An Exploration of the Down-Low Identity: Nongay-Identified Young African-American Men Who Have Sex with Men

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The Centers for Disease Control and Prevention urges that strategies are needed to increase the proportion of young men who have sex with men (MSM) who are linked to primary care and prevention services.[1] One subgroup of young men engaging in male-male sex, those that do not identify as gay, may be less likely to be reached by prevention and intervention services that are aimed at the broader MSM community.[2] Additionally, nongay-identified young men engaging in male-male sex may have risk-reduction needs that are different from those that identify as gay. At present, very little is known about this subgroup of men. This study qualitatively interviewed six nongay-identified young men engaging in male-male sex about their sexual identity, their relationships with both men and women, their perceptions of their own sexual risk behavior and their comfort in accessing primary care services. The information gathered in these interviews can be used to increase the understanding of this understudied population while improving prevention and primary care services aimed at these youth.

Key words: MSM ■ down-low ■ nongay-identified men ■ sexual risk

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INTRODUCTION

Young men from minority communities who practice same-sex activity often do not declare their sexuality because of stigmas that continue to surround homosexuality. Researchers addressing sexual activity and health risk behavior often do so using established paradigms of sexuality. For example, one study of HIV surveillance and prevention in an African-American community concluded that covert and unprotected sex among "bisexually active black men" (not black men who identify bisexually) was commonplace for reasons that included prostitution, habituation to same-sex relations during incarceration and the desire to maintain a facade of heterosexuality in homophobic communities. It was concluded that "bisexual activity is highly correlated with secrecy and unprotected sex. The risks of bisexuality among black men are exacerbated by incarceration, homophobia, drug use, and the prison and public health focus on surveillance rather than prevention".[3] However, young men from communities of color are creating their own paradigms of sexuality that must be considered when developing strategies for improved health outcomes of these youth. Some young African-American men are identifying as being "on the down-low."

Young black and Latino men engaging in male-male sex as an exposure category now account for most young men who have sex with men (MSM) with AIDS. Trends in AIDS incidence indicate that levels of HIV infection have remained persistently high in certain populations of young MSM, underscoring the immense need for HIV prevention programs targeted specifically toward these young men.[4] The term "...MSM is a descriptive umbrella that includes all men of various identities and social contexts who engage in sexual behavior with other men."[5] Data from the Centers for Disease Control and Prevention (CDC) highlight the disparity of HIV rates among young men from communities of color compared to whites. In a sample of 23,680 MSM (1996–1998) reported by 25 states with HIV reporting, the proportion aged 13–24 years present-

ing with HIV was 59% race/ethnicity minority and 9% non-Hispanic white. Among MSM whose initial diagnosis was AIDS, the proportion aged 13–24 years was 18% race/ethnicity minority and 1% non-Hispanic white.[6] Hence, relatively more young men of color, as compared to Caucasian youth, are infected with HIV and present with more advanced disease. Further evidence that HIV disproportionately affects young men of color is a study of a national sample of men, ages 15–22 years old, who underwent a survey and testing for HIV in seven urban areas. An overall HIV seroprevalence of 7% was found among this sample of men (N=3,492); however, seroprevalence varied by race/ethnicity: 14% among African Americans, 7% among Latinos and 3% among Caucasians.[1] Of note is that among the cohort of HIV-infected young African-American men (n=150), 93% were unaware of their infection.[7]

Creating health promotion and HIV prevention programs at a time when no cure is presently available is of paramount importance for communities with high rates of morbidity and mortality among youth. Further, the CDC urges that strategies are needed to increase the proportion of young men engaging in male-male sex who are linked to appropriate primary care and prevention services.[1] One subgroup of MSM that may be at particular risk for HIV is nongay-identified MSM. This subgroup may be less likely to be reached by prevention messages and primary care services that are aimed at the broader MSM community.[2] Nongay-identified MSM (NGI-MSM) may have risk-reduction needs that are different from other MSM. At present, very little is known of this subgroup of men. This study was undertaken to begin to understand the subgroup of men engaging in male-male sex but who do not identify as gay. Some of these young men identify as being on the "on the down-low."

