HHS Public Access

Author manuscript

Psychol Health. Author manuscript; available in PMC 2016 June 13.

Published in final edited form as:

Psychol Health. 2016 May ; 31(5): 549–564. doi:10.1080/08870446.2015.1120301.

Social support, psychological vulnerability, and HIV risk among African American men who have sex with men

Lena D. Saleh, PhD[1], **Jacob J. van den Berg, PhD**[2], **Christopher S. Chambers, PhD**[3], and **Don Operario, PhD**[4]

[1]Center for HIV Educational Studies and Training (CHEST), Hunter College of the City University of New York (CUNY), New York, NY, USA

[2]Department of Medicine, The Warren Alpert School of Brown University, and Division of Infectious Diseases, The Miriam Hospital, Providence, RI, USA

[3]Department of Sociology and Anthropology, Northeastern University, Boston, MA

[4]School of Public Health, Brown University, Providence, RI, USA

Abstract

Previous research has suggested a need to understand the social-psychological factors contributing to HIV risk among African American men who have sex with men (MSM). We conducted individual in-depth interviews with 34 adult African American MSM to examine their personal experiences about: (i) sources of social support, (ii) psychological responses to the presence or absence of social support, and (iii) influences of social support on sexual behaviors. The majority of participants described limited positive encouragement and lack of emotional support from family, as well as few meaningful personal relationships. Feelings of isolation and mistrust about personal relationships led many participants to avoid emotional intimacy and seek physical intimacy through sexual encounters. Findings highlight a need for multi-level interventions that enhance social support networks and address the social-psychological, emotional, and interpersonal factors that contribute to HIV risk among African American MSM.

Keywords

African American; MSM; social support; mental health; qualitative

Introduction

The HIV epidemic among African American men who have sex with men (MSM) is one of the most urgent public health challenges in the United States. African Americans comprised 14% of the national population but accounted for 44% of new HIV infections in 2009, with MSM accounting for 51% of new infections among all African Americans (Centers for Disease Control and Prevention 2014). Understanding the factors contributing to HIV risk

Correspondence to: Jacob J. van den Berg.

and reducing new infections in this population has become a national priority (The White House Office of National AIDS Policy 2010).

In order to better understand the determinants of HIV infection in African American MSM, Millett and colleagues conducted a critical review of the HIV epidemiology literature addressing risk factors among this population (Millett et al. 2006). Findings showed that, contrary to some assumptions, African American MSM do not report greater frequency of behavioral risk factors, such as unprotected sex and drug use, relative to other MSM subgroups. Instead, empirical evidence has shown that African American MSM experience multiple disparities in access to and use of health care and structural factors such as unemployment, low income, and incarceration history, which might explain risk for HIV infection (Millett et al. 2012). According to this analysis, structural factors can affect the pool of available sex partners and the context of sexual behavior, which might be concentrated in communities with a high HIV viral load.

Researchers have called attention to social-psychological factors that contribute to HIV risk among African American MSM, including racial discrimination, homophobia, family rejection, and community isolation (Brooks et al. 2005, Mays, Cochran, and Zamudio 2004, Wilton et al. 2009). Stigmatized social identities (e.g. race, ethnicity, and sexuality) are associated with social-psychological stressors as a consequence of structural patterns of inequality (Meyer 2003). The resulting psychological distress can lead to behaviors that might offer immediate physical or emotional gratification – such as anonymous or unprotected sexual behavior – but which, in the long run, can increase the possibility of HIV acquisition and transmission (Mays, Cochran, and Zamudio 2004). There is evidence that this kind of psychological distress can also manifest as alienation and withdrawal from important social support networks, such as family and friends (Wong et al. 2014).

Studies have suggested that social support from family or peers can protect against deleterious psychological and health consequences associated with stressful social conditions (Allgower, Wardle, and Steptoe 2001, Moak and Agrawal 2010). Social support can be generally defined as the presence of family, peer, and other community network members who can provide psychological and material resources when needed (Cohen and Wills 1985). The benefits of social support on psychological and physical well-being may function through its ability to buffer against stress and foster coping and adaptation skills (Thoits 1995, Uchino, Cacioppo, and Kiecolt-Glaser 1996, Tate et al. 2006). Moreover, strong levels of support are associated with lower reported levels of depression and stress, and higher levels of coping efficacy and self- esteem (Nott, Vedhara, and Power 1995, Penninx et al. 1998, Dixon et al. 2006). However, in quantitative analyses, the treatment of social support as a moderator of health and health behaviors does little to contextualize the concept of social support according to the African American experience. While the public advantages of social support are clear, research has pointed to distinctive features of social support systems for African American persons and communities who routinely contend with institutional and interpersonal forms of racism. Family and community networks contribute important social, service, and material assets that stabilize African Americans living in resource-deprived communities (Jarrett, Jefferson, and Kelly 2010, Sarkisian and Gerstel 2004). Family and community members have been shown to contribute to individual self-

esteem and racial consciousness, as well as provide support and positive strategies for coping with racism (Berkel et al. 2009, Feagin and McKinney 2003, O'Brien Caughy, Murray Nettles, and Lima 2011). While recognizing that cultures are not monolithic, scholars have noted that African American social and cultural resources, such as the black church and strong family and peer networks, accent the prominence of race in the lives of African Americans and guide collective social action in response to white racism (Ellison, Musick, and Henderson 2008, Bounds-Littlefield, Patillo-McCoy 1998). When considering social support for African American MSM, research indicates that the limited presence of family and community networks, financial hardships, and social discrimination have been associated with HIV risk (Ayala et al. 2012, Lauby et al. 2012, Schneider, Michaels, and Bouris 2012). Yet, relatively few studies have provided insight into the potential pathways by which social support networks can influence HIV risk-related behaviors among African American MSM. Social-psychological and public health interventions for African American MSM, particularly HIV prevention programs, may benefit by considering the sources and quality of social support in men's lives that are necessary to provide a compassionate, encouraging, and sustainable context for improving their well-being and for minimizing HIV risk.

