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Correlates of internalized homonegativity among black men who have sex with men

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Abstract

Black men who have sex with men (MSM) carry a disproportionate burden of HIV in the United States. Such disparities cannot be attributed to individual behavioral risk factors alone, prompting the exploration of social and contextual factors experienced by minority MSM. Societal homonegativity and the internalization of those attitudes by Black MSM may play an important role in understanding racial and ethnic disparities in HIV incidence and prevalence. This study explores the correlates of internalized homonegativity in a large multi-site sample of Black MSM. Findings reveal a number of significant contextual and psychosocial factors related to internalized homonegativity including religiosity, resilience, and gay community acculturation, which have important implications for HIV risk, HIV testing, and social and psychological wellbeing for Black MSM.

Keywords

Black MSM; Homonegativity; HIV; racial disparities

Introduction

African Americans carry a disproportionate burden of HIV in the United States. Although they represent only 12% of the total US population, African Americans accounted for an estimated 44% of all new HIV infections (Centers for Disease Control and Prevention (CDC), February 2014). If incidence trends continue at the current rate, 1 in 16 Black men will receive an HIV diagnosis at some point in their lives (Centers for Disease Control and Prevention (CDC), February 2014), and HIV will continue to remain most prevalent among Black men who have sex with men (MSM)(Bowleg & Raj, 2012). The prevalence rate of HIV among Black MSM is 28%, which is significantly higher than among Latino (18%) or White MSM (16%), and sexual minority MSM are more likely to be unaware of their HIV infection (Centers for Disease Control and Prevention (CDC), 2010). Existing research has

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established that individual behavioral risk factors alone do not explain these disparities (Clerkin, Newcomb, & Mustanski, 2011; Feldman, 2010; G. Millett, Flores, Peterson, & Bakeman, 2007). Studies to date have demonstrated that racial HIV disparities are not due to higher rates of high-risk sexual behaviors (Clerkin et al., 2011; Friedman, Cooper, & Osborne, 2009), nor can they be explained by higher rates of substance use, or a higher number of sexual partners (Clerkin et al., 2011; G. Millett et al., 2007; G. A. Millett, Peterson, Wolitski, & Stall, 2006). This has prompted exploration of social, structural, and contextual factors experienced by minority MSM that may explain HIV disparities.

Negative societal attitudes about homosexuality and the internalization of those attitudes by Black MSM may play an important role in explaining the underlying causes of the racial and ethnic disparities in HIV incidence and prevalence. Gay and lesbian individuals, as well as those perceived to be homosexual, commonly experience victimization and hatred specific to their sexual orientation (Rosser, Bockting, Ross, Miner, & Coleman, 2008) and an individual's reaction to societal heterosexism and incorporation of those attitudes and beliefs can result in internalized homonegativity (Rosser et al., 2008). Internalized homonegativity, also referred to as internalized homophobia, internalized heterosexism (Szymanski, Kashubeck-West, & Meyer, 2008b), or sexual prejudice (G. M. Herek, 2004), is the acceptance of societal anti-gay attitudes toward oneself, leading to internalized conflict, a devaluation of oneself, and poor self-regard (Mayfield, 2001; I. H. Meyer & Dean, 1998). This internalization of societal stigma can lead to negative feelings about one's own sexuality as well as adverse social and mental health consequences (G. M. Herek, 2004; Huebner, Davis, Nemeroff, & Aiken, 2002; Shidlo, 1994).

Internalized homonegativity is typically explained using the minority stress model as an underlying conceptual framework. This theoretical model allows for a focus on the excess stress to which individuals from minority groups are often exposed (V. Brooks, 1981). Applied to lesbian, gay, bisexual, and transgender (LGBT) individuals by Meyer (1995), minority stress theory posits that stress related to being gay or bisexual has deleterious effects on an individual's health and well-being (I. H. Meyer, 1995). Conflict that arises between dominant and minority social and cultural values, especially within a generally hostile or homophobic culture, can result in harassment, maltreatment, and discrimination of LGBT individuals, which in turn, can lead to stress and maladaptive coping (I. H. Meyer, 2003; Szymanski, Kashubeck-West, & Meyer, 2008a). In Meyer's model, minority stress is operationalized through internalized homonegativity, stigma, and experiences of prejudice, although internalized homonegativity is understood to be most significantly related to psychological distress (H. I. Meyer & Dean, 1995).