This study qualitatively interviewed nongay-identified young men engaging in male-male sex about their specific culture, their relationships with both men and women, perceptions of their sexual risk, and their knowledge of and comfort with accessing healthcare services. The collection of this information is necessary in order to improve prevention and primary care services for these youth. Additionally, the information gathered from these interviews will be used to increase understanding of the NGI-MSM community and informing future research projects about an underserved population.

METHOD

Research Participants

The participants were six young African-American men (mean age 21.5) who engage in sex with other men but do not identify as gay. Participants were recruited through a snowball sampling procedure, which is a purposive sampling technique that relies on previously interviewed participants to generate additional interview candidates from their social network.[8] All participants were recruited from 2002–2003 beginning from an initial contact with an HIV-infected young man receiving services at the CORE Center. The CORE Center is an outpatient medical facility that provides comprehensive services to individuals with HIV and other infectious diseases.

Procedures

Initial contact was made with a CORE Center youth who spoke openly about his relationships with DLs. This young man was approached by the investigators at the CORE Center who explained the study to him and inquired if he or his friends who self-identified as "down-low" would be interested in participating. All subsequent participants were enrolled in this study via the snowball sampling procedure, with one youth recruiting another youth leading a similar lifestyle of the DL. Participants were then responsible for contacting the investigators after hearing about the study, and an appointment then was made with them to meet with the investigator for more information. Participation in this study was strictly voluntary. During recruitment, confidentiality was strictly maintained for those who chose to participate as well as those who did not. Participants were not required to report their HIV status. Interviews were conducted with participants at a medical campus location, not at the CORE Center, to further ensure confidentiality.

Upon study enrollment, the investigators administered a survey questionnaire and conducted a semi-

Table 1. Descriptive variables of sexual behaviors of the DL cohort

Variable	Range	Mean	Standard Deviation
Age of participants	19–24	21.50	1.87
Years of school enrollment	11–15	13.00	1.55
Age (years) of coitarche (sexual debut)	9–19	13.83	4.22
Number of lifetime partners	18–300	94.67	116.49
Number of lifetime male partners	2–175	62	78.60

structured interview. All interviews were taped and transcribed. The transcriptions were reviewed by each investigator independently for common themes that surfaced during the structured interviews. The survey questionnaire assisted investigators in collecting information on demographic variables, attitudes about sex and condom use, sexual behaviors and sexual identity.

Study Variables

Demographics. Participants were asked about their age, ethnicity, education, employment status and medical treatment history, including HIV and STDs.

Self-Assessment of HIV/STD Risk. Participants were asked to answer the following question on a scale of 0–100%: "Compared to other young men like yourself, what are your chances of getting an STD?" Participants were then asked the same question but specific to HIV.

Sexual Partner Chart. Participants were asked to identify by initials their sexual partners over the past month, the gender of that partner and whether this was a primary, casual or anonymous partner. Participants were then asked about episodes of oral, vaginal, anal insertive and anal receptive sex with each partner and number of times condoms were used with each sexual encounter.

Sexual Sensation-Seeking Scale.[9] Participants completed this nine-item scale measuring the tendency to pursue high levels of sexual excitement and to engage in novel sexual experiences. Sample items include: "I like wild uninhibited sexual encounters", and "I have felt curious about having anal intercourse without a condom." This measure demonstrated internal reliability of 0.81 using Cronbach's alpha with our sample.

Sexual Identity Scale.[10] This questionnaire asks about sexual behavior during the present, the past and the ideal. Exploring many aspects of sexual orientation in addition to sexual behavior, the scale also includes sexual attraction, sexual fantasies, emotional preference, social preference, lifestyle preference and sexual identity. Participants rate their sexuality on a continuum from "exclusively other sex" to "exclusively same sex." This measure demonstrated internal reliability of 0.81 using Cronbach's alpha with our sample.

Perceived Social Support Index. Participants answered 14 items regarding their perception of their social support system over the past year. Sample items include: "In the past year, have you felt loved and wanted?" and "Have you felt as though you were part of a group of friends?" This scale demonstrated internal consistency (α=0.77) with our sample.