In order to deepen our understanding of the role of social support in HIV risk among African American MSM, we conducted individual in-depth interviews to explore how African American men describe their sources of social support, how they psychologically respond to the relative presence or absence of social support, and how social support influences their sexual behaviors.

Methods

Participants

Thirty-four participants were recruited from an urban environment in the northeastern United States. Convenience sampling, based on targeted outreach to community venues and chain referrals, was used. Participants were sampled from a variety of sources including community-based organizations and institutions that serve African American and sexual minority populations, MSM-themed spaces (e.g., bars/nightclubs, bathhouses), and virtual/electronic media (e.g., chat rooms, message boards) that are frequented by the target population. Stratification according to demographic characteristics or other relational or psychosocial factors were not used as we were interested in examining the range of participants' experiences.

Men were eligible to be in this study if they were 18 years of age or older, self-identified as Black or African American, and engaged in anal sex with a man within the past 12 months. Sampling continued until we achieved data saturation for information related to our core research questions described below. Participant characteristics are presented in Table 1.

Procedure

Participants interested in the study contacted the study staff by telephone for more detail. All men who expressed interest in the study were screened for eligibility; those who passed

screening were scheduled for an in-person interview to confirm eligibility. One individual who contacted the study and met eligibility criteria declined participation. All interviews were digitally recorded and took place in a private location. Interviews were conducted by a graduate student with prior training and experience in qualitative research methods, including conducting individual interviews and focus groups with disadvantaged populations. Participants were provided with a verbal and written overview of the study and informed consent was obtained. All participants were encouraged to use pseudonyms to protect their identity. During eligibility screening, the interviewer informed potential participants of general topic areas to be covered and that interviews would be recorded, at which point they were able to decline involvement in the study. This study was approved by the Institutional Review Boards of [removed for blinding].

The interview guide was semi-structured, with open-ended questions to loosely guide participant narratives, allowing their narratives to unfold naturally. Participants were given a priori definitions of key constructs, such as social support and high-risk behaviors. Each interview began with an exploration of each participant's sexual and racial self-identification. The interviewer asked about the participants' sociodemograhpic characteristics including family composition, living conditions, employment, education level, and economic issues. Participants were asked to describe their sources of social support, psychological responses to the presence or absence of social support, and influences of social support on sexual behaviors.

Analysis

Analyses of participants' experiences were guided by three general questions: (i) What are their sources of social support?; (ii) How do they psychologically respond to the presence or absence of social support?; and (iii) What is the influence of social support on their sexual behaviors? Audio files were transcribed verbatim by a professional transcriptionist and reviewed by the interviewer to correct any errors or discrepancies. All transcripts were entered into a password-protected computer and two independent trained researchers coded all of the transcripts using *QSR NVivo 8*, a qualitative data management and analysis software program. The initial interview analyses involved standard qualitative techniques of analysis to identify major themes. Data analysis included open-coding, which identifies and categorizes themes recurrently present in transcripts, and axial coding, which re-examines these categorized themes to determine connections and relationships. We followed Braun and Clarke's (2006) six phases of thematic analysis: 1) becoming familiar with the data; 2) generating initial analysis codes across the data set and grouping each code data; 3) searching for themes by collating analysis codes into possible themes and gathering data that is relevant to each possible theme; 4) reviewing themes and creating a 'map' of the analysis; 5) defining and naming themes; and 6) producing an analysis report and selecting appropriate, vivid quotes in support of described themes.. In the few instances of coding discrepancies, coders re-examined the transcripts together, and discussed the possible thematic meanings associated with the text in question until a final code(s) was agreed upon.

Results

Sources of social support

Family support—The majority of participants described limitations in their ability to rely on family members for material and emotional support. Dominant narratives from participants revealed a pervasive sense of resignation regarding the willingness and capacity of family members to provide assistance, guidance, or advice:

> *"No, no, there was no one I could tell anything. I could never tell them* [family members] *anything, never." Jamar, 39 years old*

> "Believe it or not…I had no help from no one. And everything I had obtained…I had obtained on my own. No one helped me. Everything: clothes, apartment, car. No one gave me anything." Michael, 27 years old

While many of the men discussed a lack of social support from family members, it should also be noted that not all of them experienced limited social support or the absence of emotionally substantial relationships with family. A subset of them described parents/guardians as their "number one fan," which encouraged them to "reach for [their] potential," and "follow [their] dreams." These participants experienced more positive, encouraging relationships and support from family.

