally alter the political context of desire, the ways in which sexual and racial inequalities retain legal support, nor how these multiple forces converge and intersect within the lives of black sexual minority men.

Although this study clearly contributes to the burgeoning applied literature on social stigma and HIV vulnerability in Black sexual minority men through conceptually describing and critically evaluating this existing literature, this study also has clear limitations. Firstly, it focuses directly on the applied stigma literature focusing on black - white disparities in HIV/AIDS among sexual minority men, although U.S. Latino and Asian American sexual minority men also have elevated sero-prevalence rates, clearly requiring increased research attention. However, given both existing levels of HIV infection domestically unprecedented among Black sexual minority men, and the comparatively lower level of research attention devoted to *directly* understanding issues of social stigma among this demographic subset of sexual minority men of color, singular focus on this group is at present clearly warranted, and will better facilitate the future study of social stigma from an ethnically comparative lens. Second, this study focuses solely on the applied public health stigma literature, rather than on the social science literature as a whole, which may display more conceptual variation. The author's decision to focus precisely on the applied public health stigma literature is because of the more direct and immediate impact this body of scholarship tends to have in terms of policy and health intervention development.

Despite having key limitations of its own, this study addresses issues which are critical to continuing to develop how we conceptualize racial and sexual stigma and inequality in relationship to HIV risk and vulnerability in Black sexual minority men. Firstly, adopting an intersectional, politically-grounded framework compels us to re-think "barriers" to healthy sexual decision-making. In the context of state-sanctioned sexual and racial marginalization which operates in relationship to desire, we need to re-cast black sexual minority men as rational agents of their own sexual lives, as well as to focus on the ways in which they enact forms of resistance against racial and sexual stigma and inequality. Also, we need to consider the more insidious ways in which social inequalities

may become embodied. One potential route may be the pursuit of what Wright (2008) terms “taboo moments of vulnerability;” condom-less sex as an emotional survival mechanism, which may partially mitigate the influence of stigma associated with being a racialized sexual minority. The larger point is that we need to re-insert the need for and pursuit of sexual intimacy, in light of tremendous social, political and economic pressures and profound alienation. Further, re-casting black sexual minority men as rational agents may also allow us to develop participatory intervention responses which are not solely “culturally” appropriate, but also structurally and politically grounded.

Chapter III

An empirical test of racial differences in perceived racial stigma and affiliation with the gay community

Introduction

There are striking racial disparities in HIV prevalence, incidence, and disease progression among sexual minority men in the United States (Millett et al., 2006; Blair et al., 2002; CDC, 2008). HIV prevalence among black sexual minority men is estimated at 46%, far surpassing that of other racial/ethnic groups, and rivaling prevalence rates in the most resource poor settings globally (CDC, 2005; Catania et al., 2001). In response, researchers have begun to explore the role of stigma in contributing to these vast and striking racial disparities. In this study I address two limitations within the studies that address stigma in their analysis. First, although the role of racial stigma has been increasingly addressed in recent years, it has not been systematically measured. And secondly, discussions of social stigma tend to adopt an additive approach, considering the independent effects of various sources of stigma, rather than considering the ways in which they may intersect. For example, an underlying presumption within some studies is that the experience of sexual stigma and its mitigating factors are generalizable across race. In order to fill these two gaps in the literature, in this study I use data from the Urban Men's Health Study in systematically testing black – white baseline levels of and racial differences in racial stigma within the gay community, and feelings of affiliation with the gay community.

Background

The existing domestic and global public health literature suggests that there is a strong relationship between stigma and HIV-risk and vulnerability (Diaz, 2004, Diaz,

2001; Meyer, 2003; Frye, 2006). The existing literature on stigma and racial disparities in HIV among MSM focuses on sexual stigma, and primarily employs indirect measures. Existing measures can be understood as indirect measures of sexual stigma insofar as they are understood to assess the presence of stigma-mitigating behaviors undertaken by those who have a 'healthy' gay identity; those who have successfully transcended the influence of interpersonal and internalized forms of sexual stigma, have personally embraced their own non-normative sexual identity, shared that identity with intimate others, and actively integrated within identifiable and visible LGBT communities; locations which tend to be a primary focus of HIV prevention programming. Specifically, measures have included the examination of racial differences in sexual self-identification, disclosure of sexual identity, and objective measures of gay community engagement.

The research illustrating racial differences in sexual self-identification is strong, such that several studies have found that black MSM are indeed less likely to self-identify as gay than their white counterparts, in a small sample of Chicago MSM (McKirnan et al, 2001) in a large multi-site study of MSM frequenting public sex environments (Goldbaum et al., 1998) among bisexually behaving MSM, (McKirnan et al., 1995) seropositive MSM (Gomez and Halkitis, 1998; Montgomery et al., 2003), and blood-donating MSM (Doll et al., 1992). In only one study of high-risk MSM living in Denver and Long Beach have researchers found that blacks were just as likely as whites to identify as gay (Rietmeijer et al., 1998). The literature testing racial differences in disclosure of gay sexual identity is far more mixed, and appears to be contingent on the person to which respondents disclose. Whereas researchers have found that black MSM are less likely than whites to disclose to casual contacts and to social network members, in general, other researchers have found no racial differences in rates of disclosure to employers, and to close social network members, such as mothers and fathers (Stokes et al., 1996; Kennamer et al. 2000; CDC, 2003; Simoni et al. 1997; Mason et al., 1997). The literature on gay community engagement is similarly mixed, such that although a study of behaviorally bisexual Chicago men found few racial differences in gay community engagement, a study of Virginia MSM found that blacks were less likely to be associated with LGBT organizations than were their white counterparts (McKirnan et al., 1995;

Kennamer et al., 2000). Moreover, the HIV-related implications of these findings are unclear: researchers have found no relationship between either sexual self-identification or sexual identity disclosure and sexual risk behavior in black MSM, and in a handful of instances found that gay sexual identification was associated with higher levels of sexual risk behavior (Hart, 2004, Wheeler et al., 2008, Crawford et al., 2002, Mutchler et al. 2008). This is deeply inconsistent with the existing literature on stigma and HIV risk, which in general suggests that sexual stigma is in fact a powerful predictor of HIV vulnerability and risk-taking behavior (Diaz, 2004, Diaz, 2001; Meyer, 2003; Frye, 2006).

One major difficulty in interpreting these findings stems from the indirect nature of existing measures of sexual stigma. Rather than directly measuring experiences or perceptions of stigma, researchers tend to focus on psychologically healthy coping responses to inhabiting sexually stigmatizing cultural environments. A key assumption of this approach is the notion of the universal gay subject; the idea that there are clear and generalizable steps which all sexual minorities can adopt in order to transcend the influence of sexual stigma, and to promote their own mental and physical health. This approach relies on a discrete approach to stigma, suggesting that the experience of sexual stigma is clearly separable from the experience of other forms of stigma and social inequality, and thus that ways to transcend it are similarly unrelated to other axes of social difference. This is not to suggest that researchers of sexual stigma do not explicitly discuss race. In fact, race has been addressed in this literature. However, the dominant way in which race (blackness) is discussed is as representing a particular cultural orientation. For example, when racial differences in indirect measures of sexual stigma are identified, researchers often attribute these differences to exceptionally high levels of homophobia within the black community (McKirnan et al., 1995; Petersen et al., 1996, Stokes et al., 1996, Montgomery et al., 2003, Doll et al., 1992, Wohl et al., 2002, CDC, 2003). Although interpersonal racial stigma has also been mentioned within the literature, it has not been systematically measured, and has for the most part been conceptualized as an 'additional' stressor with which Black MSM must cope. Furthermore, some researchers have speculated as to whether racial or sexual stigma are

"more" damaging in the health and lives of Black MSM, further drawing from a fundamentally additive approach (Solorio et al., 2003; Chng et al., 2000).

In contrast, social science theorists have argued that sexuality is an intersectional construct, which is experienced, lived and negotiated in tandem with other stigmatized differences—including race (Eng, 2005; Johnson, 2007; Cohen, 1999; Ferguson, 2005). This notion is significant not only insofar as it compels researchers to centralize the potential role of racial stigma in influencing HIV risk and vulnerability, but also insofar as it compels researchers to consider the mutually constitutive nature of racial and sexual forms of stigma (Ferguson, 2005). In other words, in emerging empirical work on stigma we must incorporate and draw from the quickly developing body of qualitative literature which documents the experience of racial exclusion and racialized sexual objectification (Han, 2007; McBride,2005; Julien and Mercer, 1991;Teunis, 2007; Hemphill, 1992) within the context of LGBT communities, and suggests the potential link between these factors and sexual-risk decision-making power (Green, 2005). And secondly, we must heed the insights of theoretical work which demonstrates that the experience of sexuality and sexual stigma are fundamentally racialized (Cohen, 1999). To this end, in this study I use a probability sample of MSM living in San Francisco, Los Angeles, Chicago and New York City in order to answer the following research questions:

RQ 1: Are there differing levels of perceived racial stigma within the gay community for blacks when compared to whites? To my knowledge, this is the first empirical study to use a probability sample of MSM in order to examine perceptions of racial stigma.

RQ 2: Are there differences in overall levels of positive and negative affiliation with the gay community between white and black MSM?

Method

Sample and Procedures

Data for this study are taken from the Urban Men's Health Study (UMHS), which employs a stratified random-digit-dialed telephone sample of adult men who have sex with men within the city limits of San Francisco, New York, Chicago, and Los Angeles

(Catania et al., 2001; Ruiz et al., 2003). The US Bureau of the Census estimates that telephone coverage within these four cities is approximately 95% (Ruiz et al., 2003; Blair, 1999). Within the UMHS, an MSM is defined as any male who reports same sex contact since age 14 or who self-identifies as gay or bisexual. Researchers conducted preliminary analysis in order to identify areas of medium to high MSM residential density within each city through the mapping of MSM AIDS caseload data, household data from the 1990 Census on male-male partnered households, addresses from gay commercial mailing lists, and areas identified as gay by local informants (Catania et al., 2001; Blair, 1999). Based on this information, the sampling frame for the study was restricted to zip codes within each city with estimated MSM residential densities of at least 4% (Ruiz et al., 2003). Next, telephone exchanges including the selected ZIP Codes were identified and then stratified by the estimated cost per interview (Ruiz et al., 2003). The areas sampled are estimated to have accounted for a majority of all MSM households within these cities (Catania et al., 2001). Sample weights were developed to account for the probability of selection, and adjusted for non-response and non-coverage (Ruiz et al., 2003).

Study investigators implemented community awareness about the survey through print advertisements and organized town meetings prior to fielding the survey within each of the four cities (Ruiz et al., 2003). The primary objective of these awareness programs was to apprise potential respondents and local agencies about the study. Households that were potentially eligible were identified through the above mentioned sampling technique. In the time period spanning from November 1996 through February 1998 over 95,000 households were screened via phone, of which approximately 55,000 were eligible (Catania et al., 2001). Households were initially screened to determine eligibility based on age, gender and zip code. Those households that were deemed eligible on these initial criteria were then contacted and the interviewer asked for an adult male household member (Ruiz et al., 2003). This household member was then asked further questions to determine eligibility of the household, such as questions which allowed him to describe either himself or any other adult male household member as MSM either behaviorally, or through self-definition as gay or bisexual. For households in which more than one MSM resided, one was randomly selected for interview. Through this screening process, 3710

households were eligible for study inclusions, of which ten were dropped because the selected respondent was not competent to be interviewed. Of the remaining 3700 households, 2881 interviews were obtained, resulting in a participation rate of 78% (Ruiz et al., 2003).