The pathways and mechanisms linking internalized homonegativity and health disparities indicate that homonegativity and heterosexism adversely influence self-esteem and depression among MSM (Diaz, Ayala, Bein, Henne, & Marin, 2001; I. H. Meyer, 1995) and are related to higher levels of psychological distress (Szymanski & Gupta, 2009). Internalized homonegativity may cause gay men to be at increased risk for depression by reinforcing negative self-perceptions (Rosser et al., 2008). Subsequently, lowered self-esteem may negate self-protection motivators, lead to multiple unsafe sexual encounters, or the use of alcohol and drugs, which impair judgment and may interfere with one's ability to

negotiate and practice safer sex (Stokes & Peterson, 1998). In particular, research suggests that internalized homonegativity among Black gay and bisexual men may lower self-esteem and lead to psychological distress, ultimately contributing to an increase in risky sexual behaviors (Stokes & Peterson, 1998). In an ethnically and racially diverse sample of HIV-positive MSM, internalized homonegativity was strongly associated with lower condom self-efficacy and not being open with one's sexual orientation (Ross, Rosser, Neumaier, & Positive Connections Team, 2008).

Research has suggested that homonegativity and stigma surrounding sexual orientation are more pervasive in the Black community and, thus, Black MSM may be more significantly affected by homonegativity. For example, research has shown that homonegativity is more common in various Black communities (Fullilove & Fullilove, 1999) and that Black Americans consistently express more conservative and negative attitudes toward homosexuality than Whites (Ahrold & Meston, 2010; Glick & Golden, 2010; Lewis, 2003). A review by Lewis (2003) of surveys conducted since 1973 revealed greater disapproval of homosexuality among Black adults than among Whites, even when controlling for religious and educational differences (Lewis, 2003). He found that Blacks were more likely "to be fundamentalist Protestants, and more likely to believe in a God who sends misfortunes as punishments" (Lewis, 2003, p. 66). Furthermore, nearly two-thirds of Black MSM themselves believe that homosexuality is *always wrong* (Glick & Golden, 2010), suggesting that Black MSM are likely to encounter stigma and homonegativity even in social settings with other Black MSM. To date, the research examining correlates of internalized homophobia have studied predominantly white samples, and our understanding of internalized homonegativity among sexual minority men of color remains primarily theoretical (Szymanski, Kashubeck-West, & Meyer, 2008b). However, among ethnically diverse samples of MSM, internalized homonegativity was highest among Black MSM and those who identified as bisexual, as compared to gay (Ross et al., 2008). Additional research has suggested that internalized homonegativity is more pronounced among poor, urban MSM and MSM of color than among White, middle-class gay men. Levels of internalized homonegativity were associated with age, lower levels of education, Black race, poverty, homelessness, and incarceration (Shoptaw et al., 2009).

Given the unique social and cultural forces that Black MSM may face, it is important to explore the role of internalized homonegativity among Black MSM. Although previous research has examined the relationship between homonegativity and a number of psychosocial correlates, this work has primarily focused on White gay men (Smolenski, Stigler, Ross, & Rosser, 2011; Szymanski, Kashubeck-West, & Meyer, 2008b), and thus, may not be applicable to Black MSM, for whom internalized homonegativity is thought to be more prevalent (Shoptaw et al., 2009). This study explores the correlates of internalized homonegativity to further our understanding of the relationship between internalized homonegativity and HIV incidence and prevalence among Black MSM. Specifically, we explored in a large multi-site sample of Black MSM the relationship between internalized homonegativity and: demographic characteristics such as age, level of education and income, HIV status, psychosocial and contextual factors including masculinity, gay

acculturation, religiosity, resilience, and AIDS conspiracy beliefs; and behavioral factors including sexual risk, substance use and HIV testing history.

Methods

Data were collected between 2012 and 2014 as a part of the baseline assessment for “Connections Creating Change” (C3), a randomized HIV prevention social network intervention trial for Black MSM. The study recruited social networks of racial minority MSM in Milwaukee, WI, Cleveland, OH, and Miami, FL., all cities in which HIV incidence is disproportionately high among racial minority MSM.