> "[My mother] used to always tell me, 'whatever it is you like…'. I always liked art and everything else that everyone else in the neighborhood didn't really like and I started to notice that I was a little different so to speak. Boys would come play with me and I would play with them and I wouldn't want them to leave. I want to play house with the boys and not just the girls and that's pretty much how I came to know that I liked my sexuality. And like I said, I had a supportive family so whichever direction I chose to go I knew that I would be accepted. And it's been like that with everything." Anthony, 22 years old

> "…the type of parents that if I tell them there's something I want to do, they know that I'm going to strive for it, go and try and do it to the best of my knowledge." Chris, 20 years old

The participants who described family support reflected on how family members held high expectations of them, encouraged their goals, and discussed specific plans on how to meet those goals.

> *"I feel that my family is really proud of me and supportive of me. I've always been a hard worker, so as long as I'm doing something, they're okay with it. If I was sitting around the house all day smoking weed, then that would be a different story…*[My family] *expects that I graduate well. They don't really bug me. 'Cause we already talked about what my future plans are and that I make sure that I work towards meeting my goals." Donovan, 21 years old*

Thus, we observed some variability in participants' descriptions of family support. A smaller subset of participants described supportive family backgrounds, which facilitated

participants' abilities to think highly of themselves and to anticipate goals for the future. However, the majority of men described non-supportive family backgrounds.

Peer support—Participants also discussed the lack of supportive peers in whom they could confide and rely upon. Central themes shared by most participants revealed few close friendships and an absence of emotionally intimate relationships with sexual partners. Participants described how lifetime experiences of low social support, frequently beginning in early family contexts, led to on-going feelings of social isolation, alienation, and the anticipation of rejection by others. As one participant stated, "I rely on myself a lot. I do what I need to do for myself," and this self-reliance was largely related to a belief that others would ultimately "let [him] down." Participants articulated several reasons for having few close relationships:

> "Whatever I need, like as far as clothing, food, housing, I do on my own. I don't, I don't ask anybody for anything…because, like I said, people can throw things in your face… I can't really rely on the people that I know because they'll tell you one thing and do another. And I learned that years ago." Nelson, 20 years old

> "I don't really associate with anybody. I just stay to myself. I just don't really feel like sharing myself with other people or sharing my time with others." Charles, 26 years old

Psychological responses to the presence or absence of social support

Many men in this sample perceived that family members provided little to no encouragement for their personal or professional success, and frequently were critical of their desire for success and skeptical of their personal goals. For example, one participant who was in his early 20s recalled how family members were dismissive about him completing a Certified Nursing Assistant course. He described that family members listed the multiple potential obstacles that would prevent him from attending or completing the course, including a perceived lack of intelligence, low likelihood of finding employment as a nursing assistant, and lack of transportation to and from class. He explained the psychological effects of the lack of support and encouragement from his family members:

> "I ended up quitting because, well, I quit, went to Boston, came back… I ended up quitting because I got depressed. I didn't want to be around anybody…I'm trying to build and people in my life are trying to tear down what I'm trying to build. It was just, I just got totally depressed… No one was being supportive [of] me being successful in life. Period. They just thought negative shit about me and was trying to stop me from progressing, and trying to change me instead of trying to understand me, and make me do what they want, instead of letting me be me." Michael, 27 years old

Another young man, who was raised in a family in which most members did not graduate from high school, similarly described how his mother set low expectations and actually expected him to fail:

> "[My mother] would always want to see someone do bad instead of seeing them do good, and she told me I wasn't going to graduate high school…but I did. I

> graduated high school, and when I did, I brought my cap and gown and I fucking bought a ticket for her and I mailed it to her, and I said 'Oh congratulations, but by the way I'm graduating, you're invited.' She didn't even come." Nelson, 20 years old

Participants described how limited family support contributed to feelings of depression. For instance, one young participant recalled how his mother's gambling addiction rendered her unable to help him in his college application process, which contributed to a sense of hopelessness in pursuing his goals:

> "One of the things that sent me into the depression that made me want to send myself to the hospital was when I found out that my mother gambled heavily and that she spent all her earnings on gambling… After that happened, I sort of didn't care about anything and felt very depressed, mainly because I felt that she didn't care about me. 'Cause when I asked her why it seemed like we had a lot of money but she couldn't afford to send me to school, she avoided the topic and I could tell that she was so wrapped up in her gambling that she didn't have enough concern for me to give me the information that I needed, which is why I had to steal it. So that made me depressed. I felt abandoned" Robert, 19 years old

Here, another participant who described his mother as being continually "aloof" reflects on how her lack of support affected his life:

> "*I don't know, I feel like there's some security in what you wanna do when you're still at home, but you still have the parents there to talk about it and I think a lot of it has to do with like if your parents talk to you about stuff, too, but my mother never really did and so I had to just learn everything by myself…that has had a huge influence on my life, it's made me feel like shit for most of my life." Victor, 20 years old*

Influences of social support on sexual behaviors

In the context of feelings of isolation and alienation due to a lack of social support, many participants described a heightened need for intimate physical contact and sexual gratification. They explained how seeking sexual partnerships in convenient and anonymous venues could satisfy immediate needs for intimacy:

> "It was my birthday and I was on my bed. I felt really alone. [Birthdays] should be fun but I was just by myself…I ended up going to a [sex party] because I wanted affection…and to spend my birthday with somebody. I hooked up with someone and for a little bit it made me feel okay… yeah, good." Curtis, 34 years old