Semistructured Qualitative Interview. This segment of the study contained components of a qualitative interview as described by Spradley, including open-ended questions.[11] Patton suggests that using open-ended questions enables the researcher to understand and capture the perspective of the participants.[8] Thus, the semistructured interview questions were designed to explored the experiences and perspectives of the nongay-identified young men engaging in male-male sex. These questions explored the participants' sexual identity, their relationships with both men and women, how they meet new partners, patterns of sexual negotiation, condom use and their level of social support and sense of community.

Coding

The coding strategy utilized for these data is called "coding and retrieving." Coffey and Atkinson suggest that this is the procedure most often associated with coding as an analytic strategy.[12] Data are reduced into categories through a process of indexing the data texts of the interviews. Seidel and Kelle identify three operations which should be undertaken in a coding and retrieving strategy: 1) notice relevant phenomena, 2) collect examples of those phenomena, and 3) analyze those phenomena to find commonalities, differences, patterns and structures.[13] By following these operations, codes can be attached as a way of identifying and reordering data, which allows the data to be contemplated in new and interesting ways.[12]

The authors read each transcript in its entirety, and a coding scheme was generated to extract prominent themes from the abstract. The authors then reread each transcript and applied a theme to each text unit. A text unit was defined as one full response given by a respondent to the interviewer's question. Agreement between the authors was 93% for the text-coding scheme. An independent judge was then used to assess the reliability of the text-coding scheme that was based on themes identified by both authors independently. The judge was

Table 2. Sexual demographics of the DL cohort

	Frequency	Percent
Ever Have Sex for Money		
Yes	1	16.7
No	5	83.3
Ever Had a Sexually Transmitted Disease		
Yes	3	50
No	3	50
Ever Tested for HIV		
Yes	6	100
No	0	0
Ever Got Someone Pregnant		
Yes	1	16.7
No	5	83.3

informed regarding the definition and meaning of the thematic categories identified by the authors. Thirty percent of the total number of text units were rated, and an overall agreement of 95% was calculated between the authors and the judge.

RESULTS

Demographics

The participants were African-American males with a mean age of 21 (range 19–24) and most attained a high school diploma and some years of college coursework. The mean age of sexual debut was about 14 years, with an average of about 95 lifetime sexual partners, and an average of 62 male lifetime partners (Table 1). Sexual debut was asked as the first time you ever had sex (no reference to gender of partner or type of sexual act was specified). Note that five of six participants had never engaged in sex for money, only one of six reported getting a woman pregnant, three of six reported ever having an STD, and all reported having been tested for HIV (Table 2).

Definition of "Down-Low"

Participants were asked to define "on the down-low" and to describe their understanding of these labels. Some of these young men used the term "down-low" and "trade" interchangeably. The following are examples of responses in this category:

To this day, I'm still trying to figure out what that word means—"the trade". They call me that all the time. Someone told me it means a guy who is gay but he looks straight, a guy that's straight but he still messes with gay men. I don't know, I just don't like that word.

Trade is like this masculine person that sells drugs or is like the neighborhood macho guy. But when it's time to go in the house, they get down with other men.

While a bisexual person might be comfortable with who they are, a DL would strictly say, "No, I don't mess with men. I just mess with women." But actually they are messing with men and women.

Table 3. Total Klein sexuality score for each participant

Participant 1 = 1	Participant 4 = 3
Participant 2 = 1	Participant 5 = 2
Participant 3 = 3	Participant 6 = 2

0: exclusively heterosexual; 1: mostly heterosexual, infrequently homosexual; 2: often heterosexual, sometimes homosexual; 3: Equally heterosexual and homosexual; 4: often homosexual, sometimes heterosexual; 5: mostly homosexual, infrequently heterosexual; 6: exclusively homosexual

Rejection of labels. During the discussion of the "DL" or "trade" label, several participants voiced their dislike of these labels. The following are examples of these responses:

I'm not insecure with myself. I just don't consider myself to be gay. I don't like the label. I just feel like I do what I do.

I don't want somebody calling me that ["trade" or "DL"]. It just sounds disgusting. It sounds like I'm nasty or something.

I don't like any of them [labels] to be honest with you. I don't know what to call myself. I don't like "gay", I don't like "bisexual", and I don't like "straight". But I'll choose "straight" before any of the others.