Recruitment of each network began by identifying an initial “seed” in community venues where Black MSM were known to meet and socialize. These venues were selected based on prior ethnographic observations and community mapping and included bars, clubs, pageants, house balls, hangout places, and other formal and informal social settings. Two field staff systematically observed a venue to watch for “social circles” (Kadushin, 1996) of racial minority men who were socializing with one another. After randomly picking one social circle, the two staff independently identified the individual who appeared to be the center of attention among others in his social circle (the “seed”). All seeds were Black MSM. Field staff then approached the seed, briefly explained the study, and asked the seed to provide the first names of his close MSM friends. The seed was given study information packets and was asked to invite each friend he had just name to participate in the study with him. These individuals constituted that network’s first “ring.” When they entered the study, members of the first ring were interviewed and asked to invite the members of their own friendship groups to participate in the research. These individuals constituted the second network ring. Members of the second ring who were enrolled in the study invited, in turn, the other friends who became the network’s third and final ring. In this way, sociocentric networks were recruited by reaching out and enlisting three waves from each initial seed. Of 39 seeds who were consented, 35 (89.7%) brought into the study at least half of their first-ring friends. The sample consisted of 35 networks that collectively included 464 participants, 230 in Milwaukee, 180 in Cleveland, and 54 in Miami. Social networks ranged in size from 3 to 47 (mean= 13.3) enrolled members from each social network.

Participants completed individual assessments in a research field office. Following an explanation of the study, participants provided written informed consent, completed assessments administered by A-CASI, provided biospecimens for HIV/STD testing, and received risk reduction counseling. Participants received \$40 for completing the A-CASI interview and an additional \$40 for completing STI/HIV testing. The study protocol was approved by IRBs of each participating institution.

Assessment Measures

Demographic variables

Participants indicated their sex at birth as well as their self-identified present gender (male, female, or transgender), age, race, whether of Hispanic ethnicity, employment status, income, highest level of education, and housing stability. Participants used a 5-point scale to

describe their sexual orientation (from exclusively gay to exclusively straight). They were asked whether they ever had an HIV test, whether it was in the past year, and the result of their most recent test. If HIV-positive, participants indicated how long they knew of their positive serostatus and whether they were presently taking antiretroviral medications.

Sexual risk practices (lifetime, the past year, the past three months, and at the most recent anal intercourse occasion)

For both lifetime and the previous year, participants indicated their total number of male and total number of female sex partners and whether they had given or received money or valuables in exchange for sex. Participants were asked to describe for their most recent act of anal intercourse (AI) with a male partner how long ago it occurred; the type of sex partner (main male partner, casual hook up, commercial partner); whether they met their partner online; whether they were insertive, receptive, or both; and whether or not a condom was used. In addition, participants reported if they drank alcohol (and the number of drinks) or if they used drugs prior to sex (and the types of drug).

Substance use

Participants were asked on how many days they drank alcohol in the past month, their number of drinks in a typical day, and the greatest number of drinks they had consumed in a single day. Participants were asked whether they smoked marijuana in the previous 30 days and the number of days in the past 30 they used marijuana. In addition, participants indicated whether, and on how many days in the past month, they used heroin, other opiates, cocaine, crack, amphetamines or methamphetamines, ecstasy, gamma hydroxybutyrate (GHB), ketamine, inhaled nitrites (“poppers”), non-prescribed medications for erectile dysfunction, illicit prescription drugs, and any injected drug. These are the drugs reported to be most commonly used by Black MSM in formative research that preceded this study. Street names were always included for all drugs.

Psychosocial contextual measures included masculinity, internalized homonegativity (homophobia), resiliency, HIV/AIDS conspiracy beliefs, religiosity, and outness with regard to sexual orientation (Bogart & Thorburn, 2005; R. A. Brooks, Etzel, Hinojos, Henry, & Perez, 2005; E. L. Fields et al., 2012; García, Lechuga, & Zea, 2012; Hampton et al., 2013; G. M. Herek, 1997; Lauby et al., 2012; Mays, Cochran, & Zamudio, 2004). The assessment included scales to assess each of these contextual domains.