Seeking physical intimacy often meant using online sex websites, having casual sex partners, or patronizing bars, clubs, bathhouses, or street locations where sex partners could be easily found:

> "I went on one of those dating websites, found someone that seemed alright, and messaged him. I don't know… I guess, I don't know, I hadn't felt anything good for anyone in so long. I just wanted to feel something, feel someone, and this was

> wham bam. No questions asked, know what I mean? I don't have to take him out for a date and do all that. We both knew what was up." Daniel, 27 years old

These partner-seeking interactions frequently culminated in many of the participants engaging in condomless anal sex with men who they had just recently met, despite having knowledge of the risk for HIV and STI transmission and knowledge about safer sexual practices. Often these unprotected sex episodes occurred while under the influence of alcohol or drugs, which allowed participants to feel more sexually uninhibited and enhanced sexual performance:

> "I just needed sex, so in order to allow myself to have sex with this person was to drink…. I just wanted to be penetrated." Anthony, 22 years old

> "We were sniffing this thing, poppers. Yeah, I gotta get away from that, because all my inhibitions just go. All my fear about HIV, it all goes when I sniff it. When I'm with him it's like I don't care, and this other guy brings poppers and it's like I'm not thinking clearly when I'm doing it." Raymond, 44 years old

Notably, participants with strong social support networks also described having unprotected sex, but these unprotected episodes more frequently occurred in the context of established partnerships – i.e., with partners whom they had dated previously, with boyfriends, etc. Participants with stronger social support networks frequently described meeting partners through friendship networks, at house parties, or on internet dating and social media network websites where they could establish deeper, more intimate relationships. These potential differences in partner selection opportunities may contribute to different opportunities for safer sex negotiation. For example, more prolonged in-person or online conversations may allow for better communication between prospective partners regarding relationship potential, HIV status, and condom use, whereas individuals meeting at anonymous sex websites or bathhouses may be more prone to immediate, spontaneous, and potentially higher risk behaviors. One man who had a very limited peer network described frequenting an internet 'hook-up' site for meeting partners:

> *"I was on my internet and there's a website called* [omitted]*, and it's a gay male website. I just went on there 'cause I was lonely and hadn't had a relationship in a long time, and like I said, depressed. I don't know, I felt really mentally sick… so I went on this website and I met this guy and we got drunk and…" Anthony, 22 years old*

Participants with lifetime experiences of limited social support networks were also likely to describe having multiple concurrent sexual partners. One participant who described being "ostracized by [his] family" and having "few friends" described a connection between his approach to anonymous sexual encounters and a fear of interpersonal intimacy and anticipatory rejection:

> "I'm in several relationships at all times. It's not a nice thing, it's just the way I protect myself because I feel like if I, I've tried being with just one person, and I always got devastated, so I just figured like if I see a few people, it's fine, as long as… if I don't really put any real, all love into it… I'll be safe like that." Raymond, 44 years old

Thus, participants' narratives revealed potential interconnections between the quality of personal relationships and their sexual risk-related behaviors. Specifically, participants who lacked socially and emotionally fulfilling relationships expressed feelings of depression, loneliness, isolation and an anticipation of future rejection. These psychological factors formed a context for the need for immediate positive gratification, which often took the form of substance use and sexual intercourse.

Participants also described a strong general desire for deeper emotional connections and to be loved and appreciated by others. Here, two participants stated the reasons underlying their need to emotionally connect with others:

> "I needed love. I needed affection. I just needed to feel safe, [someone] to say 'you're doing a good job.' You know, for someone to see my worth." Michael, 27 years old

> "Even if we don't have any sex, what makes me feel good, if I can, someone that I know, we hang out, watch TV, just to lay in the bed together and talk. Nothing else going on, I'm happy with that." Terrence, 43 years old

However, in keeping with their description of having weak relationships with family, friends, and intimate partners, many participants in this study expressed difficulty trusting others. One participant recalled how the experience of informing family members of his childhood molestation was met with derision and contributed to his inability to trust others:

> "I saw the reaction I got when I said somebody was touching me, instead of being like who's touching my little brother, they were like 'you little faggot,' and I was just like wow, these are really my relatives? Am I really a part of them? I can't trust nobody." Raymond, 44 years old

Participants who recalled difficulties trusting others also described the tendency to avoid entering close intimate partnerships and forming friendships. Many participants echoed one man's characterization of close relationships as being "more trouble than it's worth." This participant reflected on the unfulfilling nature of his peer networks:

> "I have no friends…[it's] too complicated. I've been screwed over a lot. The friends that I had…it takes for you to get older to realize that they're not your friends, they're your boys…and you've known them for 10 years and if you don't want to do [something illegal] they start saying 'what are you, scared now?' I'd rather just be by myself." Andrew, 38 years old

Many participants in this sample reported believing that they would inevitably be hurt by friends, partners, and family. These expectations may challenge participants' ability to attain the type of emotional connection they desired, and thereby may have contributed to a cycle of isolation. For example, one participant reflected on frustrations related to his desire to be emotionally connected with a sexual partner:

> "Because when, having sex for me, it's always been, when I'm doing it, I always feel like I'm always observing it. Not really, you know how people give themselves over to their passion, they're like having passion… I've never been able to just do that. And then I'm doing this because I'm scared, or I'm doing this because I'm

> angry. I've never had that connection. It's hard for me to connect. I'm just afraid to let anyone get too close, and I'm afraid to get too, I'm afraid to get too close to anybody." Lester, 41 years old

Participants described how the fear of emotional connection prevented them from entering into stable partnerships, exacerbated their needs for emotional intimacy, and encouraged them to have unprotected and anonymous sexual encounters to provide immediate yet temporary intimacy. One respondent recalled his desire for a meaningful emotional relationship led him to seek out an anonymous sexual partner:

> "I was lonely, horny. In my head I wanted a relationship. I wasn't looking for a relationship with this particular person. I felt lonely, not in a sad, depressed way, but I just wanted to be intimate with someone." Robert, 19 years old

Several participants also commented on the aftermath of a relationship break-up. One individual described how the emotional pain resulting from the recent end of a long-term relationship led him to engage in unprotected sex with an anonymous partner:

> "Because I just felt so numb from the crying and anger and pain, and I went online and met this guy and it was pretty much a hook-up and we both didn't have condoms and I don't know why I did it, but I was like you know what, fuck it, I don't care, I trust you, just let's get this over with, and it was, it was sex, just to have sex, and actually no it wasn't sex just to have sex, it was sex to just to be human for five minutes." Alex, 29 years old

Discussion

This paper explored the social support systems available to participants in this sample of African American MSM and examined how levels of social support are implicated in their sexual risk-related behaviors. The majority of men in this sample revealed emotional and psychosocial vulnerability due to limited family and peer support networks. We observed that participants who described having weak social and emotional support tended to also engage in potentially high-risk behaviors, such as unprotected anal sex and prioritizing immediate sexual gratification over sexual safety. We also observed that participants who described having strong social support systems found sex partners through their social networks and in venues geared toward establishing longer relationships, and participants who described having weak emotional support frequently found sex partners through anonymous venues that catered to finding "no-strings-attached" sex partners. While the former does not inherently confer safety and the latter does not inherently confer risk for HIV transmission, previous studies have found associations between anonymous partnerships and unprotected sex (Klein 2012). Regardless of the duration and type of relationship with one's sexual partners, this analysis underscores the social and psychological context that might influence engagement in condomless anal sex among African American MSM. Participants were also asked about how their sexual orientation/sexual behavior might have impacted their social support from family and peers, however, none of the participants discussed this within the context of experiencing stigma. Behavioral interventions have recently been developed and implemented to support an empowered, agentic, and health-promoting approach to addressing risky sexual behaviors (e.g.,

condomless receptive and insertive anal intercourse) in this population (Koblin et al. 2012, Kurtz et al. 2013). Both of these interventions found that providing supportive environments (mainly through interactions with research staff or others involved in the study) helped African American MSM reduce their engagement in risky sexual behaviors. This is consistent with our findings that suggest social support from family members and peers influences the type and quality of intimate relationships for African American MSM, which in turn impacts their sexual behaviors.

Findings presented here illuminate theoretical models on the association between exposure to social stressors and psychological and physical health problems among members of disadvantaged groups (Pearlin et al. 2005, Meyer 2003, Williams, Neighbors, and Jackson 2003, Poundstone, Strathdee, and Celentano 2004). For some men, the lack of social and emotional support in their family and peer communities may have contributed to a desire to be emotionally connected to others, while for others it may have contributed to difficulty in trusting and skepticism in forming stable relationships with others, suggesting a potential for psychological and behavioral risks. In the context of having problematic histories of social support, many participants appeared to have developed strategies to prevent themselves from being hurt by others, while still fulfilling their need for physical intimacy. These strategies included forming few friendships, setting low interpersonal expectations, and avoiding meaningful and emotionally intimate sexual partnerships as a way to circumvent feeling psychologically vulnerable. These emotionally protective strategies can potentially increase risk for HIV and STIs, and can further exacerbate feelings of isolation by obstructing opportunities for deeper levels of intimacy. In this way, it is interesting to note that the lack of support could be viewed as both a risk and protective factor for HIV transmission. For instance, some men who have low levels of social support may be at risk for increased psychological vulnerability. At the same time, some men who may recognize existing relationships/networks as harmful might remove themselves from these relationships/networks, which could be viewed as a type of resiliency or protective factor.

Cultural beliefs of sexuality and masculinity may have informed the social support available to participants in this study. Current notions of African American sexuality and masculinity are a consequence of the historical legacy of slavery and racism that mold gender-role expectations and beliefs of masculinity (Bowleg 2004, Cazenave 1984, Collins 2005, Jackson 2006). African American male bodies came to be defined as hypersexual and hyper-masculine and characterized by corporeal and sexual prowess (Hodes 1993, Hunter and Davis 1992, Whitehead 1997, Ferber 2007). Theorists suggest that these beliefs have been internalized as an accepted standard of African American masculinity, leading same sex behaviors to be viewed as inconsistent with such beliefs (Jackson 2006, Woodyard, Peterson, and Stokes 2000). This may help to explain the limited support described by some participants, and underscores the ways in which the social construction of masculinity may interact with the lack of social support provided to African American MSM who do not conform to traditional definitions of African American masculinity.. This is particularly important in light of evidence that demonstrates that higher levels of support are associated with reduced sexual risk behaviors and increased HIV testing rates (Wohl et al. 2010, Lauby et al. 2012, Schneider, Michaels, and Bouris 2012).