Sexual Identity

All study participants self-identified themselves at the time of the interview as heterosexual. However, using Klein's Sexuality scale, participants' total scores ranged from mostly heterosexual to equally heterosexual and homosexual (Table 3). Participants were also asked to rate their sexual identity on each aspect of the Klein's Sexuality Variables for present sexual activity and for what their sexual behavior would be "in an ideal world". Overall, their present activity was consistent with equally heterosexual and homosexual, while ideally, these young men identify themselves as predominantly, if not exclusively, heterosexual (Table 4).

Several examples from the qualitative interviews support the data from the Klein scale. These examples highlight how a participant's current behavior is viewed as separate from their identity:

I don't speak of myself as being gay, because I'm not gay. I don't speak of myself as being bisexual, because I'm not bisexual. Now, if I choose to be with a male, then I choose to be with a male—but I'm not gay. I don't speak about being gay, and I don't intend to be gay. Actually, I don't even want to think about it—it's discouraging to me.

It's not that I try to hide it. This is just me. It's like what you do sexually should not reflect on who you are as a person.

Relationships with Men

Showing interest & reading cues. The participants were asked how they met other men and what cues were present to signal a mutual interest. Several of our participants reported meeting men on telephone party lines, while others described meeting

potential partners on a bus or train, or "on the street." The following responses are examples of cues that were identified by participants that signaled interest by or toward another man:

It's just certain things that they do to let you know that they will mess around with a male. It's hard to explain, but it's just easy for me to know because I've known so many males that are like that. Some people can probably just sense it. There's something about eye contact, I guess.

Well, with me, I kind of stare a lot. Like if we're at a party, I'll just be closer to him than I would a friend and I just look at him.

Some people are bold. One guy on the train just sat next to me and wrote me a note. So eventually I asked him why did he approach me, did I look gay or something? He said no, he just thought I was cute. I mean, for all he knew, I could have beat him up. Some people are just bold.

Negotiating sex. Participants were asked to discuss the process of negotiating sexual intercourse. All of the participants reported that the most important question was the other person's preference for either the "top" or "bottom" position. A "top" prefers to be the insertive partner, while a "bottom" prefers to be the receptive partner. Most of our participants initially defined themselves as "tops" but reported that they could be "versatile" depending on the characteristics of the sexual partner. The following responses are examples from this discussion:

Stereotypically, bottoms are very feminine and "switchy". I'm not "switchy". My voice isn't high-pitched like most bottoms are, and I'm not little.

Typically in the first conversation they'll tell me what they are. I'm very much an opportunist. Whatever you want, I'm the opposite. It doesn't matter to me. Sex is sex.

I don't want to be put into this role like I'm just a tight bitch boy or something. I don't like that. I feel like I'm a man the same as they are. It doesn't matter if I'm on top or bottom with you—I'm still a man when we get up, so don't treat me like that. I've never been an effeminate person so I don't expect to be treated like I'm some little lady ... I don't like being treated like that.

It's easier with men. The participants were asked to describe the differences that they experienced in seeking out sexual relationships with males versus females. Overall, participants reported that securing a sexual relationship was much easier with other males. The following responses highlight this distinction:

It's a billion times easier for me to get laid with guys than with girls. It's more difficult prey with girls, if you want to put it that way. The amount that I'm hit

Table 4. Klein sexuality variables: comparison of perceived present sexuality vs. ideal sexuality

	Variable	Range	Mean	Standard Deviation
P	Sexual Attraction	0–5	3.00	1.67
R	Sexual behavior	1–5	3.33	1.37
E	Sexual Fantasies	0–5	4.00	2.28
S	Emotional preference	0–3	2.33	2.42
E	Social Preference	0–5	2.50	1.76
N	Self Identification	0–5	2.33	1.97
T	Lifestyle	1–5	3.83	1.60
	Total		21.32/7=3.05	
	Sexual Attraction	0–4	1.17	1.83
I	Sexual behavior	0–5	2.17	2.14
D	Sexual Fantasies	0–5	2.17	2.48
E	Emotional preference	0–6	2.00	2.45
A	Social Preference	0–5	2.83	1.60
L	Self-Identification	0–3	1.17	1.33
	Lifestyle	0–4	2.33	1.51
	Total		13.84/7=1.98	

0: exclusively heterosexual; 1: mostly heterosexual, infrequently homosexual; 2: often heterosexual, sometimes homosexual; 3: Equally heterosexual and homosexual; 4: often homosexual, sometimes heterosexual; 5: mostly homosexual, infrequently heterosexual; 6: exclusively homosexual

on in the gay world is a thousand times more that I'm hit on in the straight world.