Internalized homonegativity (homophobia) assessed participants’ comfort with their sexual orientation and sexual practices. Using 5-point Likert scales, respondents indicated their level of agreement with nine statements, including “I wish I were not sexually attracted to men” and “Having sex with other men is not a problem for me”(score range from 9 to 45, Cronbach’s alpha=0.86 in the study sample). The scale was adapted from measures developed by Herek and colleagues (1998), Myers (1989), and Wagner (1998) to assess gay men’s comfort with their sexuality and sexual attractions. The items on in the original scale were derived from the diagnostic criteria in the DSM III for ego-dystonic homosexuality, or discomfort with and desire to change one’s sexual orientation.³⁹

Self-ascribed masculinity was measured with a 4-item scale adapted from Garcia et al. (2012); (sample item: “I can pass as a straight man”). Participants responded to each statement using 5-point Likert response options from strongly disagree to strongly agree (score range from 4 to 20, Cronbach’s alpha=0.83). The scale was initially developed by Garcia et al. (2012) to measure self-presentation and gender non-conformity to dominant conceptions masculinity among Latino MSM.

Resilience, defined as beliefs in one’s personal competence and acceptance of self that improve one’s ability to adapt to difficult life situations was assessed using 10 items from Wagnild and Young’s (1993) 25-item Resilience Scale. Sample items included “My belief in myself gets me through hard times” and “When I am in a difficult situation, I can usually find a way out of it.” A 5-point Likert scale was used to indicate level of agreement with each statement (score range from 10 to 50, Cronbach’s alpha=0.88). This adapted resilience scale was used to assess MSM’s perceived internal capacity to handle adverse life experiences.

AIDS conspiracy beliefs represent the view that HIV is the result of a conspiracy or an intentionally-created genocide. These beliefs were measured with Bogart and Thorburn’s (2005) 9-item measure scale and included items such as, “AIDS was created by the government to control the Black population” and “HIV is a man-made virus.” Respondents indicated their level of agreement with each statement using a 5-point Likert scale (score range from 9 to 45, Cronbach’s alpha=0.89). This scale was used to assess participants’ beliefs that HIV was specifically created to control the Black population and participants’ trust of physicians. Previous research has suggested that AIDS conspiracy beliefs were associated with negative attitudes toward condoms and inconsistent condom use among men.

Religiosity and church involvement was measured with 6 items adapted from Forehand and Brody (2000). This scale was intended to assess the importance of religion in the lives of participants and frequency of religious participation. Sample items include “How often do you attend religious services?” and “How religious would you say you are?”.(Forehand et al., 2000) Respondents selected from one of five responses to describe their level of religious engagement (score range from 6 to 30, Cronbach’s alpha=0.80).

Finally, seven items developed specifically for this research measured level of *gay community acculturation*. This scale assessed the extent to which the respondent actively participated in gay-identified community activities including attending gay house parties or gay clubs, the frequency with which he read gay magazines and followed news within the gay community, and how involved respondents were with the gay community in general. Sample items include “How often do you socialize with people who are gay?” and “How much do you feel you are part of the gay community?”. Respondents used 5-point Likert scales to indicate strength of agreement with each statement (score range from 7 to 35, Cronbach’s alpha=0.86).

Statistical Analysis

The statistical analyses examined correlates of internalized homonegativity among 427 participants who reported ever having engaged in anal intercourse (AI) with a male partner. Our initial analyses focused on testing univariate associations between homonegativity and demographic characteristics (e.g. age, HIV status, education level), psychosocial and contextual factors (e.g. masculinity, resilience, and religiosity), and behavioral risk factors (e.g. sexual risk and substance use). Mixed-effects linear regressions were then conducted to analyze these associations. To control for the interdependency of responses among members of the same social network, network was included as a random-effect in each regression. Predictors that met a threshold p -value $< .15$ in the univariate analyses were retained for the multiple mixed-effects regression. A backward stepwise procedure was used to select covariates in the final model. An α of .05 was our criterion for statistical significance; however, predictors that met a threshold p -value of .10 in the stepwise model were tentatively retained in the model for discussion as trends in the data. All regression analyses were Generalized Estimating Equations for mixed-effects models and were performed using IBM SPSS Statistics, Version 20 (2011) software.