In order to minimize underreporting of eligibility, study investigators instituted several procedures in order to provide a comfortable context in which respondents could report their eligibility. These efforts included community "town hall" meetings, establishing contacts at the CDC whom respondents were able to call in order to verify the study, and placing advertisements in print media which indicated that the study was currently in the field. Furthermore, because of prior data suggesting that men are more likely to disclose same gender sexual behavior to a male interviewer, only male interviewers were used. Lastly, careful language was used in the MSM screening process, to subtly communicate to potential respondents that disclosure of same-sex sexual activity or self-identification is not an unusual occurrence. Interviews lasted on average 75 minutes. Data were collected using computer-assisted interviewing software.

Sample Representativeness

Demographic comparisons with other reputable surveys of MSM suggest a high level of agreement with the proportion of MSM found in this study (Ruiz et al., 2003). Aggregated across the four cities, UMHS found that of all households in which an adult male resides, 13.3% had an MSM. This is consistent with the General Social Survey, which found the level of men reporting same-gender sex since age 18 was 13%. Similarly, both the San Francisco Men's Health study, and the San Francisco Young Men's Health study had MSM prevalence of 28-30% in the Castro area of San Francisco, closely matching the UMHS' finding of 30% for this area (Ruiz et al., 2003). These comparisons suggest a high quality of sampling within the UMHS.

Measures

Outcome Variables

This study compares blacks and whites on three different outcome measures. Perceived racial stigma in the gay community is a two-item measure, which assesses to

distinct dimensions of racial stigma[4]. The first item asks for a direct assessment of perceptions of racism within the gay community by asking respondents to directly rate to what extent they feel that "there is a lot of racism" in their city's gay community. In contrast, the second item asks respondents to what extent they feel that "men of color are an important part of" their city's gay community. Thus, this question gauges the dimension of racial stigma that pertains to the perception of racialized hierarchies of value. Given that these two items assess distinctly important underlying components of racial stigma, I elected keep them separate in all analyses.

Positive affiliation with the gay community is measured with a two-item scale. The first item is assessed with a global measure of feelings of belonging within the gay community; a question which asks respondents to directly rate the extent to which they feel part of their cities' gay community. The second item asks respondents to more specifically rate the extent to which participating within the community is experienced as positive, thereby getting respondents to critically consider and gauge their own subjective experiences within the community. For analytic purposes, this scale is calculated as the mean score across each of the two questions. The scale demonstrates good reliability, with a Cronbach's Alpha of .74. Negative affiliation with the gay community is measured by one item that asks respondents to assess the extent to which they feel that the problems of the gay community are also theirs. Unlike the prior measure, which assesses positive dimensions of group affiliation, this measure assesses the extent to which respondents feel personally invested in major problems faced by their city's larger gay community. Each of these items is measured on a 4-point Likert Scale, including the following response categories: disagree strongly, disagree somewhat, agree somewhat, agree strongly. Also, each measure is treated as continuous variables in all OLS regression models.

Covariates

All final regression models include statistical controls for age and education. Age is a continuous measure, and was derived from a question asking respondents' date of

[4] A very low Cronbach's alpha provides further evidence to support the notion that these items measure two distinct underlying dimensions of racial stigma.

birth. Education was assessed with an item which asked respondents' highest level of schooling completed, and has five levels: 1. Less than high school 2. High school diploma 3. College degree 4. Master's degree, 5. Doctoral degree

Analysis

In order to provide a basic understanding of the distribution of these variables across race and within the full sample, I first present univariate descriptive findings, documenting characteristics of the sample and also the proportion of respondents who "somewhat agree" or "strongly agree" with the separate items. Cases with missing data were deleted from these analyses. Next, in order to test for black - white racial differences in these measures I run two separate ordinary least squares regression models; the first of which controls only for age, and the second of which controls for both age and education, in order to reduce the effect of confounding by socio-economic status. Graphical methods were used to ensure that no violations to the assumptions of the linear regression model were present. All presented findings are weighted to adjust for probability of selection, non-response and non-coverage. In order to account for the study's complex sampling design, I used SAS version 9.2 to conduct all analyses. SAS 9.2 was selected for analysis because of its use of the Taylor series method to correctly estimate standard errors, given the study's complex design. Thus, in all analyses I use the appropriate "surveyreg" procedures of SAS version 9.2 to ensure the computation of standard errors which are corrected for the study's complex design.

Results

Descriptive Statistics

Table 1 shows descriptive statistics for the final sample (n=2881). Of the sample, 2270 (78.7%) are white, 138 (4.27%) are Black, 250 are Latino (9.49%), 123(4.18%) are Asian/Pacific Islander, 76 (2.67%) are Native American, and 10 (.29%) identify as part of another ethnic/racial group. The average age for the full sample is 39.1, with little variation across race, such that the average age for whites is 39.94, and that for blacks is 39. Similarly, overall the sample is well-educated, with less than 5% having less than a high school education, about one quarter having a high school diploma, nearly half

having a college degree and a quarter having a graduate degree. However, there appear to be racial differences in the distribution of education across race. Whereas three quarters of whites have at least a college degree, less than half of blacks have a college degree or higher. Racial disparities in HIV/AIDS are also evident within this sample. Overall, there are high levels of HIV within the full sample, with approximately 17% of respondents self-reporting that they are HIV positive. However, Black men in this sample are twice as likely as whites in this sample to be HIV positive, with levels of sero-positivity at 29%. There appears to be little variation in levels of never having been tested for HIV, with levels hovering at around 11% for whites, blacks, and in the full sample.

In reference to the outcome variables of interest, descriptive findings suggest that for the first perceived racial stigma item (i.e. that there is a lot of racism in their city's gay community) approximately 60% of the full sample somewhat, or strongly agrees, reflecting that a high proportion agrees that this is a major local issue. However, there appear to be major racial differences in the extent to which this is cited as a problem, such that although slightly more than half of whites report that it is, roughly 90% of blacks feel so. For the second item measuring perceived racial stigma (i.e. racial hierarchy: "men of color are an important part of" their cities' gay community) nearly all of men across the full sample, and nearly all of white men feel that men of color are an important part of the community. However, it appears that fewer blacks than whites feel that men of color are an important part of their city's gay community. Although approximately 85% of the full sample, and of whites in the sample agree that they personally feel that men of color are an important part of their city's gay community, only three quarters of blacks feel that this is the case. Similarly, although approximately 83% of both whites and the full sample agree that they feel part of their city's gay community, only three quarters of Blacks agree with this statement. And, although approximately 85% of both the full sample and of whites agree that participating in the gay community is a positive thing, slightly fewer blacks than whites agree with this statement. In contrast, approximately 80% of the full sample, and of whites and blacks agree that the problems of their city's gay community are also their own, with slightly more blacks in the sample agreeing with this statement, as compared to whites.

Tables two and three present the results of the regression models to test racial differences in key outcomes. The findings are as follows:

Research question 1: In answer to research question one, are there differing levels of perceived racial stigma within the gay community for whites when compared to blacks, overall, Blacks are more likely than whites to perceive racial stigma within the gay community. Blacks are much more likely than whites to report that there is a lot of racism in their city's gay community ($p<.001$). And, Blacks are less likely than whites to report that men of color are an important part of their city's gay community ($p<.01$).

Research question 2: In answer to part one of research question two, are there differences in overall levels of positive affiliation with the gay community between white and black MSM, blacks are less likely than whites to report feelings of positive affiliation with the gay community ($p<.01$). However, blacks and whites do not differ in feelings of negative affiliation with the gay community; blacks and whites are equally likely to feel that the problems of their city's gay community are also their own.

Discussion

Researchers have recently underscored the importance of highlighting issues of social stigma in an effort to better understand and respond to vast black - white racial disparities in HIV/AIDS among MSM living in the United States (Mays et al. 2004; Malebranche et al., 2007; Kraft et al., 2000). However, the bulk of existing work focuses on forms of exclusion and devaluation based on sexual stigma, with a focus on identifying psychosocial factors related to gay identity that may mitigate the effects of sexual stigma. Issues of racial stigma are in general less centralized within the given literature, although qualitative studies have begun to explore the role of racial stigma in the lives of Black MSM, finding that black MSM report feelings of alienation within LGBT settings, perceived racial discrimination, and explicit physical exclusion from gay venues (Malebranche et al.,2007; Kraft, 2000; Han, 2007; Teunis, 2007). Qualitative researchers have also documented the more subtle ways in which racial stigma operates, for example illustrating the existence of racialized sexual objectification, and the severe consequences this may have in the ability to exert decision-making power within the context of sexual encounters (Green, 2005). However, given the solely qualitative nature

of existing research on racial stigma, and the use of non-probability samples, we are not yet able to make more widely generalizable claims about the prevalence of racial stigma as experienced by Black MSM within the context of LGBT communities. This study adds to our knowledge about stigma by using a multi-site probability sample of MSM to document the existence of perceived racial stigma within local LGBT communities. Consistent with the emerging qualitative research focusing on Black sexual minorities, I found that nearly 90% of black MSM report that racism is a major problem within their city's gay community. Furthermore, although --- notably— nearly half of whites also feel that racism is a major issue within the gay community, blacks are far more likely than whites to agree that this is the case (89% of blacks). The second dimension of racial stigma (racial hierarchy) explored within the study examined whether respondents perceive that men of color are an important part of the gay community, finding that while in general, whites and blacks tend to agree that men of color are an important part of their city's gay community, significantly fewer blacks agree with this assessment, as compared to whites. Consistent with the qualitative research which leads us to believe that a smaller proportion of Black sexual minority men would perceive the importance of men of color to local LGBT communities, markedly fewer Blacks than whites endorse this sentiment, as compared to whites. Taken together, these findings suggest that blacks and whites strongly perceive the existence of racial stigma within local gay communities, although blacks are much more likely than whites to report these feelings. High levels of perceived racial stigma are daunting, particularly in the face of high rates of HIV among Black MSM and the general lack of supportive venues in which to mitigate the stressors associated with straddling multiple systems of stigma and social inequality. However, that white MSM also perceive high levels of racial stigma suggests that members of local gay communities may be more amenable than the general population to working to eradicate racialized forms of stigma.

A second limitation of existing approaches to stigma and HIV risk among MSM is the tendency to theorize optimal psychosocial modes of coping with sexual stigma from a racially neutral perspective. In other words, Black MSM tend to be theorized either as "gay men who are black or gay men in the black community" an approach which fails to consider the multiplicative ways in which racial and sexual forms of stigma

are experienced and negotiated (Mays et al., 2004; Han, 2007). In recent years however, social science theorists have begun to more explicitly address issues of intersectionality as they manifest in the lives of sexual minorities of color (Cohen, 1999; Ferguson,2005; Eng,2005). The conceptual position espoused by current intersectionality scholars goes even further than arguing for the need to incorporate the multiple systems of stigma that impinge on the lives of multiply marked subjects. Rather, it argues that the experience of sexuality and sexual stigma are fundamentally racialized, suggesting that the very experience of sexual stigma, and the forms of successful coping which may mitigate it will vary by race. Borrowing from this intersectional perspective, the second research question of this study focused on whether perceptions of affiliation with local gay communities vary across race. Although this is certainly not a direct assessment of stigma, it grapples with an issue critical to contextualizing existing findings regarding the relationship between gay identity-related factors and HIV-risk, which to date are inconsistent with broader findings regarding the relationship between stigma and HIV risk and vulnerability. To this end, this study considers gay community affiliation, a construct which is antecedent to sexual stigma-related psychosocial coping responses. In other words, an undergirding postulate of this study is that the extent to which gay community integration is experienced as protective for sexual health will depend on both the quality of one's experiences and sentiments of attachment within the community, factors which I propose -- consistent with intersectionality theory -- vary by race. Consistent with this perspective, in this study I found that blacks are less likely than whites to report feelings of positive affiliation with the gay community. These findings are consistent with qualitative research, suggesting that Black MSM report feelings of isolation and conditional group membership within LGBT communities. In contrast, in this study I found no racial differences in the measure of negative affiliation with the gay community (i.e. the extent to which MSM feel that the problems of the gay community are also theirs). Taken together, as compared to whites, this study suggests that the quality of black MSM's experiences within the gay community are experienced as overall less affirming than that of white MSM. However, secondly, the study suggests that blacks and whites feel equally invested in and influenced by the problems faced by their local gay communities. In other words, although Black MSM feel in general more alienated

from their local gay communities, they feel equally implicated by the problems faced by these communities.