It is easier to meet males than females. Females don't realize that what he can get from you he can get from another male. You won't give him sex—he basically has to beg and scream and holler and buy you $800 worth of stuff. The only thing he's gotta do is casually ask this dude for sex, show him what he's working with, and the dude will lay down and give it to him. So, it's a lot easier [with men].

It's not hard to obtain what I want from men and it's not hard to be rid of it.

Relationships with Women

Traditional goals. Participants were asked how they met women and what their expectations were for those relationships. Our participants reported meeting women through family or friends as well through church and school. Whereas participants reported that their interest in men was predominantly sexual, their expectations for their relationships with women were different. The following responses are examples of such differences:

A woman who isn't quick to jump into sex. So, if you're not talking about sex, that's the furthest thing from your mind, that actually gets me more interested in you. I think, okay, that shows me that you have some class about yourself.

I'm a relationship-oriented person. My momma always said you need to be with somebody and you need to be with them forever. I've never been able to shake that out of my head. Even when I was in third grade I was looking for a girl.

I have faith I'm going to get married and all the other stuff with it. I just have to get myself together so the relationship will work.

Partner expectations. Participants often described their relationships with men as easier than their relationships with women. They described a desire to avoid what they perceived as gender role expectations in the relationships. The following responses are examples from this discussion:

It's the attitude. I think women have this whole "you need to do this" and "this is what I expect" attitude. But that's not the attitude that I have. So, normally that creates tension and every time we have a conversation about it, it doesn't get done because they expect for me to do it.

It's the whole "you're the man and I'm the woman." They got things for us to do. I guess it's passed on from person to person because I see the way my mom deals with her boyfriend—that's just the way.

Safer Sexual Behavior

Condom use. Participants were asked about their patterns of condom use with both male and female partners. During the interview, participants reported greater condom use with male partners than female partners. Examples of responses from this category follow:

Most women who I've ever messed with don't want to initiate them [condoms]. I've had a couple of females who were on birth control or whatever, so they didn't want to use condoms—that's how I got my first STD.

I just suggest it [condom use]. They [women] don't ever suggest it.

Some women, they're like: you don't have to use one [a condom]. So a lot of women that say you don't have to use one, they say it don't feel the same. But I always try to use one. I make it a priority.

[With males] It's like the first thing we talk about. I always let them know from the beginning that I will use condoms, even if we do have oral sex or anal sex, I always use condoms. I tell them if you don't have enough, I'll bring some.

Using the Sex Partner Chart, a proportion of condom use over the past month was calculated for oral, vaginal, anal receptive and anal insertive sexual intercourse. The average percentage of condom use for oral sex was 15%, vaginal sex was 100%, anal receptive sex was 91% and anal insertive sex was 78%. With the exception of oral sex, the rates of condom use appear to be relatively high. Additionally, condom use with vaginal sex over the past month was reported by all participants to be 100%, which is contrary to their reports of condom use with women from the interview.

Self-perception of risk. Participants were asked to identify their perception of their risk for HIV and other STDs compared to other men like themselves. Using a scale of 0–100%, participants were asked to rate their risk level. When asked what their chances of getting HIV were, the median response was 43% (range 30–100). When asked what their chances of getting an STD other than HIV were, the median response was 65% (range 20–80). Thus, when comparing their own sexual risk to that of their peers, the participants self-identified their risk as substantial.