Linkages between social support and sexual risk-related behaviors among men in this sample may be influenced by their racial and largely lower socioeconomic circumstances. For African American MSM, the withdrawal of social support can accentuate feelings of alienation, stress, and psychological distress associated with living in a racist society. In the face of difficult socioeconomic circumstances, more basic needs such as securing food and clothing may tend to be prioritized over longer-term sexual health promotion goals. For instance, one study examined the health priorities of low-income residents in urban Washington D.C., and found immediate concerns such as access to health care and housing were prioritized over health behavior promotion (Danis et al. 2010). Further research and analysis into the cumulative life experiences of African American MSM can provide enhanced understanding of the role of financial and material resources in promoting sexual health.

Several limitations to this paper must be considered. First, this qualitative analysis relied on participant's personal experiences, which might be affected by recall or self-presentational demands. Second, the interview protocol may have biased study participants to share mostly negative narratives; however, all efforts were made to avoid doing this and it is meaningful to observe that some participants reported mostly positive or optimistic experiences. Third, due to the use of qualitative interview methodology, we cannot draw inferences about quantitative effects or causal directions and pathways. However, this study's results does seem to support the idea that to examine the relationship between social support and HIV risk among African American MSM, social support may be better conceptualized as a mediator in mediation analyses rather than through moderation analyses. Fourth, findings must also be interpreted with caution due to limitations in generalizability and the non-representative nature of the sample. In particular, there is a potential bias in recruitment of men from MSM-themed bars, clubs, and online locations, as men who access these venues may be different from men who do not frequent these venues. Finally, we recognize that African American culture is not static or monolithic, and we caution against any interpretation that the patterns described by participants in this study are fixed or intrinsic to African American communities.

Findings have important implications for HIV prevention strategies. Many researchers have criticized studies in the HIV prevention literature that measure individual-level risk behaviors in African American MSM but do not include sociocultural and psychosocial factors (Malebranche 2003, Mays, Cochran, and Zamudio 2004, Millett et al. 2006). Our findings support this argument, indicating that stronger consideration of the holistic well-being and sources of family and/or peer social support available to African American MSM is needed in the HIV prevention literature. Specifically, HIV prevention strategies for African American MSM must better address emotional health and expectations about intimate relationships in order to understand the motivations and contexts for these men's sexual behaviors.

Findings also highlighted a need for programs that can address challenges in forming intimate relationships and maintaining satisfying partnerships. Many men expressed the desire for stable, long-term partnerships but lacked opportunities to form these relationships. However, we are cautious about the interpretation that, from a health promotion perspective,

casual or anonymous sexual encounters should be universally discouraged in favor of promoting stable, long-term partnerships. This is especially important given the high frequency of condomless anal sex and possible HIV transmission within the context of established relationships noted in the extant literature (Mustanski et al. 2012). Sexual partnerships and behaviors are motivated by a myriad of factors, and we are hesitant to promote any singular or simplistic approach to HIV prevention and sexual health promotion. However, we argue that individuals must be educated and empowered to make decisions that meet their relational and psychological needs, satisfy their sexual desires, and optimize their long-term health. These are not incompatible objectives.

This research calls for more complex programmatic approaches to HIV prevention for African American MSM which go beyond condom usage, safer sex information, and HIV testing. In light of the multiple factors that can contribute to HIV risk in African American MSM, multi-component interventions that provide a “menu” of options might be especially useful. Interventions that span levels of analysis - including structural, community, individual, and biological factors - are needed to address the complex layers of HIV risk described here and elsewhere (Malebranche 2003, Mays, Cochran, and Zamudio 2004). It must be acknowledged, however, that the majority of validated HIV prevention interventions are brief in duration and generally focus on the individual alone rather than on the individual’s social, psychological, and environmental context. We also acknowledge that community-based organizations and HIV prevention providers are limited in their capacity to provide more in-depth psychological counseling to high-risk MSM clients, due to staffing, resources, time, and funding. Establishing linkages between HIV prevention educators, HIV/STI testing services, clinical treatment and care providers, and culturally sensitive psychological counseling may offer a useful “bundle” of complementary yet necessary strategies for reducing the burden of HIV infections in African American MSM.

References

Allgower A, Wardle J, Steptoe A. Depressive symptoms, social support, and personal health behaviors in young men and women. Health Psychol. 2001; 20(3):223–227. [PubMed: 11403220]

Ayala G, Bingham T, Kim J, Wheeler DP, Millett GA. Modeling the impact of social discrimination and financial hardship on the sexual risk of HIV among Latino and Black men who have sex with men. Am J Public Health. 2012; 102(Suppl 2):S242–S249. [PubMed: 22401516]

Berkel C, Murry VM, Hurt TR, Chen YF, Brody GH, Simons RL, Cutrona C, Gibbons FX. It takes a village: protecting rural African American youth in the context of racism. J Youth Adolesc. 2009; 38(2):175–188. [PubMed: 19636716]

Bounds-Littlefield M. The Black church and community development and self-help: The next phase of social equality. The Western Journal of Black Studies. 29:687–693.