This study provides useful evidence for contextualizing existing findings on the relationship between gay-identity-related factors and HIV risk in Black MSM, which in general stand in contrast to the larger body of literature on both sexual and racial stigma and health. For example, in a multi-site study of Latino MSM both experiences of homophobia and experiences of racism were independent significant predictors of participation in sexually difficult situations, for example, with partners resistant to using condoms (Diaz, 2001). Similarly, in a sample of rural MSM Preston and colleagues (2003) found that rural men who perceived high levels of negative attitudes toward homosexuality within their communities were at higher risk of engaging in high-risk sexual behavior. The link between experiences of racial discrimination and sexual-risk is less clear, although experiences of racial discrimination have been found to be associated with hypertension and substance use (Krieger and Sidney, 1996; Clark, 2003; Kwate et al., 2003). Findings from this study provide evidence to contextualize existing empirical data on the relationship between indirect measures of stigma and sexual risk. Perhaps the present failure to demonstrate a strong and consistent relationship between indirect measures of stigma and sexual risk in Black MSM stems from the way in which existing research conceptualizes stigma-reducing, psychologically healthy adaptive responses to sexual stigma. Given that, as shown in this study, Black MSM perceive high levels of racial stigma and lower levels of positive affiliation within their cities' local gay communities, they may not experience high levels of contact and identification with their local gay communities as purely protective in terms of sexual health. However, future studies must explicitly address the empirical link between racial stigma, affiliation with the gay community and sexual-risk behavior, as well as more directly assess the relationship between stigma and HIV-related vulnerability. Also, our ability to more clearly map out these relationships also requires the use of more direct and comprehensive measures of sexual and racial stigma, incorporating how these forms of inequality manifest within the wider and more diverse social contexts within which Black MSM live and work, beyond the confines of the LGBT community.

A limitation in this study is the low number of Black MSM represented within the sample. However, a statistical power analysis was conducted, demonstrating that there was indeed sufficient statistical power to detect significant differences between Blacks and whites. Another key limitation of this study is that although it is in fact a probability study, the sample is representative only of those living in high-density gay neighborhoods, rather than to MSM more generally. Given that black MSM have been described as being less well-integrated within gay enclaves, and that gay enclaves have been described as socio-economically exclusive, this study may only reflect the experiences of Black sexual minority men who are the most integrated within identifiable gay areas. However, if empirically consequential, this limitation is most likely to result in an under-estimation of the effects tested, given that those who elect to live high-density gay neighborhoods are most likely to have the highest baseline levels of gay community affiliation, and the lowest expectations of racial stigma. A final limitation of this study is its singular focus on Black and white MSM, to the exclusion of other ethnic/racial subgroups of MSM. The decision to focus solely on Black MSM was intended to maximize the level of pointed examination of Black MSM's experiences of social stigma, given the comparatively lower levels of focus on stigma as it influences this group. However, there are clear disadvantages associated with excluding non-black MSM of color from this study. Firstly, MSM in urban settings navigate deeply multi-ethnic social worlds, in which Latino, Asian American and other men of color play a critical and often under-examined role. And secondly, given that racial stigma is itself a complex construct which influences different groups of MSM of color in unique ways, studying this construct in a comparative fashion would much more accurately unravel the complex ways in which the construct operates. Nonetheless, this study provides data critical for understanding the current state of research on stigma and sexual risk in Black MSM, and sets the stage for more theoretically informed empirical investigations of the relationship between stigma and sexual risk within this population, which has experienced a disproportionate share of suffering due to HIV/AIDS.

Table 3.1. Descriptive Characteristics of the UMHS			
Percent (Standard Error)			
1. Race/ethnicity	N		
Whites	2270	78.7% (.94%)	
Blacks	138	4.27(.42%)	
Latinos	250	9.49%(.70%)	
Asian/Pacific Islander	123	4.18%(.47%)	
Native American	76	2.67%(.36)	
Other	10	.29%(.11%)	
2. Mean Age	**Full Sample**	**Whites**	**Blacks**
	39.1(.28)	39.94(.31)	39.39(1.17)
3. Education			
LT HS	2.06%(.37%)	1.21% (.30%)	6.32%(3.03%)
HS	27.72%(1.02%)	24.79%(1.12%)	45.44% (5.06%)
College Degree	45.08%(1.18%)	46.88%(1.36%)	36.32%(4.63%)
Graduate Degree	25.14%(1.02%)	27.11%(1.19%)	11.91%(3.11%)
4. HIV Status			
Positive	16.60%(.89%)	15.86%(.97%)	29.14%(5.26%)
Negative	72.42%(1.09%)	73.03%(1.21%)	59.52%(5.42%)
Never Tested	10.98%(.77%)	11.11%(.89%)	11.34%(3.23%)
5. % Agree Racism in Gay Community	59.17%(1.21%)	55.65%(1.39%)	88.80%(3.56%)
6. % Agree Men of Color Important	94.31%(.54%)	95.9%(.49%	85.47%(3.60%)
7. % Agree Feel part of the Gay Community	82.56 (.87%)	83.6%(.95%)	74.23%(4.41%)
8. % Agree Participating Positive	85.61%(.80%)	86.20%(.90%)	79.4%(4.15%)
9. % Agree Problems of Gay Community Mine	79.72%(.92%)	79.51%(1.05%)	82.44% (1.02%)

Table 3.2. Racial Differences in Levels of Perceived Racial Stigma
Regression Coefficient (S.E.)

1. Racism	Model 1	Model 2
Race		
Blacks	.73(.086)***	.71(.087)***
Whites (Comparison)	1	1
Age	.002(.0022)	.0018(.0022)
Education		-.040(.027)
2. Racial Hierarchy	**Model 1**	**Model 2**
Race		
Blacks	-.30(.10) **	-.31(.10)**
Whites (ref)	1	1
Age	.0004(.002)	.0005(.002)
Education		-.016(.020)

Table 3.3 Racial Differences in Levels of Gay Community Affiliation
Regression Coefficient (S.E.)

Positive Affiliation	Model 1	Model 2
Race		
Blacks	-.27(.096) **	-.25(.096)**
Whites (ref)	1	1
Age	.0056(.0017)***	.0058(.0017)***
Education		.040(.019)*
Negative Afffiliaton	**Model 1**	**Model 2**
Race		
Blacks	.087(.089)	.087(.089)
Whites (ref)	1	1
Age	.0015(.0019)	.0015 (.0019)
Education		.0014(.0023)

Chapter IV

Resisting the State: Social stigma in the illness narratives of HIV-positive Black men living in New York City

Introduction

There are striking racial disparities in HIV prevalence, incidence, and disease progression among sexual minority men in the United States (Millett et al., 2006, Blair et al., 2002, CDC, 2005). HIV prevalence among Black sexual minority men is estimated at 46%, far surpassing that of other racial/ethnic groups, and rivaling prevalence levels in the most resource poor settings globally (CDC, 2005, Catania et al., 2001). Although researchers have focused increased attention on the problem of HIV/AIDS among Black MSM, much of this work is epidemiologic in its approach, focusing on constructs which mediate risk behavior (Mays, Cochran and Zamudio, 2004). Given that existing research strongly suggests that racial differences in risk behaviors are *not* driving existing racial disparities in HIV/AIDS among sexual minority men, leaders in the field are increasingly asserting that what is required is a broader theoretical perspective, based upon the experiences and accumulated wisdom of those most affected (Millett et al., 2006; Mays et al., 2004). This study directly responds to these assertions through qualitatively exploring the theme of social stigma, a construct which has been identified as central both to the production of social inequalities and disparities in health, and which researchers working in the area of racial disparities in HIV/AIDS among sexual minority men have identified as a particularly critical site of direct inquiry (Parker and Aggleton, 2003; Stuber et al., 2008; Millett et al. 2006; Wilson et al., 2009; Malebranche et al., 2004). Filling key gaps in the existing literature, in this study I present a thematic analysis of the role of stigma within the illness narratives of a sample of older gay and bisexual Black men who have been living with HIV/AIDS since prior to the advent of highly active antiretroviral therapies (HAART) in 1996. Given the lack of existing in-depth qualitative studies based

on the life experiences of Black sexual minority men living with HIV/AIDS, this study deepens current understandings of the ways in which social inequalities related to the stigmatized attributes of race, sexual non-normativity and HIV status are experienced, managed and resisted.

It has been firmly established that a full understanding of the experiences of people living with HIV/AIDS (PLWHA) is critical to forwarding effective HIV prevention interventions (Kelly and Kalichman, 2002; Baskin, Braithwaite, Eldred and Glassman, 2005; Halkitis, Parsons, Wolitski, Remien, 2003; Johnson, Holtgrave, McClellan, Flanders, Hill, Goodman, 2005; Wolitski, Parsons, Gomez, Purcell, Hoff, Halkitis, 2005). Moreover, although typically perceived as a disease of the young, the proportion of HIV/AIDS cases in older adults nearly doubled between 2000 and 2004, such that approximately 30% of those reported to be living with HIV/AIDS in New York City are over fifty years old (Emlet, 2006; Kohli, Klein, Schoenbaum, Anastos, Minkoff, and Sacks, 2006; Shippy and Karpiak, 2005). Furthermore, recent projections estimate that in the next decade the greatest proportion of PLWHA will be older than fifty (Shippy et al., 2005). Despite these trends, the qualitative literature focusing on older ethnic minority gay and bisexual PLWHA is virtually non-existent. However, existing data strongly suggest that research focusing exclusively on aging Black gay and bisexual survivors is *particularly* critical, given levels of HIV infection heretofore domestically unprecedented in younger cohorts, which are now far more likely than ever before to survive to older ages, the unique impact of social exclusion and invisibility related to ageism in youth-oriented mainstream gay communities, and the unique experiences of racial discrimination and homophobia (CDC, 2005; Emlet, 2006; Heaphy, 2007). Thus, by specifically focusing on older Black sexual minority PLWHA this study both directly contributes to our *current* ability to appropriately respond to the needs of existing cohorts of older Black sexual minority PLWHA, as well as contributes to enabling current primary and secondary prevention planners to be optimally prepared to negotiate and serve the needs of future cohorts, whose numbers are expected to dramatically increase in approaching years.