Sexual sensation-seeking. Participants were asked to complete this questionnaire assessing their tendency to engage in high levels of sexual excitement. Potential scores on this scale range 9–36, with higher scores indicating higher levels of sexual sensation-seeking behaviors. The median score for this sample was 27, indicating a relatively high occurrence of sensation-seeking. For example, 83% of participants reported that they "liked to have wild and uninhibited sexual encounters." Sixty-seven percent of participants positively endorsed the item: "I have felt curious about having intercourse without a condom." Additionally, 83% of the participants positively endorsed: "I am interested in trying out new sexual experiences" and "I like new and exciting sexual experiences and sensations."

Sense of Community

Secrecy and social isolation. Participants were asked to discuss their sense of community and their social support systems. Most reported that their sexual lives were secret and they chose to keep them that way. The following examples illustrate this tendency toward secrecy:

Why did I keep it [the relationships with men] from her? I don't know. It was effective, at the time I really liked her and didn't want to hurt her, but sometimes she wasn't giving me what I was looking for. And sometimes I wanted to tell her, but at the time it wasn't realistic for me to tell anybody.

I kind of keep it separate. I tell the males that I do have sex with girls, but the women, I keep it secret.

They [DLs] usually interact in secret. You see guys pretending to be straight, and then when you get to the clubs, it's just all-out gay.

Some people aren't acknowledging the lifestyle that they live. It's mostly from the way they're raised as children or homophobic friends, or just the lifestyle. There's not much you can do about that—it would take therapy.

Participants were asked to answer several questionnaire items regarding their perceptions of their social support systems. Overall, participants reported feeling some level of loneliness in the past year. For example, 83% of participants reported that they "have felt all alone" in the past year. Additionally, 50% of the participants rarely "felt as though they were part of a group of friends," and 67% of the participants had at some time in the past year "felt that no one knew them very well." However, when asked specifically "if someone would be available to talk with you if you were upset, nervous or depressed", 83% of the participants reported having such support.

The gay community. Participants were asked to describe their comfort level and sense of belonging in the gay community. Responses were mixed with some participants feeling very comfortable within the gay community, while others felt that they didn't belong. Examples of these variations can be seen in the following responses:

No, we don't fit into the gay community, but a lot of people in the gay community want trades. That's who they want to be with. So it's like the whole community goes around seeing what trade they can get, what boys they can get, because a lot of people are not attracted to feminine people.

I could be down there [in the predominantly gay area of Chicago] and feel like I don't fit in. Everyone there is white, feminine, and a couple of times I've been there, and it's a whole different world. It's a trip there—it's just not something I do.

Actually, I feel more comfortable there [in the gay community] than I do in the heterosexual one. I don't have too many relationships with heterosexual men. I can't be friends with heterosexual men for some reason.

Seeking Healthcare

Participants were asked about their experiences in seeking healthcare. In particular, participants were asked about their comfort in disclosing their sexual behavior to their healthcare providers. Most participants reported that it is difficult to trust providers with that information and that only through the development of a trusting relationship with that provider would accurate information about sexual behaviors be revealed. The following responses are examples of the participants' hesitation with disclosure:

It's all about how comfortable you are with somebody. When you first meet them, you're not gonna say well, I had sex with a man. Because first I want to figure out how they are going to judge me. The way society is now, homosexuality may be accepted. But, if you know that I've tapped into homosexuality, you would judge me a certain way, so I've got to be comfortable with you ... it's kinda easy if you're comfortable with someone. So when you first meet someone, no [they won't disclose]—it's not until you break the ice with them that they'll actually tell you.

It's like the whole label thing—they [doctors] would even ask and I told them no, and they're my doctors. They were the people that I trusted, but it's the whole mental thing. I'd say no, no, I'm not having sex with men. I like women.

No, it's a structure that's not possible—because I've had sessions with my doctors, and they've asked me questions about being gay or DL or whatever ... I don't think anyone will ever understand it, but you should all be experts.

