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The Down Low, Social Stigma, and Risky Sexual Behaviors:

Implications for Health Communication Interventions
The “down low” is purported to contribute to the spread of STD’s and increased rates of HIV, especially among Hispanic and African American men. While this phenomenon is a frequent topic of popular and scholarly press, empirical testing in the current literature remains limited, in part due to difficulty of identifying and recruiting participants. This paper addresses several unanswered questions regarding communication patterns of stigmatized groups, specifically in the social context of the DL, through the analysis of 32 structured interviews and five focus groups with African American men who have sex with men. Results highlight the negative emotions associated with labels based on sexual practices, the influential role the church may play in curtailing the problem, the possible utility of the openly gay community to serve as connectors, and barriers associated with targeting a stigmatized group. Findings can aid in informing health communicators about culturally appropriate sexual risk interventions.
The Down Low, Social Stigma, and Risky Sexual Behaviors:

Implications for Health Communication Interventions

“Now you have to say that DL brothers are everywhere. They are in the church, they are in your grocery store, and they are in bookstores. They are everywhere. Wherever you are, they are right there with you.”

--Focus Group Participant (FG.B P#2)

The so-called “down low” or “DL” has received considerable attention in both the popular and scholarly press in recent years (e.g., Denizet-Lewis, 2003; Boykin, 2005). Evidence indicates that the prevalence of this phenomenon is higher among Black and Hispanic men and the down low (DL) has been implicated in inconsistent condom use and elevated rates of HIV prevalence in these populations (Boykin, 2005; Wolitski, Jones, Wasserman, & Smith, 2006). The DL phenomenon is believed to be associated, particularly in the Black community, with social stigma related to bi- and homosexuality (Herek & Capitanio, 1995). The scant empirical evidence available on the down low phenomenon suggests that persons on the down low might benefit from culturally appropriate health communication interventions on a variety of topics (Mays, Cochran, & Zamudio, 2004), but the literature holds little information about the nature of such interventions. Furthermore, the DL phenomenon represents a particularly interesting case with which to address a number of unanswered theoretical questions about social stigma more generally including: how do people who themselves may be a member of a stigmatized group recognize, conceptualize and communicate social stigma? And, do people view stigma as an influence on their communication patterns and risk behaviors?
This study was conducted to fill a gap in existing literature (Mays et al., 2004; Wolitski et al., 2006) and to examine the social context of the down low phenomenon from the perspective of African-American men who have sex with men (AAMSM; both on the DL and not) in order to draw some conclusions regarding culturally appropriate interventions for this population particularly around sexual risk behaviors. The following sections will describe the functional role of stigma in human social systems, the nature of the DL phenomenon, and explicate a series of research questions. Data from interviews and focus groups with AAMSM are presented and from this data, conclusions are drawn about health communication interventions for AAMSM and DL men in particular.

The Role of Stigma in Social Systems

People who exist on the down low are believed to do so, in part, because of their concerns over the social stigma attached to homosexuality. Stigma is defined as a mark or token of infamy, disgrace, or reproach that sets a person apart from others and links the labeled person to undesirable characteristics (Lewis, 1999). In his influential work on stigma, Erving Goffman (1963) described stigma as “an attribute that is deeply discrediting within a particular social interaction” (p. 3). The process of stigmatizing a particular individual or group is generally characterized as having four interrelated components (Link & Phelan; 2001): initial labeling and distinguishing of human differences, linking labeled persons to “undesirable characteristics or negative stereotypes,” separation of the labeled persons into social categories distinct from the larger social system, and discrimination against those who have been labeled (p.367).

It has been pointed out that stigma can be considered as a form of social control (UNAIDS, 2002); one way conformity is obtained in societies is by contrasting those who are considered normal by society with those who are considered different or deviant. Those who
conform to normative expectations are accepted or rewarded by society and those who deviate from the norm are punished (Blum, 2002; Fredriksson & Kanabus, 2003). Social sanctions are attached to the deviation from normative behavior (termed injunctive norms; Cialdini, Reno, & Kallgren, 1990); stigmatization is one form of social sanction. Moreover, stigmatizing others allows people to engage downward social comparison process that serves to maintain self-esteem (Dovidio, Major, & Crocker, 2000).

Thus, stigma is a complex social force that serves as a tool to marginalize groups of people perceived to act outside of social norms (e.g., homosexuals, injection drug users, and commercial sex workers; Herek, 1999) or who are afflicted with some condition (e.g. people with mental illness, Falk, 2001; or HIV/AIDS; Pryor, Reeder, Vinacco, & Knott, 1989). One group that has historically been stigmatized in the U.S. is men who have sex with men (MSM; Herek, 1999); examining the social stigma associated with this group can enhance our understanding of the social context in which MSM enact health behaviors as well as social stigma more generally. Several critical questions remain unanswered about social stigma. First, how do people, particularly those who themselves might be a target of stigma, recognize, conceptualize and communicate about social stigma? Second, do people view stigma as an influence on their communication patterns and risk behaviors? This paper examines these issues using the case of stigmatizing attitudes about AAMSM with a particular focus on how social stigma is linked with the so-called “down low” phenomenon.