Rather than focusing on the life experiences of older Black sexual minority PLWHA from a broadly descriptive lens, this study closely focuses on subjective

experiences and articulations of social stigma, and takes a grounded theory approach, building theory from close and iterative comparative analysis of respondents' narratives, rather than testing theory using already circulating conceptualizations (Corbin and Strauss, 1998). This "building theory" approach is particularly critical given the nature of existing limitations within the applied social stigma literature focusing on Black sexual minority men. First, much of the existing stigma-related research focusing on black MSM is fundamentally de-politicized, theorizing stigma to be a fairly static and contained phenomenon, solely enacted and experienced through interpersonal acts of racial or homophobic exclusion. A second limitation of the existing literature is that tends to theorize stigma to be a cultural attribute, focusing primarily on instances in which forms of discrimination and exclusion are wielded within the mainstream Black and LGBT communities. These limitations within the current applied literature are problematic for two reasons: first, they may obscure the more complex and insidious ways in which various forms of stigma may intrude within the lives of Black sexual minority men, and second, they potentially re-stigmatize already marginalized communities, casting them as the foundational source of inequality, rather than as uniquely situated agents within a vastly complex web of unequal power relations

Using grounded theory in order to explore and illuminate subjective constructions of social stigma in the lives of older Black sexual minority PLWHA, this paper presents three core arguments, based on careful analysis of respondents' narratives. The first brief section of this paper presents some key ways in which respondents narrate the experience of interpersonal forms of social stigma related to race, non-normative sexuality, and HIV-status. Consistent with the broader literature on stigma and health, experiences of interpersonal discrimination were fairly commonplace (Link and Phelan, 2001; Meyer, 2007). However, in contrast to the broader literature, in many instances interpersonal acts of discrimination and disapproval were wielded in passive rather than directly confrontational ways, particularly with regard to sexual stigma. Secondly, a corollary argument presented in part one of this paper is that stigma-related forms of discrimination and inequality are often experienced in intersecting rather than discrete ways, such that the experience of one form of stigma is fundamentally coded through one's location within seemingly unrelated social hierarchies of value. This core theme that emerged

within the interviews is deeply consistent with some emerging theories of social stigma and inequality, which describe the mutually constitutive nature of multiple systems of social inequality (Cohen, 1999; Ford et al., 2007; Eng, 2005).

The broader literature on stigma and social inequality includes several nuanced discussions of the ways in which stigma is experienced in relationship to the state. For example, in a critique of de-politicized approaches to the study of stigma and social inequality, Parker and Aggleton (2003) argue that stigma is wielded not only by individual and community agents, but also --centrally-- by the state. These scholars assert that the continued maintenance of social inequalities is ultimately *dependent* upon the exercise of stigma from these multiple sources (Parker and Aggleton, 2003). Several other scholars also describe the ways in which the state and its agents routinely exercise stigma in order to sustain and reinforce social inequalities related to sexual non-normativity, race, and HIV-status. For example, Martin Manalansan describes the heightened state-directed regulation and police harassment of sexual minorities of color in New York City, which he argues is in part a consequence of widespread neoliberal practices, the privatization of historically public spaces, and the post-9/11 need to preserve "homeland security", to which these groups are often deemed inherently threatening (2005). Similarly, Concannon (2008) describes the ways in which social policies and laws continue to violently exclude sexual minorities from full citizenship, thereby facilitating and reinforcing social hierarchies of value based upon hetero-normativity. Other scholars note the ways in which social inequalities are reinforced through official discourses of the state. For example, Cohen (1999) describes the ways in which early CDC definitions of AIDS as "immune malfunction in previously healthy people" immediately cast out of epidemiologic vision members of disproportionately poor and unhealthy communities of color, whose poor health may have been interpreted as normative, rather than requiring further investigation. Similarly, Ford and colleagues describe the ways in which historically entrenched beliefs about Black men as possessing a sort of "dangerous" sexuality have functioned to support data-sparse epidemiologic focus on the behaviors of bisexually behaving black men as a core cause of racial disparities in HIV/AIDS (2007).

Consistent with some of these propositions about the relationship between the state, stigma, and social inequalities, respondents in this study identify the role of the state[5] as central. In part two of this paper, I describe the ways in which respondents articulate the ways in which the stigmatized attributes of non-normative sexuality, black race, and HIV-status have positioned them in marginal ways relative to the state, narrating several instances in which these marginal social positions have been reinforced through their interactions with representatives of the state, as well as within public spaces. Although these marginal relationships are indeed not experienced in fully discrete ways, in general respondents tend to articulate their value relative to the state as African-American/blacks in terms of the extraneousness, and the perceived need for hyper-regulation. In contrast, they articulate this marginal position relative to the state as sexual minorities in terms of provisional toleration, contingent on their ability to maintain codes of gender normativity. And thirdly, they articulate this marginal position relative to the state as PLWHA as characterized by blatant disregard as well as paternalistic "possession," which functions to subvert and displace subjective knowledge of their own bodies.

While the first two arguments presented in this paper focus on the experience of stigma in relationship to other individuals and in relationship to the state, the last argument within this paper focuses on the ways in which respondents exercise agency. In other words, consistent with much of the existing qualitative research focusing on stigmatized populations, although respondents describe the painful nature of having to negotiate multiple forms of stigma and social inequality, they also actively and creatively engage several strategies to resist and manage the influence of stigma in their lives (Parker and Aggleton, 2003; Padilla et al., 2008; Padilla, 2007). In this final section of the paper, I describe some of the strategies respondents employ in order to negotiate the influence of social stigma, which include appeals to collective identity, self-monitoring, and the construction of 'exceptional' personal identities. In addition, deeply consistent

[5] In this study I define "the state" as those legal, cultural and governmental institutions responsible for ensuring that the rights of national and cultural citizenship are protected and upheld. This definition includes both agents of these core institutions, such as police officers and public health workers, as well as those public spaces where the borders of belonging are rendered visible, including subways, public hospitals, and federally funded health and social service organizations.

with the existing literature on stigma management, respondents also describe engaging strategies of careful management of information regarding their possession of stigmatized attributes, often employing modes of indirect communication, particularly with regard to sero-status and sexual identity (Hawkeswood, 1995; Decena, 2008; Carillo, 2002; Padilla, 2007).

Method and Sample Characteristics

This study explores subjective constructions of social stigma and its management in the narratives of ten New York City Black gay and bisexual men ages fifty and older, who have been living with HIV/AIDS since prior to 1996; the advent of highly active anti-retroviral therapies. Data used in this study are derived from a larger study of the illness narratives of an ethnically diverse sample of thirty older adult sexual minority men living with HIV/AIDS, of whom ten are Black, ten are Latino, and ten are white. Study investigators closely collaborated with the directors and key staff members of the Center for HIV Educational Studies and Training (CHEST) a local community-based HIV/AIDS research institute closely affiliated with Hunter College, which has close ties to the population of interest. Study investigators elected to closely collaborate with this socially embedded and deeply established research institute in order to optimize rapport and trust between interviewers and respondents, to refine the recruitment and interview protocol, to ensure that key themes of interest were reflected in the semi-structured interview guide, as well as to ensure the cultural congruity of recruitment materials, and the study's overall substantive and methodological rigor. Respondents for the source study were recruited via contact cards posted at New York city lesbian, gay, bisexual and transgender (LGBT) and community-based organizations known to serve the population of interest, including Services and Advocacy for Gay, Lesbian and Transgender Elders (SAGE), AIDS Community Research Initiative of America (ACRIA), Citywide Harm Reduction, Poder Latino, the Latino Commission on AIDS, and Housing Works. Upon calling to request information about the study, respondents were screened for study inclusion using ACASI, a computer-based screening software system. In order to be eligible for the larger study, respondents needed to self-identify as gay or bisexual, as Black, Latino, or white, be at least 50 years old, and have been diagnosed with HIV prior

to 1996. As noted above, the findings included within this smaller study focus exclusively on the interviews conducted with the ten Black participants.

In-depth semi-structured interviews were conducted by the PI of the larger study, a Latino man, as well as by the Co-Investigator of the larger study, a Black woman. One on one in-depth semi-structured interviews were conducted in private sound-proof rooms located at the offices of CHEST, our primary institutional collaborator, which is widely known within the national and New York City HIV/AIDS community for routinely conducting credible research studies. Interview topics addressed within the semi-structured in-depth interview guide include experiences of social stigma, reactions to a positive diagnosis, methods of coping with the diagnosis, self-care, perceptions of social support, quality of life, and perceptions of the future. Research participants selected their own pseudonyms, both to protect their confidentiality and to facilitate a sense of empowerment within the research context. All names in this publication reflect pseudonyms chosen by respondents. Furthermore, respondents were compensated $50 per interview in order to compensate their time and effort in traveling to the interview location. All but one of the respondents in this study were interviewed twice, in order to augment already strong levels of rapport, and in order to further probe on key topics addressed within the first interview. In total, interviews for this study lasted on average between two hours and fifty minutes and seven hours and twenty-two minutes, with an average total interview length of about five hours. Rapport between interviewers and interviewees was quite high, with several respondents thanking interviewers for having devoted time listening to their perspectives, articulating how cathartic it felt to narrate their experiences, and sometimes even offering to meet with interviewers again, without compensation. After one particularly cathartic interview, one respondent jokingly suggested that rather than receiving compensation for his time, he should in fact "give something" to the interviewer, stating that he physically felt "lighter" after the interview. All study procedures were approved by the University of Michigan and Hunter College Institutional Review Boards.

Interviews were taped and transcribed verbatim, and transcripts were imported into Atlas-TI and coded using the following process. Initially, all ten interview transcripts were carefully read and analyzed according to the line-by-line and microscopic analytic

techniques seminal to grounded theory methodology (Strauss and Corbin, 1998). The goal of this was to generate a clear understanding of core themes emerging within each interview, and to begin to identify initial categories for inclusion in the final data analysis code-book. As part of this iterative analytic process, I systematically compared core themes across and within interviews and began to further refine my initial identification of key thematic categories, using in-vivo codes in order to label them. Finally, as part of this open coding process, I also employed comparative analysis and axial coding to identify sub-themes and more subtle dimensions of initial core categories and themes. Based on these foundational analytic procedures, I developed a provisional analysis codebook, and conducted preliminary coding of transcripts in order to test its utility and validity across all interviews. As part of this process, I further refined the working codebook through systematically employing it with an initial sample of interview transcripts, after which I made several changes to this provisional codebook, ultimately generating a final validated code-book. After this process, I systematically re-coded all ten interviews using the finalized code-book. Data for this study focuses on themes related to descriptions, perceptions and modes of managing social stigma related to HIV status, non-normative sexuality, and race.

In addition to the semi-structured interview guide, interviewers also fielded a brief structured demographic and health questionnaire, which was independently completed by each respondent. In order to further assure privacy and comfort, interviewers left the room for approximately twenty minutes in order to allow ample time for completion of the survey. All survey data were imported into SPSS version 16.0.2, which facilitated descriptive analysis of the sample by key variables of interest. Table one summarizes these key characteristics of the sample. The average age of study participants is 56 years, and on average respondents have been living with HIV/AIDS for 18 years. 50% of respondents self-identify as bisexual, with the remaining 50% of respondents self-identifying as gay. However, several respondents who self-identified as bisexual within the structured questionnaire described themselves as gay within the in-depth interviews, suggesting that these terms are employed and experienced in fluid and dynamic rather than discrete and static ways. 30% of participants have a high school education or less, while 40% have had some post-high school college education, and 30% have a college

degree or higher. In addition, 90% of respondents are currently taking physician-prescribed HIV/AIDS-related medications, with 80% of respondents paying for their medical care through public assistance programs, and the remaining 20% using a combination of public and private health insurance mechanisms in order to meet these expenses. Respondents in general characterize their physical and mental health as good, and have high expectations for their future health prospects. 80% of respondents describe their present physical health as good, very good or excellent, and 90% expect their physical health to be good, very good or excellent over the next five years. Similarly, 90% of respondents report their current mental health to be good, very good or excellent.