DISCUSSION

In the vocabulary of some African-American men engaging in same sex activity, "on the down-low" refers to having a girlfriend but secretly continuing to have sex with men on the side. Fears that "down-low" behavior could be putting women at risk of getting HIV have been published in the popular press/news media.[14,15] Young men engaging in male-male sex who do not disclose their same-sex activity (nondisclosers) may in fact lack the social support networks and prevention services available to men who are open about sexuality (disclosers) and, thus, are not only at great risk like "disclosers" for acquiring HIV infection, but also may not be receiving the health services needed once infected.[16,17] Analysis of men engaging in male-male sex activity revealed that "8% of 637 nondisclosers were infected with HIV compared with 11% of 4,952 disclosers". And the differences were greater in African-American men, where "prevalence of HIV infection was 14% among 199 nondisclosers compared with 24% among 910 disclosers." In addition, "compared with disclosers, nondisclosers had similar high risks for other STDs, reported less sexual behavior with men and more sexual behavior with women, reported less use of HIV testing services, and among those who were HIV infected, were less likely to be aware of their infection".[18] In essence, the rates for HIV infection were high among both disclosers and nondisclosers; however, new prevention strategies must be developed to target nondisclosers. By comparison, the cohort of youth in our study felt that they have a 43% chance of getting HIV and a 65% chance of getting another STD, in relation to their peers. In other words, our participants felt they had just under a 50% chance of acquiring HIV and an even greater risk of contracting other STDs. Thus, the importance of understanding the "down-low" experience cannot be divorced from addressing health outcomes, such as acquiring HIV/AIDS and STDs. It is important to note that although the term "down-low" is relatively new—the behavior of men across ethnicity and cultures to have sex with other men and still have sexual and long-term relationships with women predates the "down-low" subculture. It is also important to note that the DL experience appears to be a developing subculture within a spectrum of sexual identities for young African-American men engaging in same-sex activity. The popular press described this experience as quite different from what has been perceived as the "traditional closet narrative, where men are in isolation". The youth identifying as DL tend to be "relatively open about their sexuality—if only to each other—but under the radar".[19]

This study attempts to understand young men engaging in same-sex activity, who don't identify as gay, and are African-American and identify as "down-low." The qualitative data set on this small cohort of youth should not allow for conclusions to be made about these young men but should stimulate further research. These young men had a wide range of sexual experiences with many female sexual partners and with "few too many" sexual experiences with other men (range 2–300). These young men reported a history of an STD (50%), only one had gotten a woman pregnant (16.7%), and all (100%) had previously tested for HIV. Although these young men wanted to ideally identify as "exclusively" to "most often" heterosexual (Klein Score=1.98, Table 4), they as a group, in practice, self-assessed their sexuality "equally" heterosexual and homosexual (Klein Score=3.05, Table 4) on parameters of sexual attraction, sexual behavior, sexual fantasies, emotional preference, social preference, sexuality self-identification and sexuality lifestyle. These young men, however, report not fitting into the gay community. They describe themselves as living in secret about their male-male sex activity and as loners. This is in contrast to the DLs, described in the popular press, who congregate in bars and bathhouses frequented by DLs and who describe not living in the "closet" but developing their own subculture and lifestyle, with private parties and having fun.[15]

The young men in this study describe their attraction for other men as one for men who are perceived as "straight" or "straight-acting" but not "feminine boys". The relationships with men are described as shorter in duration than those with women. And obtaining sex with men is described as easier compared to obtaining sex with women, more readily available and less financially stressing. Also described is negotiating the sexual encounter as a "top" or "bottom", and how neither role in the sexual act reflects on the masculinity of these young men. Only one male described having relationships with transgendered male-to-females (TG) and not with heterosexual men. He reports engaging in sex with TGs, because they give the illusion of a woman. This young man reported losing his sexual excitement at the site of another man's genitalia, hence preferring the TGs not to reveal their genitals. This young man may reflect a spectrum of sexuality or sexual preferences even within the DL identity/ lifestyle. All of the men describe a greater likelihood to use condoms in their sexual encounters with men. Reported venues for meeting other men include church, on trains or

buses (city public transportation), on the street, on a party line (on the telephone). The party line, described by two participants, is a free service with personal mailboxes where they can retrieve messages at their convenience and where a DL-specific party line was available. The DL party line has a different number than the one for gays, and men with this identity could arrange for encounters of their choosing. None of these youth reported arranged encounters through the use of the internet, and this may be a function of socioeconomic status.