Bowleg L. Love, sex, and masculinity in sociocultural context: HIV concerns and condom use among African American men in heterosexual relationships. Men and Masculinities. 2004; 7(2):166–186.

Brooks RA, Etzel MA, Hinojos E, Henry CL, Perez M. Preventing HIV among Latino and African American gay and bisexual men in a context of HIV-related stigma, discrimination, and homophobia: perspectives of providers. AIDS Patient Care STDS. 2005; 19(11):737–744. [PubMed: 16283834]

Cazenave N. Race, socioeconomic status, and age: The social context of American masculinity. Sex Roles. 1984; 11(7/8):639–656.

Centers for Disease Control and Prevention. CDC Fact Sheet: HIV Among African Americans. 2014. http://www.cdc.gov/nchhstp/newsroom/docs/CDC-HIV-AA-508.pdf

Cohen S, Wills TA. Stress, social support, and the buffering hypothesis. Psychol Bull. 1985; 98(2): 310–357. [PubMed: 3901065]

Collins, P. Black sexual politics: African Americans, gender, and the new racism. New York: Routledge; 2005.

Danis M, Kotwani N, Garrett J, Rivera I, Davies-Cole J, Carter-Nolan P. Priorities of low-income urban residents for interventions to address the socio-economic determinants of health. J Health Care Poor Underserved. 2010; 21(4):1318–1339. [PubMed: 21099082]

Dixon D, Cruess S, Kilbourn K, Klimas N, Fletcher MA, Ironson G, Baum A, Schneiderman N, Antoni MH. Social Support Mediates Loneliness and Human Herpesvirus Type 6 (HHV-6) Antibody Titers. J Appl Soc Psychol. 2006; 31(6):1111–1132. [PubMed: 20407593]

Ellison CG, Musick MA, Henderson AK. Balm in Giilead: Racism, religious involvement, and psychological distress among African-American adults. Journal for the Scientific Study of Religion. 2008; 47:291–309.

Feagin, JR.; McKinney, K. The many costs of racism. Lanham, MD: Rowman and Littlefield; 2003.

Ferber A. The construction of Black masculinity: White supremacy now and then. Journal of Sport and Social Issues. 2007; 31(1):11–24.

Hodes M. The sexualization of reconstruction politics: White women and Black men in the south after the civil war. Journal of the History of Sexuality. 1993; 3(3):327–348.

Hunter AG, Davis JE. Tearoom trade: Impersonal sex in public places. Gender & Society. 1992; 6(3): 464–479.

Jackson, R. Scripting the Black masculine body: identity, discourse, and racial politics in popular media. Albany, NY: State University of New York Press; 2006.

Jarrett RL, Jefferson SR, Kelly JN. Finding community in family: Neighborhood effects and African American kin networks. Journal of Comparative Family Studies. 2010; 21:299–328.

Klein H. Anonymous sex and HIV risk practices among men using the Internet specifically to find male partners for unprotected sex. Public Health. 2012; 126(6):471–481. [PubMed: 22559946]

Koblin BA, Bonner S, Powell B, Metralexis P, Egan JE, Patterson J, Xu G, Hoover DR, Goodman K, Chin J, Tieu HV, Spikes PA. A randomized trial of a behavioral intervention for black MSM: the DiSH study. AIDS. 2012; 26(4):483–488. [PubMed: 22156967]

Kurtz SP, Stall RD, Buttram ME, Surratt HL, Chen MA. Randomized trial of a behavioral intervention for high risk substance-using MSM. AIDS Behav. 2013; 17(9):2914–2926. [PubMed: 23732957]

Lauby, JenniferL; Marks, Gary; Bingham, Trista; Liu, Kai-Lih; Liau, Adrian; Stueve, Ann; Millett, GregorioA. Having Supportive Social Relationships is Associated with Reduced Risk of Unrecognized HIV Infection Among Black and Latino Men who Have Sex with Men. AIDS Behav. 2012; 16(3):508–515. [PubMed: 21805191]

Malebranche DJ. Black men who have sex with men and the HIV epidemic: next steps for public health. Am J Public Health. 2003; 93(6):862–865. [PubMed: 12773340]

Mays VM, Cochran SD, Zamudio A. HIV Prevention Research: Are We Meeting the Needs of African American Men Who Have Sex With Men? J Black Psychol. 2004; 30(1):78–105. [PubMed: 20041036]

Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychological Bulletin. 2003; 129(5):674–697. [PubMed: 12956539]

Millett GA, Peterson JL, Flores SA, Hart TA, th Jeffries WL, Wilson PA, Rourke SB, Heilig CM, Elford J, Fenton KA, Remis RS. Comparisons of disparities and risks of HIV infection in black and other men who have sex with men in Canada, UK, and USA: a meta-analysis. Lancet. 2012; 380(9839):341–348. [PubMed: 22819656]

Millett GA, Peterson JL, Wolitski RJ, Stall R. Greater risk for HIV infection of black men who have sex with men: a critical literature review. Am J Public Health. 2006; 96(6):1007–1019. [PubMed: 16670223]

Moak ZB, Agrawal A. The association between perceived interpersonal social support and physical and mental health: results from the National Epidemiological Survey on Alcohol and Related Conditions. J Public Health (Oxf). 2010; 32(2):191–201. [PubMed: 19864495]

Nott KH, Vedhara K, Power MJ. The role of social support in HIV infection. Psychol Med. 1995; 25(5):971–983. [PubMed: 8588016]

O'Brien Caughy M, Murray Nettles S, Lima J. Profiles of racial socialization among African American parents: Correlates, context, and outcome. Journal of Child and Family Studies. 2011; 20:491–502.