Table 4.1. Descriptive Characteristics of the Black Sample

Average Age	56 years
Sexual Self-Identification	
Gay	50%
Bisexual	50%
Education	
High School or less	30%
Some College	40%
BA degree or above	30%
Average Years HIV-Positive	18 years
% describing current physical health as good, very good or excellent	80%
% describing current mental health as good, very good or excellent	90%
% expecting health in next 5 years to be good, very good or excellent	90%
% currently taking HIV-related medications	90%

Results

Experiences of Interpersonal Social-Stigma Related Discrimination

Consistent with existing stigma theory, several respondents reported acts of interpersonal discrimination. Similar to other studies, common forms of racial

discrimination reported by respondents included being called racist slurs, and exclusion within gay social environments (Han, 2007; Kraft, Beeker, Stokes, and Peterson, 2000; Berube, 2001). Personal experiences of sexual-stigma related discrimination were generally more indirect, and included passive declarations of disapproval by family members. For example, after several years of seemingly genuine acceptance of both him and his romantic partners, Jacob, 55 described an incident in which his sister mailed him an anti-gay religious text. Similarly, Butch, 58, who is not explicitly "out" to his immediate relatives regarding his sexual identity described several instances in which family members expressed general disapproval of gays, although not of him, directly. These general statements of disapproval caused him to fear more direct discussions of sexuality. The most direct acts of sexuality-related discrimination which respondents reported took place among strangers. For example, informants with a more feminine gender affect recount being bullied as children by peers, while others report acts of verbal harassment in public settings during more recent years.

In contrast to some emerging work, which presumes the "safety" of health-care environments with regard to damaging experiences of sexual-identity related disapproval and discrimination, respondents also describe episodes in which physicians have expressed extreme discomfort with explicitly discussing health issues directly related to their sexual orientation (Bernstein, 2008). Fifty-six year old "C" for example explains having been dismissed after asking his physician to conduct an anal smear, because of having learned about the risk of anal HPV in men who have sex with men. Consistent with much of the existing qualitative literature on HIV-related stigma, reports of interpersonal HIV-related discrimination were commonplace within the narratives, particularly during earlier years of the epidemic, during which respondents describe having been fired from jobs as a result of the discovery of their sero-status, and having been routinely de-humanized in their interactions with hospital staff (Mahajan, Sayles, Patel, Remien, Sawires, Ortiz, Szekeres, and Coates, 2008). Although many of these HIV-related discriminatory incidents occurred in the past, respondents also report being recoiled from by hospital staff and particularly uninformed family members during recent years.

A second major theme that emerged within interpersonal narratives of stigma-related discrimination is the fundamentally intersectional way in which forms of stigma and social inequality are experienced. For example, Jacob describes his current discomfort with openly discussing his sexual and emotional desires for men as rooted in his racial socialization, as a dark-skinned child in the South. He clearly explains this lack of current comfort as in large part a direct consequence of growing up to feel withdrawn, shy and unacceptable; being made to feel like

"you were nothing but cause you were dark skinned… our teachers were like that, you know"

In this way, Jacob's personal feeling of a lack entitlement and ease in claiming his own sexual desire is influenced by his lower status within racialized social hierarchies of value, which he directly experienced in childhood, but which have had persistent effects, over time. Similarly, a second way in which respondents articulate the core mutually constitutive nature of intersecting forms of stigma and social inequality is in the manner in which stigma-related grievances are institutionally managed. For example, after seeking the help of a local community based organization in the wake of an act of homophobic harassment, Freire, age fifty, was finally able to attract the attention of the Dean of the College in which the incident occurred. However, increasing his sense of frustration and sense of powerlessness vis-a-vis entrenched systems of social inequality, although Freire identified four attackers, the sole attacker held accountable by College officials was the sole black student; the only attacker who formally apologized. Although all four attackers were equally involved in the act of homophobic violence, the entire incident was institutionally understood as emanating from the exceptional homophobia of the one black assailant.

"Learning one's place: social stigma, inequality and the state"

Leading theoretical approaches assert that stigmatization is a complex phenomenon which operates in part through de-valuing relationships (Parker and Aggleton, 2003; Goffman, 1963). One prominent de-valued relationship that emerged

within the narratives as a key manifestation of racial, sexual and HIV-related stigma is a degraded relationship with oneself, consistent with classical stigma theory (Goffman, 1963). A key prism through which respondents articulate this sentiment is through the theme of the "damaged" self, devoid of inherent value. For example, "Sho", sixty-one, who grew up in Harlem describes this race-related sense of his own inherent lack of value in the following terms:

> "I was *raised* like that. I...I'm a product of a family that came to the south....that passed on inferiority from one generation to the next. When I was a child, I wanted to be a white boy. When I was a man, I wanted to be a white man."

The theme of self as inherently "damaged" was also prominent within narratives of sexuality-related stigma, in which respondents reported feeling constitutionally flawed as a result of their physical and emotional attraction to men, sometimes fearing that their sexual behavior was morally wrong and could potentially, as one respondent stated, "send me to hell or something." Some respondents attribute these fears to having been raised in deeply religious families, and many recounted periods during which they carefully regulated their relationships with men, even publicly ignoring past sexual contacts, giving them false names in order to protect the integrity of their own reputations. Furthermore, the stigma of HIV/AIDS and non-normative sexuality are clearly intertwined in the narratives, such that several respondents viewed themselves at some point as "deserving" HIV/AIDS, because of both possessing and acting upon sexual desire for other men. In other words, some respondents posit that the suffering they have endured has a result of having HIV is a direct moral consequence of their inherently "damaged" sexual identity and practices. Tom, 53 who grew up in the North Carolina and migrated to New York in the 1990s articulates this causal reasoning most clearly in stating

> "So I thought maybe I had to pay the ultimate price … that price is having HIV and Hep C and uh, having a, a unsound life. A life of confusion, life of debauchery, whatever, ya know, having a bad life period, from the results of my sexual nature. "

Similarly, Tim, fifty-nine, a single father who moved to Harlem from Washington DC in order to continue working as a nurse in under-served black communities described his

initial response to having been diagnosed with HIV as follows,

> "Of course I went to the point where I thought God was punishing me for being involved with men, you know.

Although some existing research on stigma as it relates to Black sexual minority men suggests that where present a sense of inherent lack of value and low self-esteem is primarily learned in response to poor treatment by homophobic blacks, or by racist gay whites, respondents in this study clearly articulate having learned their "lower" value in relationship to their personal interactions with representatives of the state, as well as from their own critical observations of the worth of other similarly stigmatized individuals vis-à-vis the state. Relative to the state, its agents, and the larger national body, respondents articulate that blacks have been positioned as extraneous, threatening, and worthy of regulation rather than protection. Some respondents recall first learning this lower social value accorded to blacks as children. For example, Ully a sixty year old native of Mississippi recounts as a child instinctively understanding the potential danger of marching for civil rights after nightfall, because the Ku Klux Klan could freely, without authoritative, state-directed reprimand, "shoot you and kill you," as they had done to several others. Similarly, Sho recounted one of his first direct experiences of the lowered social value of blacks relative to the state when he was a young adult, during the 1968 Harlem riots, during which he observed a police officer kick a pregnant black woman. He graphically describes the incident and his emotional reaction as follows.

> "I watched a white cop take his foot and kick a black woman in her ass, and I wanted to murder him. Didn't want to shoot him. I just wanted to … strangle him, ya know. And she was pregnant, and it didn't matter. And I could see the hate in his eyes, even now. [pause] Only reason I didn't go down there is cause they held me, I mightta gotten killed that day because I was really, really enraged. I wanted to … hurt him bad. I wanted to kill him. I wanted to do bad things to him … cause this was a woman. A woman with a child. And he takes his foot and kicks her in her behind, "Keep going, bitch."

Respondents also articulated the sentiment that this lower value accorded black bodies extends even to the dead, who are also hierarchically arranged as possessing a lower social value relative to whites, even in the contemporary era. Describing the town in

Virginia in which he grew up, Tom describes the clearly visible nature of these hierarchies of value within the space of the cemetery,

> "Well, the white, Pleasant Shed would be a very nice cemetery, very nice looking, lawn kept up … and the other cemetery would be unkept, ya know tombs falling all over, things looking raggedy and messy because they wouldn't keep it up like they would the other one, so you can see the difference. You could see, go on the black side and it was sort of a rumpus way or just thrown together or whatever, and you go to the other white side and all the stones are in line and very neat and ya know, it's well kept, you'd always notice that, it was noticeable."

Respondents also clearly describe more direct and deeply personal encounters in which they have been taught the social value of black people. "C", an only child who grew up in Virginia and moved to New York in the early 2000s recalls several moments – over time-- in which he observed the lack of value accorded black bodies within public health care settings. The chain of encounters educating him regarding his own lack of inherent social value included the moment of HIV diagnosis, during which he was curtly told by a field epidemiologist that he had "bad blood" and was commanded to ingest the contents of a mysterious paper bag filled with tablets, and has continued over time, including an encounter where he was dismissed by a physician after having inexplicably lost thirty pounds, as well as immediately following a severe psychiatric episode after which he was promptly discharged from a hospital, although he clearly posed a danger to himself. Rather than displaying shock or even anger at these events, "C" recounts them in a matter of fact manner, explaining

> "They don't care, you just one more black body that we ain't have to be concerned with on the planet. And that's just how they feel about it. That's *life,* that's life."

Although many of these experiences of witnessing the devaluation of black bodies relative to the state were articulated with respect to the past, several respondents spoke of this lower placement within existing racialized social hierarchies during the contemporary era as well. For example, Jacob, a long-term resident of New York who was raised in Jacksonville Florida spoke at length about his persistent fear of police harassment in his neighborhood, and the consequences this has had for his own unfettered movement within the City. He explains

> "I don't live in a crime-ridden neighborhood, but the *police,* you couldn't even go *outside*, and you can't even go outside up there where I live in the mornings, like when people go get their newspapers and sit out, I see some friends, and the police comes along and searched people and that. …That's another thang… I don't want to be coming out of the store, and they decide to target me."

From Jacob's perspective as well as from that of other respondents, the streets represent a dangerous space, not necessarily because of civilian crime, but because of the learned expectation that they will be harassed by the police. Consistent with Manalanasan's (2005) ethnographic research in Queens and Greenwich Village, which documents heightened police regulation of sexual minorities of color during the post-9/11 era, Jacob explains observing extreme police regulation in recent years, which has had the effect *not* of making him feel more safe, but of making him fear leaving his home. Of course, having grown up in the deep south, Jacob is no stranger to the realities of police brutality, which he personally experienced as a teenager, having been arrested and nearly killed by a police officer after expressing displeasure at his use of obscenities in the presence of black women. Although he recognizes the need and value of law enforcement, drawing on personal experiences, observations, and awareness of current events like the murders of black men like Amadou Diallo, Sean Bell and others, respondents do not express confidence that the gaze of the state upon black bodies such as their own is protective, instead describing it as regulatory and potentially life-threatening.