Their relationship with women is described as mostly sexual, with very few women insisting on condom use. They also described the desire to marry a woman at some time in their life but never disclosing their sexual relationships with men to these women. Further, they found sexual relationships with women more often involving financial support, assuming more responsibilities within a relationship and sex not as readily available as with men. In addition, contrary to their reports of very infrequent condom use with women (from the interviews), the average percentage of condom use in the past month for vaginal sex was 100%. With the exception of oral sex, the rates of condom use appear to be relatively high. We are left with conflicting information on the extent of condom use among these youth. However, the extent of risk for STDs and HIV that these youth place themselves and their partners when engaging in unprotected sexual activity cannot be minimized as highlighted from the CDC data on "disclosers" vs. "nondisclosers" described previously.[18]

No one knows how common same-sex relationships are among men who are ostensibly heterosexual. Some researchers report that African-American men do not believe that same-sex desire and behavior are an indication that a person is gay, identifying instead as bisexual or heterosexual.[20-23] The result is an identity that is complex, requiring an understanding of new paradigms of sexuality.

To create health services for these young men and to improve HIV prevention programs, further research is needed on this group of young men who do not readily disclose having sexual relationships with men. In face-to-face interviews, these young men described the difficulty in accessing healthcare: "When you first meet somebody [in a health clinic], no, you're not gonna say well, I had sex with a male. Because firstly I figure out how they're gonna judge me". Creating these health services will be not be an easy task given the life of secrecy and isolation that these young men describe. However, these men describe the importance of having providers who can develop trusting relationships with them to have them openly disclose their sexual activities.

The study findings also highlight the importance of extending the health guidance (or anticipatory guidance) time that clinicians spend with young women engaging in sexual activity. Some of the men in our sample reported that the women were less likely to request condom use as compared with their male sexual partners. Of note is that in the CDC study of young men engaging in MSM activity in seven cities, overall 61% of the men also engaged in sex with women.[1] We also know from national samples of youth in high schools, that overall, prevalence of using condoms at their last sexual encounter was higher among men (68.8%) than among women (57.4%), and higher among African-American males (81.2%) than among African-American females (63.6%).[24] Thus, we encourage clinicians to conduct anticipatory guidance with both young men and women on the importance of postponing or abstaining from sex, as well as using safer-sex measures (e.g., condoms) if they decide to engage in sexual activity. In addition, local communities must develop health promotions and social marketing campaigns directed at both young men and women and that "ring" with these youth, rather than demonize men or women for their sexual behaviors.

Limitations and Future Directions

The primary limitation of this study is the small sample size. Additionally, the data from the qualitative interviews should only be used to generate more questions about young African-American men who identify as "down-low." The common themes identified from the interviews help us to begin to see the commonalities among these young men but should not allow us to make conclusions about the DL. These young men were difficult to reach, done only through indirect contact through a small network. Yet, the importance of doing more research in this area is highlighted when seen in the context of sexual risk behavior.

Health service organizations with prevention programs for young African-American males must respond to the cultural or environmental context of these young men who identify as "down-low." These services/programs should conduct case finding of these young men and link them to comprehensive, developmentally appropriate health services. These services/programs will also benefit from feedback/evaluation by these young men to ensure that these programs are designed and administered appropriately, and accomplish what they are intended to do.

Future research on these young men should evaluate their social interactions with men, women and transsexuals as sexual and/or long-term partners, their knowledge levels of HIV and comorbid issues, and measures for quality of life. Longitudinal research studies beginning in adolescence examining sexual identity development and behaviors

towards men and women would provide more knowledge about these relationships and reasons for assumed sexual labels. Research should also focus on where these men find social support, as many face alienation from both the gay and African-American communities, and many conceal their sexual identity in traditional settings of family and church.

Research should also focus on how to find/access these young men, as many cannot be reached at gay clubs. It is unclear whether they frequent locations, such as parks, truck stops and public restrooms. Thus, prevention and case-finding programs must be willing to be creative in designing venues to recruit and enroll these young men in care. From our interviews, it appears that a DL party line would be one venue for accessing these young men.

Finally, providers must be willing to target the sexual partners of these young men. Although these young men may not be at greater risk of acquiring HIV than other MSM, those that are already infected pose a high risk for transmitting these infections to their male and female sex partners, especially their female partners since condom use is reportedly less than with male partners.

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