Results

Table 1 summarizes the demographic characteristics of men in the sample. The mean age of participants was 27.4 years. Although all participants reported that their gender at birth was male and most defined themselves as males, 5.9% of participants self-identified as transgender and 1.6% as female. 76.8% of participants described their sexual orientation as exclusively or mainly gay, 20.1% as bisexual, and 2.8% as mainly or exclusively heterosexual. Approximately 69% of participants were either unemployed or employed part-time and a majority had a high school education or less and an annual income of under \$10,000 in the past year. Two-thirds of participants said their housing was very stable, while 9.4% said they had somewhat or very unstable housing.

Alcohol and marijuana were the most commonly reported substances used by study participants; nearly 86% of participants drank, and did so on an average of 7.9 days in the past month, and nearly 60% smoked marijuana on an average of 17.3 days. Other substances used by over 2% of participants in the past month included cocaine (9.6%), ecstasy (7.5%), illicit prescription drugs (7.3%), opiates (4.2%), and inhaled nitrites (4.4%). A summary measure of illicit drug use (excluding marijuana) indicated that 22.5% of participants reported the use of street drugs during the past 30 days and did so on an average of 6.3 days. Injection drug use was rare; only two participants in the sample reported drug injection in the past month. Almost 97% of participants said they had been tested for HIV, including almost two-thirds in the past year. Among those ever tested, 23.7% said they were HIV-positive based on their most recent test.

Table 2 shows the results of the univariate associations as well as the multiple mixed regression analysis that examined the associations of demographic characteristics, situational factors, and psychosocial scales with internalized homonegativity, controlling for social network membership. As is clear in from the multiple regressions in Table 2, a

number of factors predicted internalized homonegativity in this sample of Black MSM, including several psychosocial scales. Religiosity or church involvement and AIDS conspiracy beliefs were significant ($p < .001$) predictors of internalized homonegativity; higher levels of religiosity and greater AIDS conspiracy beliefs were both associated with increased homonegativity among Black MSM. In addition, greater self-perceived masculinity was associated ($p < .04$) with higher levels of internalized homonegativity. On the other hand, the regression results showed negative relationships between internalized homonegativity and both resilience ($p < .001$) and gay community acculturation ($p < .001$). Greater resilience and greater gay community acculturation were both predictors associated with lower levels of internalized homonegativity among the participants.

In addition to the psychosocial scales, the analysis revealed two significant demographic predictors of internalized homonegativity. Specifically, participants with annual incomes over \$30,000 and men who reported bisexual or heterosexual, as opposed to gay sexual orientation, had higher levels of internalized homonegativity. As reported in Table 1, over 20% of the men in this sample identified as bisexual or heterosexual, and this was significantly associated with internalized homonegativity ($p < .001$). With respect to substance use, men who used any street drugs in the past 30 days reported higher levels of internalized homonegativity. Two non-significant trends also resulted in the mixed multiple regression model. There was a trend toward higher levels of internalized homonegativity associated with never testing or not testing in the prior year, as well as with smoking pot in the previous month.

Discussion

This study assessed correlates of internalized homonegativity among Black MSM, prompted by prior reports that racial minority MSM often encounter heterosexism and anti-gay attitudes from within their social environments and communities, including families and churches (Jeffries, Marks, Lauby, Murrill, & Millett, 2012). Although several studies have explored the relationship between internalized homonegativity and psychosocial factors, much of this work has used predominantly White samples and research exploring these concepts with men of color has remained primarily theoretical in nature (Szymanski, Kashubeck-West, & Meyer, 2008b). Our study is among the first to explore internalized homonegativity in a large, multi-site sample of Black MSM.

Given the complex nature of internalized homonegativity, it was important to explore pathways by which internalized homonegativity may affect Black MSM, and our results revealed a number of significant contextual and psychosocial factors to consider. For example, given its prominence in the Black community, the Black Church has played a significant role in defining attitudes toward same-sex behavior and relationships, is often cited as a source of homonegativity (Balaji et al., 2012), and is criticized for perpetuating negative attitudes toward homosexuality (Fullilove & Fullilove, 1999; Woodyard, Peterson, & Stokes, 2000). Research has previously demonstrated that LGBT individuals of color are less likely to be open with their sexuality in religious environments than White LGBT individuals (Moradi et al., 2010), although religious environments are also a documented source of support and resilience for LGBT people of color (Bowleg, Huang, Brooks, Black,