Similarly, respondents describe the relationship between their own bodies—as sexual minorities-- and that of the state as contentious, characterizing themselves as cast outside the state's protective gaze, as their lives and bodies are provisionally tolerated, rather than inherently valued. From the perspective of the state, by virtue of the lower social value accorded sexual minorities, respondents describe their personal welfare as deemed at worst insignificant and at best *less* significant. Freire, who was adopted by a wealthy couple as an adolescent and grew up largely in lower Manhattan explains that his first direct encounter with homophobic violence, to his shock, occurred at age 50, within the "safe" walls of a local college located in Chelsea, where he was taking an English class. Weeks after having had surgery, he was cornered by fellow male students, who called him a 'fag', and threatened him with severe physical violence. Although he was

able to leave the incident physically unharmed, Freire was terrified to return to school, and promptly alerted the University and local police authorities, whom he expected to investigate in order to prevent a recurrence. Instead, he explains

> "absolutely *nothing* was done, *nothing*. The police precinct actually closed my case the day the case was opened because I guess they figured I'd let it ride…"

Respondents also articulate the lower value accorded sexual minorities relative to the state in more subtle ways, based on their own critical interpretations of the tenuous and competitive funding context for HIV/AIDS and LGBT social service organizations within New York City. A frequent and socially embedded participant of several local support groups, 'C" recalls directly observing the social position of sexual minorities and PLWHA within state-sanctioned hierarchies of valued bodies and lives, stating

> "a few of these organizations have dropped AIDS or gay in their name to continue to get that funding from the CDC. Which kinda let me know, uh, *my* assessment on that is, if the government is saying we're not going to fund a gay organization or an AIDS-related organization, then the government is of the mind that neithah one of them are *that* important."

Given a keen sense of awareness regarding their social location outside the protective gaze of the state, respondents did not in general presume an inherent "right" to public space and expression, as sexually non-normative citizens. Moreover, respondents articulate a fear and recognition that public space may not be safe space for them, and others like them. Riding the subway on gay pride Sunday, Chris, a fifty-two year old formerly homeless native of Queens recounts an incident where a man wearing a rainbow-colored gay pride bracelet was harassed and threatened by another subway patron, stating – regarding gay bashing in the contemporary era, that

> "they still doing it, so it doesn't give him license you know, to put hisself out there… That's what I have to remember"

Chris partly holds the victim of the incident accountable for the attack, and uses the case as personally instructive, illustrating his understanding that one's right to space as a sexual minority citizen is in fact suspect, and thus that his primary responsibility should

be to promote his own physical survival within public space, given the constant threat of harassment – even if the personal cost is suppressing self-expression. As poor black sexual minorities, Chris and other respondents do not presume a sense of inherent entitlement to full-fledged citizenship within public space. Similarly, respondents clearly articulate the sense that gay and lesbian citizens occupy a provisional, conditional form of citizenship relative to the state, and that one's right to public space is partly contingent upon the ability to uphold, or at the very least the ability to *appear* to uphold codes of gender normative conduct. Butch clearly articulates this understanding in his critical reading of the gender non-normative self-presentation of "young queens", whose failure to respect and embody codes of gender normativity he perceives as both personally threatening, and threatening to sexual minorities in general, as a collectively stigmatized population. Butch states

> "The young queens … make the bad stigma for gay people. You know. They're just out of control…They're just loud, obnoxious, uh…the way they dress, I mean. You see some now…they wear scare drags. Now a scare drags is [chuckles]. Scare drags is half girl clothes and half men's clothes. You know, they have on…girl pants, maybe a man's hat, with hair. A girl's blouse, and they looking…they looking like a freak. You know, and…*that* makes people look, that makes straight guys make comments, you know…"

From his perspective and those of others, sexual minority citizens can inhabit public space, even while violating codes of gender normativity, provided that their violation is invisible. In contrast, if their failure to conform is visible, they are in effect *inviting* the harassment of others, and heightening the already widespread stigma shouldered by sexual minorities as a collective. In this way, respondents illustrate that their sexual difference is acceptable provided that they neither pose a radical threat to, nor critique of the sanctity of normative gender presentation in general.

Similarly, looking back, respondents view the state as a source which inspired and rationalized violence and disregard for the bodies of PLWHA, particularly those who were gay. In the memory of several respondents, rather than supporting the health and well-being of PLWHA, the state has cast them as undeserving of care and protection, and meriting their own physical suffering, because of having engaged in allegedly illicit and

immoral sexual conduct. Recollecting this period, earlier during the epidemic, Tom describes that it was during

> " the Regan era, and there wasn't that much being done politically about it and Anita Bryant was out and these crusaders were out condemning uh, gays and saying that that was something that came from God"

Moreover, although stigma narratives which express seething skepticism regarding the willingness of federal sources to take seriously the lives and deaths of PLWHA were more commonly articulated with respect to the early years of the epidemic, other respondents describe this general sentiment of disregard for the bodies and lives of PLWHA as having been merely born again in recent years, in the form of the intense bureaucratization of AIDS service organizations, which some respondents perceive as having become institutionalized, and more dedicated to organizational longevity than to effectively reducing morbidity and mortality due to AIDS among vulnerable populations.

In contrast, other narratives of stigma, the state and the bodies of HIV positive people articulate these relationships in terms of ownership. Rather than understanding themselves as fundamentally outside of the state, as relates to their status as PLWHA, respondents articulate a sense of being "possessed" by the state. For example, Butch spoke at length about the negative aspects of being on public assistance, as an HIV-positive person. Although he is intensely grateful for the medical care and housing that he receives, he feels disempowered and in many senses disembodied; that his own subjective knowledge of his body is persistently de-valued, and that the state is fundamentally in control of his physical destiny, weakening the sense of mastery that has been demonstrated as critical for the well-being of older adults (Forbes, 2001). In describing this phenomenon, Butch explains a recent although not uncommon incident, in which when feeling physical pain, he was *forced* to go to the hospital, despite his own self-knowledge that the ailment would pass. He describes this experience in a way that suggests that neglecting to respond to physical symptoms in a manner consistent with state-sanctioned protocols is nearly criminalized, explaining that

> "a couple of people have called the ambulance *on* me. You know, and stuff like that. In my building. And, um…I refused to go, and the cops said, you're goin.

> You know, but I'm saying, you know, like, uh, I've had this before, you know, I know that it's going to pass, you know"

Similarly, although respondents express a great deal of gratitude for receiving government assistance -- a unique and coveted benefit of living in New York City-- they also express a clear sense of how difficult it is to navigate the social welfare system, and recount several stories of having health benefits cut off at particularly critical moments. "Possessed" by the state, respondents articulate a sense of powerlessness in promoting and advocating for their own clinical care, given their dependence on social services, and their experience that the consistent provision of these social services is intensely precarious. Freire's health benefits were for example temporarily severed in the midst of receiving critical treatment for Kaposi's Sarcoma, which had spread to his brain. Luckily, given strong rapport between himself and his physician, the treatments themselves did not cease, although he described the intense fear of this potential, and its related stress in graphically physical terms, stating "I know I lost t-cells." Similarly, Freire describes this experience as fairly normative among other HIV positive friends, as well as his inability to understand the reasoning, stating

> "They *fuck* with you. I don't know the reason why they do that, but I've had friends of mine and it stresses you out… it's killing you."

"Resistant Self in relationship to Hierarchies of Race, Sexuality and HIV Status"

Although respondents report acts of interpersonal discrimination, and describe learning a sense of their marginalized social value in relationship to the state, they are by no means passive beneficiaries of social stigma and inequality, and instead actively engage several strategies to resist, mitigate and manage the deployment and consequences of social stigma. One strategy which respondents employ is adopting a sense of collective identity with others with whom they share one or more stigmatized statuses. For example, Sho describes feeling a sense of collective identity and purpose with other Blacks, explaining

> "when I seen another black man, I cared for him, I liked me, cause I liked him, when I seen a black woman, I liked her, she was my sister. And I would protect her. He was my brother, and I would protect him. And that woman was my mother. That woman was my aunt. That woman was my sister. That woman was my cousin, and I cared about her."

Respondents describe collective identity as useful insofar as it reduces feelings of isolation and worthlessness, and in some instances has even given them the courage to challenge regulatory norms within the group with which they identify. For example, Ully describes his feeling of collective racial identity as giving him the confidence to challenge sexual stigma within the context of a popular straight Black nightclub in the late 1970s. Initially excluded from entering the club due to their feminine appearance, dressed in what he describes as "our best gay outfits" Ully and his friends insisted and were ultimately successful in becoming welcome at the club, despite an initially bitter reception. In describing why he elected to engage in this contentious form of what he terms "subtle social activism," Ully explains

> "I don't care whether you straight or gay. If you know Black people. I do. I have—I have five brothers. Everyone in there I knew. These are my brothers. And whether they knew it or not, they knew me. Okay? It took them time to realize they knew me."

Although collective identity was in some instances a successful stigma mitigating strategy, respondents also describe several constraints on the utility of collective identity. One such constraint is social hierarchy internal to the collective group to which individuals appeal, through which the borders of belonging and authenticity are policed. Moreover, the extent to which appeals to collective identity are successful in mitigating stigma are contingent on whether respondents are embraced as full cultural citizens of the collective. For example, self-described as "red-bone" Yellowdaddy, fifty-two, explains that his family members admired him for his light skin, feeling that it may provide him with an easier life. However, he describes being made to feel like an outsider; that his racial authenticity was constantly called into question, casting him outside the borders of authentic group membership. Yellowdaddy states that as a child growing up in Harlem he

> " wanted to be blacker. They made me feel like I wasn't black enough"

Appeals to collective racial identity were similarly unsuccessful for Freire, who was adopted and raised by a white couple and describes having had his racial authenticity constantly called into question, even and perhaps most painfully within the LGBT of color activist community, in which he has taken part. Although he recognizes the importance of racial pride and in some cases solidarity, Freire describes being constantly reminded of his lack of racial authenticity, and his position "outside" of the racial collective, ultimately preventing him from experiencing any attempt at racial collective identity as stigma-mitigating. He states

> "Oooooh, honey! You think you're white. I get the "you think you're white" line, more than anybody else, from *my people*."

The strategy of collective identity was also employed by respondents in order to mitigate the harmful effects of sexual and HIV-related stigma. And, while in general respondents truly benefit from and are partially dependent upon resources both within LGBT and HIV/AIDS community organizations, as well as from the sense of community derived from adopting a deep sense of collective identity with these groups, internal regulatory norms and intersecting social hierarchies also constrain the extent to which appeals to collective identity based on sexual identity and HIV status are experienced as beneficial. The experience of racial exclusion within the LGBT community is one clear example. For example, describing his pursuit of support from a large LGBT organization in New York directly after learning about his HIV positive status, Chris describes being turned away, which he perceives to be a result of his failure to conform to the image of physically desirable black men within the gay male community. He explains that they were discriminatory, and –consistent with ethnographic research on the persistence of racialized sexual objectification (see Green, 2005)—that they provided support for only particular kinds of black men; those who were

> "bulky and liftin weights you know, the strong black guy"

A second example of the limited utility of collective identity as an effective stigma management technique is respondents' pursuit of collective identity within HIV support organizations rooted in the Black church. Although respondents recognize the

increased visibility of and support for Black PLWHA within the Black Church, lines of belonging within these settings are understood to be carefully policed, and contingent upon one's mode of HIV-exposure. As some respondents see it, the newfound space for PLWHA within the Black church is a function of the disassociation of HIV/AIDS from homosexuality. Unfortunately for respondents, gay black PLWHA still remain fundamentally cast outside the boundaries of "worthy" beneficiaries of support, remaining literally outside the church doors. Tom states, regarding the Black Church,

> "They're seeing that HIV is not necessarily gay-related, and so they're opening their doors to understand that um, they're not inviting gays in, but they're inviting people in, you know because HIV does not have a particular gender or preference."