Patillo-McCoy M. Church culture as a strategy of action in the Black community. American Sociological Review. 1998; 63:767–784.

Pearlin LI, Schieman S, Fazio EM, Meersman SC. Stress, health, and the life course: some conceptual perspectives. J Health Soc Behav. 2005; 46(2):205–219. [PubMed: 16028458]

Penninx BW, van Tilburg T, Boeke AJ, Deeg DJ, Kriegsman DM, van Eijk JT. Effects of social support and personal coping resources on depressive symptoms: different for various chronic diseases? Health Psychol. 1998; 17(6):551–558. [PubMed: 9848806]

Poundstone KE, Strathdee SA, Celentano DD. The social epidemiology of human immunodeficiency virus/acquired immunodeficiency syndrome. Epidemiol Rev. 2004; 26:22–35. [PubMed: 15234945]

Sarkisian N, Gerstel N. Kin support among Blacks and Whites: Race and family organization. American Sociological Review. 2004; 69:812–837.

Schneider J, Michaels S, Bouris A. Family network proportion and HIV risk among black men who have sex with men. J Acquir Immune Defic Syndr. 2012; 61(5):627–635. [PubMed: 23011395]

Singer MC, Erickson PI, Badiane L, Diaz R, Ortiz D, Abraham T, Nicolaysen AM. Syndemics, sex and the city: understanding sexually transmitted diseases in social and cultural context. Social Science & Medicine. 2006; 63(8):2010–2021. [PubMed: 16782250]

Tate DC, van den Berg JJ, Hansen NB, Kochman AA, Sikkema KJ. Race, social support, and coping strategies among HIV-positive gay and bisexual men. Culture, Health, and Sexuality. 2006; 8:235–249.

The White House office of National AIDS Policy. National HIV/AIDS Strategy for the United States. 2010

Thoits PA. Stress, coping, and social support processes: where are we? What next? J Health Soc Behav. 1995:53–79. Spec No. [PubMed: 7560850]

Uchino BN, Cacioppo JT, Kiecolt-Glaser JK. The relationship between social support and physiological processes: a review with emphasis on underlying mechanisms and implications for health. Psychol Bull. 1996; 119(3):488–531. [PubMed: 8668748]

Waldo CR, Coates TJ. Multiple levels of analysis and intervention in HIV prevention science: exemplars and directions for new research. AIDS. 2000; 14(Suppl 2):S18–S26. [PubMed: 11061638]

Whitehead TL. Urban low-income African American men, HIV/AIDS, and gender identity. Med Anthropol Q. 1997; 11(4):411–447. [PubMed: 9408898]

Williams DR, Neighbors HW, Jackson JS. Racial/ethnic discrimination and health: findings from community studies. Am J Public Health. 2003; 93(2):200–208. [PubMed: 12554570]

Wilton L, Herbst JH, Coury-Doniger P, Painter TM, English G, Alvarez ME, Scahill M, Roberson MA, Lucas B, Johnson WD, Carey JW. Efficacy of an HIV/STI prevention intervention for black men who have sex with men: findings from the Many Men, Many Voices (3MV) project. AIDS Behav. 2009; 13(3):532–544. [PubMed: 19267264]

Wohl AR, Galvan FH, Myers HF, Garland W, George S, Witt M, Cadden J, Operskalski E, Jordan W, Carpio F. Social support, stress and social network characteristics among HIV-positive Latino and African American women and men who have sex with men. AIDS Behav. 2010; 14(5):1149–1158. [PubMed: 20107888]

Wong CF, Schrager SM, Holloway IW, Meyer IH, Kipke MD. Minority stress experiences and psychological well-being: the impact of support from and connection to social networks within the Los Angeles House and Ball communities. Prev Sci. 2014; 15(1):44–55. [PubMed: 23412944]

Woodyard J, Peterson J, Stokes JP. "Let us go into the house of the Lord": Participation in African American churches among young African American men who have sex wtih men. Journal of Pastoral Care. 2000; 54(4):451–460. [PubMed: 11190999]

Table 1

Characteristics of study participants (n=34)

Variable	n	%
Sexual Orientation		
Gay	26	76
Bisexual	6	18
Prefer to not categorize	2	6
Age		
18–24 years	13	38
25–34 years	9	26
≥ 35 years	12	35
Sexual Partner History		
Sex with men only	24	71
Sex with men and women	10	29
Highest Education Level		
Did not complete high school	7	21
In high school	1	3
Completed high school	6	18
Earned GED	4	12
In college	7	21
Some college	5	15
Completed College	3	9
Graduate/Professional studies	1	3
Employment		
Unemployed	19	56
Employed	15	44
History of Incarceration		
No previous incarceration	22	65
Previous incarceration	12	35
Sex Work		
No previous sex work	19	56
Previous or current sex work	15	44
Self-reported HIV Status		
Positive	7	21
Negative	27	79