& Burkholder, 2003; Gómez, Mason, & Alvarado, 2005; Miller, 2005). This perceived need to conceal one's sexuality within an environment that simultaneously provides support and a sense of community can lead to significant internal turmoil and distress and subsequently, to internalized homonegativity. It is not surprising, then, that higher religiosity or church involvement significantly predicted internalized homonegativity. The relationship between religious engagement and internalized homonegativity is thought to begin in early life and is reinforced through continued participation in non-affirming religious settings (Barnes, 2012). Homophobic messages and beliefs acquired during childhood or emerging adolescence may become internalized when individuals begin to identify as gay, even if they eventually disassociate from such environments (Barnes, 2012). However, despite anti-gay messages, some LGBT individuals may retain affiliations with non-affirming religious settings because of the great personal benefit and connection with a community, especially for Black Americans, for whom the Church has often been viewed as central to racial identity and pride (Lincoln & Mamiya, 1990).

Real or perceived anti-gay attitudes from within the Black community may also affect perceptions of masculinity and sexual identity among Black MSM. Higher levels of masculinity and being an MSM who identifies as bisexual or heterosexual were both significant predictors of internalized homonegativity. The constructions of masculinity for Black men may be influenced by experiences of racism and socioeconomic disparities, which may affect the daily behaviors, attitudes, and perceptions of Black MSM (Mays et al., 2004). The social and cultural environments of many Black men may inhibit their expression of non-heterosexual behaviors and identities (Mays et al., 2004; G. Millett, Malebranche, Mason, & Spikes, 2005; Operario, Smith, & Kegeles, 2008), as Black MSM may face cultural and community rejection when they openly identify as gay (Dodge, Jeffries IV, & Sandfort, 2008; Malebranche, 2003). In response to societal stigma and homonegativity, and as a strategy for self-preservation within the Black community, some Black MSM report needing to conceal their sexual identity (Choi, Han, Paul, & Ayala, 2011). Other men may seek to portray a hypermasculine public image in an effort to conceal their homosexuality, which is often viewed as inconsistent with traditional masculine gender roles (E. L. Fields et al., 2014). Thus, individuals with higher levels of internalized homonegativity may be more likely to attempt to be perceived by others as masculine. It is possible that identifying as bisexual may not be as stigmatizing as identifying as gay, and thus, Black MSM who are more uncomfortable with their sexuality and have internalized negative societal attitudes about their sexual orientation may feel more comfortable identifying as bisexual or heterosexual. This is consistent with previous work suggesting that more 'closeted' men tend to have higher levels of internalized homonegativity (Berg, Ross, Weatherburn, & Schmidt, 2013). In general, it seems as though Black MSM face the potential loss of support from the broader Black community if they disclose their sexual identity, yet are likely to experience greater internalized heteronormativity and psychological distress if they do not.

Two social and cultural factors were found to be negatively correlated with internalized homonegativity for Black MSM in this study. First, greater gay community acculturation was associated with lower levels of internalized homonegativity, suggesting increased isolation from LGBT peers and the gay community. This may present a unique challenge as

Black MSM struggle with the intersection of stigma due to sexual orientation and race and may face racism from the White gay community (Choi et al., 2011), potentially leading to exclusion and isolation from the broader gay community. Furthermore, higher levels of societal homonegativity within the Black community (Fullilove & Fullilove, 1999) may simultaneously result in isolation and stigma from the Black community. Black MSM may feel a lack of support from the Black community and a simultaneous disconnection from the largely White LGBT community, which may translate into the internalization of more negative attitudes about themselves (Szymanski & Gupta, 2009).