Internal regulatory norms also function as a constraint on the utility of collective identity within the general HIV/AIDS service organization (ASO) community. For example, pursuing and in many senses receiving hope and support within the ASO community, Butch also describes being painfully and publicly judged against normative codes of "ethical" conduct for PLWHA which are local to this collective, which he perceives as including mandatory sero-status disclosure. Within the context of a support group, where he described difficulty and hesitance in disclosing his HIV status to immediate family members, rather than receiving the empathy he had anticipated and hoped for, he was asked

> "how do I feel like—how do I feel taking a lie to the grave with me"

Butch describes this experience as causing him great pain and stress, and describes himself as chronically located "in between" worlds—alienated from the gay and HIV-positive worlds by virtue of his failure to conform to normative codes of behavior, as well as alienated from the straight, HIV-negative world, because of his fears of being judged. Consequently, Butch feels unable to open up to anyone fully and on guard within the context of both realms, and describes the pain of navigating this borderland territory in physical terms, stating "I'm losing T-cells."

In addition to collective identity, a second key strategy that respondents employ in order to mitigate the consequences of social stigma is carefully monitoring their own gender presentation, as well as that of one's friends and sexual contacts. Some

respondents discuss regulating their contacts with men they are seen with publicly, in order to avoid being associated with particularly "obvious" gender non-conformists. Butch for example avoids contact with "queeny" gay men, because they "may make me look bad." In addition, he emphasizes the importance of looking "presentable" in public, which he characterizes as being either masculine, or unreadable, and also carefully ensures that he publicly associates only with others similarly inclined. He describes the gay men with whom he chooses to associate as follows,

> "They look presentable, and they carry theyself....you know, I'm not really into, like, that-that flash…you know. [laughs] That real out there, you know, I try to dis-distance myself from those."

Similarly, respondents note the importance of gender fluidity, or being able to be flexible with one's gender presentation as a strategy for maintaining their own safety and avoiding direct acts of sexuality-related discrimination, noting that maintaining a publicly masculine gender presentation eases the social stress of being a sexual other.

A third stigma-mitigating strategy that respondents use -- of which the aim is to repair the identity-related costs of being a sexual minority in the context of homophobic environments --is constructing self-identities which define them as "exceptional" relative to sexual minorities in general. Butch for example describes the way in which straight friends openly embrace him, despite general ambivalence about gay and bisexual people. He describes this "exceptional" acceptance in the following terms.

> "You know, I was always like the life of the party, the one that kept the party going for people….a lot of my friends, they knew I was gay, you know, but they never really, you know. And it was like, oh, I can hang out with them, but if he's gay, he couldn't hang out with them. You know. So, I-I mean, I was like really accepted. Why, I have no idea. You know, they say, you know, like I just have this thing about me that people like to…hang out with me and be around me. You know, whether I'm gay or straight or whatever. It really didn't make no difference, you know."

Just as Butch's exceptional social prowess makes him a uniquely acceptable sexual minority subject, Tim understands his socially conservative nature to strongly set him apart from the majority of gay men, and in general holds his identity as socially conservative and "respectable" in high regard. Sharply distinguishing himself from

mainstream gays, Tim explains that

> "I don't like talking that little talk that a lot of gay men talk…It's like they, you know. I'm pretty sure you know what kind of conversations gay men can have. I don't….I guess you can just say I'm just conservative."

A fourth strategy which respondents employ in order to manage the consequences of social stigma is careful management of public knowledge regarding their possession of a stigmatizing attribute, which Goffman (1963) terms "information management." The extremes of the sexual identity disclosure continuum, complete candor or complete secretivity are not common within the narratives, although a handful of respondents describe fairly borderless relationships with family members in terms of discussions around sexuality, and Tom describes a complete absence of such discussions within his family. Consistent with much existing qualitative research, a more prominent information management technique that respondents employ with others is indirect communication about sexuality (DeCena, 2008; Carillo, 2002; Padilla, 2007). In many instances respondents note that family members "know" about their sexual identity, and whether or not they are partnered; however, direct and detailed discussions about it tend not to be normative. In some cases, respondents simply decline to directly share any personal information with family members, including that pertaining to sexual identity, in part because of fears of how others could potentially react. For example, respondents describe "don't ask don't tell" norms within their families, through which lines of privacy and polite distance are vigilantly guarded. Some respondents even describe deep fear of discussing issues of sexual identity explicitly, in the event that such discussions could make already distant relationships more difficult to honestly sustain. In other cases, neglecting to explicitly discuss issues of sexual orientation with family members is described as a function of fractured and overburdened family networks, and the sense that the personal and financial problems of family members would make it difficult for them to provide meaningful support. However, others feel that direct disclosure is itself excessive, and is neither an effective stigma management tool, nor an accurate marker of authentic comfort with one's sexual identity. Ully explains that direct disclosures are themselves insufficient strategies for transcending the stigma of sexual difference, asserting that rather than openly disclosing one's sexuality, one should instead simply

behave in a natural fashion, without fearing, responding to or acting out of the assumptions or opinions of others. He explains,

> " think it's stupid to disclose, ya know? It's just like being yourself, not caring what people assume. Or think. You know, you don't have to announce it to the public, you don't have to wear a sign, but you don't have to be worried, either about what people are gonna con-what conclusion people are going to come to."

In contrast to strategies of managing information regarding sexual identity, direct disclosure of sero-status to family members was a more frequently employed strategy for managing the stigma of HIV, and deriving social support to manage the illness. All respondents disclosed their HIV status to at least one family member, and for the most part receive emotional support at least in part through family relationships. In general, respondents who opted to directly disclose their sero-status to family members were met with support and care, which was instrumental in managing and coping with the illness, as well as coping with stigma related to HIV/AIDS. For example, the warm and caring response given to Jacob by his sisters, uncle and mother was central to his ability to feel unconditionally supported. Jacob recounts his disclosure narrative as follows, when during a phone conversation his sister said

> "Jacob, something is wrong with you, and what is it? I said, (lowers voice) *nothin*. And she said, yes it is, tell me right now (laughs). And I *told her*, and a few days later, I had a reservation to go to Atlanta and be with them for a while, then they got a reservation to go to Florida. And I stayed with them and then from Atlanta to Jacksonville, Florida for well over thirty days. I was never subjected to any kind of um any kind of discriminatory uh practices, like throwing away the glass and all of that stuff. And that-that really helped me, that built my confidence, the love they showed me, through their actions, more so than anything else."

In contrast, although Freire was in general accepted by close friends and his own adoptive family, he also describes the "dangerous" nature of disclosure, in that it can occasionally fracture friendships, and heighten rather than alleviate social suffering due to HIV/AIDS. Among the first black gay men in New York to become of aware of his HIV status, Freire was diagnosed during the era in which the disease was widely believed to affect only white men. Consequently, when he disclosed his status to close gay black

friends he was cast as personally responsible, due to the alleged recklessness of his decision to have sex with white men from downtown. After the death of his adoptive parents, the memory of having been judged further dissuaded Freire from seeking social support from close friends. Rather, often when ill he retreats into isolation, primarily caring for himself. Similarly, "C" was met with outright rejection by his biological mother after having disclosed to her his sero-status. Unable to directly confront him with this rejection, his sister imparted the news, and he was promptly asked to leave the family home, as a result of her fear and inability to cope with his HIV positive status.

The remainder of respondents communicated with their families regarding their HIV status using a mixture of indirect and explicit measures, gradually and selectively deciding when and to whom to disclose. For example, upon receiving the diagnosis Chris immediately told his stepmother, who has consistently responded with care, concern and support. And, although he is certain that the majority of people in his family know about his HIV status, he has openly denied being HIV positive to his father, whom he feels would not be able to cope with a direct confirmation of his sero-status, given the rapid nature of his own aging process and his increased sensitivity. However, Chris is certain of his father's knowledge of his HIV status, since he openly and frequently speaks about his work in a day treatment program at a large HIV/AIDS community based organization. Like others, Chris describes this tacit mode of communication as normative within Black culture, and explains it mostly as a mechanism to avoid directly discussing one's mode of exposure, which could potentially be a source of judgment, lowered social status or discomfort. He describes this mode of communication as follows

> "You know, we speak *around* it, you know, but that's what most black people do anyway, you know they know things, and it's best to keep it hush."

Conclusion

Findings from this study are consistent with much of the existing theoretical work on stigma, particularly in the sense that respondents' narratives describe a major consequence of social stigma to be the internalized belief in one's own lower social value (Goffman, 1963; Link and Phelan, 2001). However, in sharp contrast to the existing

research on social stigma in Black sexual minority men, although interpersonal experiences of stigma were salient, respondents also articulated a critical and nuanced understanding of their own position within broader stigma-related social hierarchies. Respondents clearly described the ways in which as black men in the U.S. they are positioned as threatening 'outsiders' vis-à-vis the state, and described the multiple ways in which this location manifested in the form of extreme regulation of their bodies, particularly with regard to their movement within public spaces. Consistent with other qualitative studies of racial stigma in sexual minorities of color (see Manalansan, 2005), respondents also described being the objects of heightened surveillance, and that the potential for police harassment influenced them in many instances to fear leaving their homes; a particularly harmful outcome for older PLWHA, among whom levels of isolation and depression have been described as dangerously high (Karpiak, 2006). Similarly, as black sexual minorities, respondents do not presume a sense of entitlement to public space and sexual expression, and instead understand themselves to be outside the protective gaze of the state; provisionally tolerated, provided that they remain largely invisible, posing no major threats to existing codes of gender normative behavior and appearance. Respondents describe their relationship to the state as PLWHA as involving paternalistic yet precarious care, which sometimes has the consequence of increasing levels of stress and lowering feelings of mastery, particularly dangerous outcomes for older adults, in whom a sense of personal mastery has been described as critical to maintaining optimal levels of mental and physical health (Forbes, 2001).

A second major finding within this study is that although respondents clearly and painfully articulate the presence of stigma and its consequences within their lives, they also actively engage several strategies to resist, mitigate and manage the impact of stigma, consistent with much existing qualitative research on stigmatized populations (Parker and Aggleton, 2003; Padilla, 2007; Padilla et al., 2008). Contributing to the literature by exploring the role of personal agency in resisting stigma among Black sexual minority men, in this study I identify some of the following key stigma management techniques: appeals to collective group identity, the construction of 'exceptional' social identities which guard against association with the most maligned characteristics of the stigmatized group to which they belong, and careful information management about their

stigmatized attributes. Consistent with some existing studies, respondents also describe engaging indirect rather than explicit forms of communication with regard to their possession of stigmatizing attributes, carefully managing the potentially dangerous nature of disclosure (Carillo, 2002; DeCena, 2008; Padilla, 2007).

A third major finding of this study is that respondents describe the experience of intersecting forms of social stigma, such that one's experience of sexuality is fundamentally influenced by one's location within racialized social hierarchies. Although this concept has been discussed in several works of scholarship across the social sciences and humanities, including important works which emerged within women of color feminist movements of the 1970s and 1980s (see Combahee River Collective, 1986; Lorde, 1984; Crenshaw, 1991; Ferguson, 2005; Bowleg, 2008; Hemphill, 1992; Schulz et al., 2006), this study represents one of few health-related qualitative studies (see Green, 2005) which attempt to specifically illustrate how these processes may actually manifest in the lives of Black sexual minority men. For example, one key way in which the intersection of multiple forms of social stigma intersect is through constraining the effectiveness of collective identity as a stigma mitigating strategy. In other words, respondents describe vigilantly policed borders of authentic group membership, which often cast them outside the "collective" group in which they pursue comfort. Thus, for example, respondents describe the ways in which appeals to collective black identity are limited by hetero-normative internal hierarchies, which often cast respondents as tangential, inauthentic group members. Similarly, appeals to a collective LGBT identity are limited by internal racial hierarchies which also cast them as provisional group members, sometimes unworthy of support.