Minority stress theory suggests that Black LGBT individuals are exposed to greater stress, and subsequently worse health and mental health outcomes, than White LGBT persons because of the stress related to both homonegativity and racism, as well as more limited support and community resources compared to White LGBT individuals (I. H. Meyer, 2010). Theories of resilience, however, posit that because of negative experiences with racism experienced in early life, Black MSM may be better able to guard against some of the deleterious consequences of homonegativity as adolescents and adults (I. H. Meyer, 2010; Moradi et al., 2010). Resilience theories suggest that despite increased stress exposure, Black MSM may actually have higher levels of individual- and social-level resilience and resources need counter some of the potential negative effects of stress and protect against some of the negative consequences associated with homonegativity (I. H. Meyer, 2010). In our study, resiliency was found to be negatively related with internalized homonegativity; higher levels of resilience were associated with lower levels of internalized homonegativity. As other researchers have pointed out (I. H. Meyer, 2003; I. H. Meyer, 2010), additional research focusing on stress and resilience, especially among Black MSM, is needed to fully understand the nuances and occasional inconsistencies in these theories and understand how stress and resiliency affect internalized homonegativity.

These correlates of internalized homonegativity are important not only to mental health and psychosocial coping among Black MSM, but also have implications for HIV prevention interventions. Although this study did not establish a direct link between sexual risk behaviors and internalized homonegativity, many of the factors associated with internalized homonegativity have been found in other studies to have an association with sexual risk behaviors. For example, MSM with higher levels of internalized homonegativity may invoke any number of maladaptive coping mechanisms to minimize stress, including substance use, which increases the odds of engaging in unprotected anal intercourse (Fendrich, Avci, Johnson, & Mackesy-Amiti, 2013). Our findings support this, as internalized homonegativity was associated with use of marijuana or other hard drugs in the previous 30 days. Black MSM may turn to drug use as a coping mechanism for the stress related to internalized homonegativity, which in turn, may lead to risky sexual behaviors or inhibit safe sex negotiation. Similarly, isolation from the gay community or family and community may also affect HIV risk behaviors (Mimiaga et al., 2009), suggesting an indirect relationship between internalized homonegativity and sexual risky behaviors. Furthermore, we found a significant association between internalized homonegativity and either never receiving an HIV test or being tested more than a year ago. This has important implications for HIV risk, as delays in testing may result in unknowingly transmitting the virus to sexual partners. Other researchers have suggested HIV disparities may be partially explained by

late HIV testing among Black MSM, and their likelihood of having undiagnosed and untreated HIV infection (G. A. Millett et al., 2006).

Despite the importance of these findings, they should be considered in light of the study's limitations. The analysis presented here is based on self-reported cross-sectional data, so causality cannot be determined. For example, our cross sectional results cannot determine whether Black MSM with lower levels of homonegativity are more likely to seek out gay venues and socialize with other gay men, thus showing higher gay acculturation, or whether socializing with gay men serves to lower homonegativity. Additionally, the data are based on individual self-report, which is appropriate in this study given our focus on Black MSM's experiences and perspectives. However, self-report data must be interpreted as individuals' subjective perceptions. It is possible that individuals over- or under-report certain variables (e.g. substance use or church involvement) in response to social desirability.

Black MSM are the subject of this research given their startlingly high rates of HIV and an absence of research focusing on minority samples of Black MSM. Although they may share demographic characteristics (i.e. race and sexual behavior), black men are not a homogenous group. The term 'Black MSM' may unintentionally obfuscate individual differences due to diverse and distinct cultures, identities, and experiences. Thus, although referred to as a single group throughout the paper, it is important to remain cognizant of the diversity that exists among racial minority MSM.

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Table 1

Sociodemographic Background, HIV Testing History, and Substance Use in the Past 30 Days Among 427 Men Who Ever Had Anal Intercourse with a Male Partner

<i>Sociodemographic Background:</i>	
Age in years—Mean (SD) ^a	27.4 (8.1)
Gender Identity—% (n)	
Male	92.5% (395)
Female	1.6% (7)
Transgender	5.9% (25)
Sexual orientation—% (n) ^a	
Exclusively or mainly gay	76.8% (328)
Bisexual	20.1% (86)
Exclusively or mainly heterosexual	2.8% (12)
Education—% (n)	
Did not finish high school	16.4% (70)
Complete high school or GED	37.7% (161)
Any higher education	46.0% (196)
Unemployed or employed part-time—% (n)	69.1% (295)
Annual income—% (n) ^b	
<\$10,000	53.4% (228)
\$10,000 - \$30,000	32.1% (135)
>\$30,000	13.3% (57)
Stable housing—% (n)	
Very stable	60.0% (256)
Somewhat stable	30.7% (131)
Somewhat or very unstable	9.4% (40)
<i>HIV Testing History:</i>	
Ever been tested for HIV—% (n)	96.7% (413)
[If tested] Most recent test was less than 1 year ago ^a	64.4% (275)
[If tested] Tested HIV-positive at most recent test ^c	23.7% (101)
<i>Substance Use in the Past 30 Days:</i>	
Drank alcohol—% (n)	85.9% (367)
[If yes] Days drank alcohol—Mean (SD)	7.9 (6.7)
Smoked marijuana—% (n)	59.7% (255)
[If yes] Days smoked marijuana—Mean (SD)	17.3 (11.8)
Used any street drug (excluding marijuana) —% (n)	22.5% (96)
[If yes] Days used any street drug—Mean (SD)	6.3 (8.6)

Table 2

Bivariate and Multiple Regression Analyses Predicting Internalized Homonegativity Among Participants in 35 Social Networks^a

Variable Domain/Predictor:	<i>Univariate Regressions</i>		<i>Multiple Regression</i>	
	Coefficient (SE)	<i>p</i>	Coefficient (SE)	<i>p</i>
<i>Sociodemographic Variables:</i>				
Age (in years)	0.09 (0.05)	.063		
Hispanic ethnicity	-1.42 (1.47)	.334		
Working full-time	0.46 (0.82)	.569		
Annual income [ref: \$0 - \$10K]--				
\$10K - \$30K	-1.74 (0.84)	.039		
>\$30K	0.83 (1.16)	.475	2.61 (0.94)	.006
Attends school	0.08 (0.90)	.930		
Education level [ref: Some college+]--				
< Complete high school	0.56 (1.09)	.607		
High school grad or GED	-0.65 (0.83)	.431		
Has an unstable housing situation	2.38 (1.29)	.066		
Bisexual or heterosexual orientation	6.93 (0.83)	<.001	4.43 (0.79)	<.001
Has a main male partner	-1.57 (0.77)	.041		
<i>HIV Testing Variables:</i>				
Never tested or tested over a year ago	1.30 (0.79)	.100	1.17 (0.65)	.071
Test result was HIV-positive	0.05 (0.89)	.958		
<i>Psychosocial Contextual Scales:</i>				
Religious/church involvement	0.33 (0.07)	<.001	0.34 (0.06)	<.001
Masculinity	0.47 (0.09)	<.001	0.17 (0.08)	.039
Gay community acculturation	-0.44 (0.06)	<.001	-0.27 (0.06)	<.001
Resilience	-0.43 (0.07)	<.001	-0.35 (0.07)	<.001
AIDS conspiracy beliefs	0.29 (0.05)	<.001	0.20 (0.04)	<.001
<i>Factors Related to Last Anal Intercourse with a Male Partner:</i>				
Occurred more than 6 months ago	1.50 (1.07)	.163		
Casual hookup or commercial partner	1.54 (0.89)	.084		
Met partner online	-1.40 (0.85)	.099		
Did not tell partner your HIV status	0.23 (0.94)	.808		
Partner disclosed he was HIV+ or refused to tell his status	0.82 (0.80)	.305		
Condom not used at last AI	-0.68 (0.77)	.375		
Used drug or alcohol at last AI	1.14 (0.79)	.148		
Was high or buzzed at last AI	1.25 (0.83)	.132		
<i>Substance Use in Past 30 Days:</i>				
Drank any alcohol	0.90 (1.08)	.405		
Number of days drank alcohol	0.05 (0.06)	.418		
Smoked marijuana	1.25 (0.77)	.104	1.14 (0.66)	.086

Variable Domain/Predictor:	<i>Univariate Regressions</i>		<i>Multiple Regression</i>	
	Coefficient (SE)	<i>p</i>	Coefficient (SE)	<i>p</i>
Number days smoked marijuana	0.03 (0.03)	.349		
Used any street drug (excluding marijuana)	2.52 (0.89)	.005	1.60 (0.77)	.039
Number days used street drugs	0.08 (0.07)	.317		

^a A backwards stepwise algorithm was used to select covariates for the final mixed regression model from all predictors that achieved at least a *p*-value < .15 in the univariate analysis. Data were presented for all covariates in the multiple regression that achieved a *p*-value < .10.

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