Findings from this study lend credence to HIV/AIDS intervention strategies based on human rights approaches (Farmer, 2005; Parker, 2007). Human rights approaches to social stigma reduction differ vastly from psychosocial approaches, which although important in terms of generating *immediate* outcomes, tend to focus on increasing tolerance and empathy on the part of individuals who stigmatize, and increasing the capacity to cope with stigma on the part of those who are its objects (Brown, Trujillo and Macintyre, 2001; Parker and Aggleton, 2003; Parker and Aggleton, 2003; Mahajan et al., 2008). In contrast to psychosocial responses, human rights approaches tend to focus on

and seek to substantively address the role of unequal power relationships, which are often codified in laws and uncontested social conventions which privilege and protect access to rights and full-fledged citizenship among certain groups, at the expense and the exclusion of other groups. As scholars have noted, addressing these more insidious and underlying facilitating conditions of social stigma-related health disparities requires supporting policy-level shifts, which will likely require community mobilization and social change efforts (Parker and Aggleton, 2003). Findings from this study suggest that these are types of the approaches that would most effectively respond to the experiences narrated by respondents in this study, who often painfully articulate a clear sense of themselves as de-valued not just relative to other individuals, but also in clear relationship to the state and its agents, even outlining the damaging ways in which they have been multiply positioned as "threatening" and "provisional" citizens.

Chapter V

Conclusion

Black-white racial disparities in HIV within the United States continue to be a problem of enormous magnitude. Despite that Blacks represent only 12.3% of the population, they accounted for half of new HIV cases diagnosed in 2004, and have a rate of infection seven times higher than that for whites, 2.2 times higher than that for Latinos, 9.5 times higher than that of Asian/Pacific Islanders, and 6.3 times higher than that of American Indians (CDC, 2006). Moreover, in all age groups stratified by gender, blacks had the largest proportion of HIV/AIDS diagnoses (CDC, 2006). And, contrary to popular belief, HIV infection was *the leading* cause of death for Black men twenty-five to forty-four years old in 1998, accounting for 16% of deaths and representing a death rate markedly greater than that due to homicide (Smith, 2000). In addition, in 1997 HIV was one of the leading causes of years of life lost before age 75 for both Black men and women (Smith et al., 2000). MSM also bear a vastly disproportionate share of social suffering due to HIV/AIDS. As a unified group, MSM overall continue to account for the largest number of existing AIDS cases and new HIV infections, despite overall declines in HIV/AIDS diagnoses and new infections (Mays et al., 2004; Blair, Fleming and Karon, 2002; Karon et al., 2001; Quan et al., 2002).

At the intersection of these two groups, Black MSM have been estimated as having HIV prevalence levels of 46% (CDC, 2005) a level domestically unprecedented. Furthermore, researchers have firmly established the existence of vast black – white racial disparities in HIV prevalence, incidence and disease progression among sexual minority men in the United States (Millett et al., 2006; Blair et al., 2002; CDC, 2005). Many scholars have been responsive to these disturbing epidemiologic trends, with some researchers critiquing the data-sparse focus on bisexually behaving men as a potential cause of racial disparities in HIV/AIDS (Ford et al., 2007), others arguing that there must

be renewed focus on the role of social power and privilege, given the failure of individual risk behaviors to account for racial disparities in black – white rates of infection among sexual minority men (Mays et al., 2004; Millett et al., 2006), and several others pointing out the importance of explicitly exploring the role of social stigma (Millett et al., 2007; Millett et al., 2006; Malebranche et al., 2004; Wilson and Moore, 2009), given the existence of studies which empirically demonstrate the importance of stigma in influencing HIV risk and vulnerability among other ethnic/racial subgroups of sexual minority men (Diaz, 2004; Diaz, 2001; Padilla et al., 2008; Meyer, 2003; Frye, 2006; Wilson and Yoshikawa, 2004). Although there has been far less explicit focus on the relationship between social stigma and HIV risk and vulnerability among Black MSM, focus on this construct is supported by the wider social determinants in health literature, which has identified social stigma as a fundamental cause of health disparities, and as a requirement for the perpetuation of social inequalities more broadly (Stuber et al., 2008; Link and Phelan, 2001, Parker and Aggleton, 2003).

In response, in this dissertation I have sought to build our current understanding of social stigma as it relates to HIV/AIDS among Black MSM through the use of a multi-methodological approach. Based on the premise that moving forward in the development of our understanding of social stigma requires being firmly grounded within the forms of knowledge that currently exist, chapter two of the dissertation I conducted a critical qualitative analysis of the existing stigma-related applied public health research focusing on black – white racial disparities in HIV/AIDS among sexual minority men in the United States. To date, this research has loomed fairly anomalous within the broader literature on social stigma and health, in terms of its inability to identify a clear link between social stigma-related factors and HIV risk and vulnerability (see Wheeler and Lauby, 2008; Mutchler et al., 2008; Crawford et al., 2002). Thus, in the first part of this paper I examined the ways in which race, racial stigma and inequality, sexuality and sexual stigma and inequality are theorized within this applied public health stigma literature. Next, employing key insights from the broader interdisciplinary literature on social stigma and health (see Parker and Aggleton, 2003; Padilla, 2007; Padilla et al., 2008; Stuber et al., 2008; Link and Phelan, 2001), I propose that the lack of a clear empirical link between social stigma and black – white racial disparities in HIV/AIDS

among MSM may be rooted in conceptual limitations. Specifically, chapter two argues that although this applied public health stigma-related literature is in many ways nuanced, and provides a firm foundation upon which to further develop our understanding of stigma and HIV risk in Black MSM, it suffers from two key limitations. First, consistent with existing critiques of social stigma theory (see Parker and Aggleton, 2003) I argue that it primarily casts racial and sexual stigma and inequality in cultural ways, with these constructs spoken about primarily from the perspective of interpersonal discrimination, thereby obscuring the more institutional manifestations of racial and sexual stigma and inequality. And secondly, this existing applied literature tends to theorize racial and sexual stigma and inequality in discrete ways, inhibiting more intersectional investigations of how these constructs may contribute to racial disparities in HIV/AIDS among sexual minority men. In order to empirically and conceptually build upon existing knowledge, I argue that we must employ a broader approach, taking into key consideration the contribution of theories of intersectionality, which clearly describe the mutually constitutive nature of racial and sexual forms of stigma and inequality (Ford et al., 2007; Collins, 2000; Lorde, 1984, Ferguson, 2005; Cohen, 1999; Eng, 2005).

Moving forth from the evaluative qualitative approach employed in paper one, chapter three employs quantitative research methods, and builds upon the theoretical insights central to chapter one. In this chapter, I re-visit a critical limitation of the existing applied public health social stigma literature focusing on racial disparities in HIV/AIDS among sexual minority men: that the experience of sexuality is fundamentally generalizable across race. Arguing that this core assumption of the literature may thwart our attempts to fully understand the role of social stigma in influencing racial disparities in HIV/AIDS among sexual minority men, I use ordinary least squares regression to quantitatively explore two research questions, using a multi-site probability sample of MSM living in Los Angeles, New York, Chicago, and San Francisco (Ruiz et al., 2003). First, I explore whether there are black – white racial differences in perceptions of racial stigma within the gay community, finding far higher levels of perceived racial stigma among Black MSM. Second, I explore whether there are racial differences in positive and negative affiliation with the gay community, finding that while Black MSM are less likely than whites to endorse feelings of positive affiliation with the gay community,

Blacks and whites do not differ in levels of negative affiliation with the gay community. In other words, although Blacks report their interactions within their cities' gay communities to be in general less affirming than do whites, they are just as likely as whites to feel connected to and invested in the problems faced by this community. Overall, and consistent with intersectional theories of social stigma (see Cohen, 1999; Ferguson, 2005; Ford et al., 2007; Lorde, 1984) these findings suggest that studies which seek to explore the relationship between social stigma and health should account for the ways in which experiences of sexuality and sexual stigma are fundamentally intertwined with one's social position within racialized hierarchies of value.

Chapter four employs a classical qualitative approach, using semi-structured interviews to explore the illness narratives of a sample of older HIV positive sexual minority Black men. Specifically, in this paper I explore subjective constructions of social stigma within these narratives, contributing to the further development of existing theoretical approaches to social stigma in this population. To this end, in this paper I employ a grounded theory approach (Strauss and Corbin, 1998), seeking to *build* theory based on lived experience. In part one of this chapter I describe some of the key ways in which respondents articulate interpersonal manifestations of social stigma, focusing particularly on acts of discrimination. Secondly, I argue that the ways in which experiences of racial and sexual forms of social stigma are experienced appear to be fundamentally intertwined rather than discrete. The second core part of this paper argues that the state and its agents position respondents in marginal ways relative to sexual, racial and HIV-related hierarchies of value. Although this chapter's discussion of the role of the state is unique within the applied public health literature on Black sexual minority men, its focus on the role of the state is deeply consistent with qualitative work on the role of social stigma among other demographic groups, both within and beyond the field of public health (Parker and Aggleton, 2003; Manalansan, 2005; Concannon, 2008; Cohen, 1999; Padilla, 2007). In this study, respondents articulate the way in which their marginal position within racialized hierarchies operates in terms of casting them as threatening, and requiring increased police regulation. In contrast, they articulate their position within hierarchies of sexual value as fundamentally provisional, contingent on their ability to conform to established codes of gender normative conduct. Lastly,

respondents articulate their value within systems of HIV-related inequality in terms of "possession," through which the state and its agents systematically subvert and displace their own subjective knowledge of their bodies. Lastly, the final part of this paper explores the role of agency, describing the multiple ways in which respondents actively and creatively engage strategies to resist and manage the multiple forms of social stigma in their lives, including: the pursuit of collective identity, self monitoring, and indirect forms of communication with intimate others.

This dissertation contributes to knowledge on social stigma and HIV risk and vulnerability in the following ways. First, in borrowing the insights of both intersectionality scholars and those whose work focuses on the political economy of stigma in order to critically assess the existing applied public health literature I suggest two ways in which the existing applied research may refine its approach to social stigma and HIV vulnerability among Black MSM: 1. through exploration of the institutional manifestations of stigma, and 2. through studies which consider the mutually constitutive nature of racial and sexual forms of stigma and inequality. Second, I provide preliminary empirical evidence for the prominence of racialized stigma in the lives of Black MSM. Third, I provide empirical evidence for a core tenet of intersectionality theory: that the experience of sexuality varies by race. And lastly, I provide qualitative evidence for the further development of stigma theory, based on grounded analysis of the stigma narratives of older HIV positive Black sexual minority men. Consistent with other qualitative work with Black sexual minority men (see Mays et al., 2004; Millett et al., 2006) these narratives illustrate the importance of re-centralizing the role of structural inequalities, and of adopting community-based participatory approaches, which pursue, centralize and apply the enormous wealth of critical knowledge of Black sexual minority men in responding to the problem of HIV/AIDS within this group.

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