The Down Low

Wolitski et al. (2006) explicated the characteristics of the down low phenomenon and suggested that those on the down low are MSM who do not explicitly identify as homosexual or bisexual and lead an outwardly heterosexual lifestyle; termed non-gay identified MSM by
Martinez & Hosek (2005). Though this term has most frequently been invoked as solely applying to Black men (Millett, Malebranche, Mason, & Spikes, 2005), it has also been used more broadly to define all men who meet the above criteria, regardless of race. Studies of the down low are challenged by difficulties in accessing down low men and MSM more generally and tend to be small scale (e.g., N=6; Martinez & Hosek, 2005) or anecdotal in nature (e.g., Boykin, 2005).

In a notable exception, Wolitski et al., (2006), used a convenience sample from 12 cities (N =455) and found 20% of MSM in their sample identified as being on the DL. This study also found that DL men were more likely to be behaviorally bi-sexual than men not on the DL; DL MSM were more than ten times as likely as non-DL MSM to report having had a female sexual partner in the previous six months (Wolitski et al., 2006). DL MSM were less likely than openly gay MSM to have had over seven partners in the previous month but more likely to have had unprotected vaginal sex.

Critically, MSM who identified as DL were less likely to have been tested for HIV than MSM who were not on the DL even though they also reported being more likely to have sex with a partner whose HIV/AIDS was unknown when compared with non-DL MSM (Wolitski et al., 2006). There is other evidence linking stigma with avoidance of HIV testing for other populations (Boyd, Simpson, Hart, Johnstone, & Goldberg, 1999; Fortenberry et al., 2002; Simpson, Johnstone, Goldberg, Gormley, & Hart, 1999; Woods, Dilley, Lihatsh, Sabatino, Adler, & Rinaldi, 1999), which undermines one of the key methods for slowing the spread of HIV (Hays, Ekstrand, Kegeles, Stall, & Coates, 1997; Janssen, Holtgrave, Valdiserri, Shepherd, Gayle, & De Cock, 2001) and hinders prevention efforts. As Wolitski et al. point out, their study and others to date are limited in that it does not provide a qualitative understanding of how MSM conceptualize the down low and understand its influence on risk behaviors. A better
understanding of this phenomenon would allow health communicators to appropriately target risk communication messages to a historically marginalized group (Mays et al., 2004).

Research Questions

Based on the literature above, a number of research questions guide the current study. At a fundamental level, we were first interested in determining whether members of our sample were familiar with the term the “down low” (aka. “DL”, “trade”, “cake;” Martinez & Hosek, 2005), and if so, how they conceptualize this phenomenon. Although Woltiski et al. (2006) have clearly documented that the down-low phenomenon exists in social systems, it is not known whether scholarly conceptualizations of it accurately represent community perceptions of the phenomenon (Martinez & Hosek, 2005; Wolitski et al., 2006). Furthermore, although the DL phenomenon is believed to be a direct result of discrimination and stigma (Martinez & Hosek, 2005), it is not clear if people recognize this link. The fourth research question explores AAMSM’s perceptions of the role of organized religion in the DL; the church has considered a strong normative force in the Black community and has been criticized as slow to respond to the growing HIV/AIDS epidemic among Black men and women (Denizet-Lewis, 2003). AAMSM’s beliefs about the role of the church in social stigma are unknown and determining this can enhance our understanding of institutions’ roles in shaping normative perceptions.

These issues drove the first set of research questions:

RQ1: Have AAMSM heard of the term the down low?
RQ2: How do AAMSM conceptualize the down low and to whom does it apply?
RQ3: What do AAMSM see as the role of discrimination and stigma in the down low?
RQ4: What do AAMSM see as the role of organized religion in the down low?
Social norms more broadly, and social stigma in particular been implicated as a driving force behind sexual risk behaviors (xxxxx in press, Blinded for Peer Review; Wolitski et al., 2006); because of perceived lack of access by AAMSM and DL men to appropriate prevention services (Mays et al., 2004) and because secrecy and shame make communication about safe sex with partners less likely. The fifth research question examines this linkage by asking participants about how the DL and the social stigma relate to sexual risk behaviors.

RQ5: What do AAMSM see as the role of the down low in sexual risk behaviors?

Researchers have only begun to understand the ways in which normative information is communicated and how normative forces, such as social stigma, influence communication patterns (Lapinski & Rimal, 2005). It may be the case that one way in which stigma is reduced is by ‘normalizing’ talk about stigmatized issues and behaviors. Moreover, it is clear that referent beliefs about behaviors can influence action (Ajzen & Fishbein, 1980) but it is requisite that one has knowledge of referent beliefs for this influence to occur. Understanding how AAMSM communicate in their everyday lives about their sexuality and about HIV specifically can add to our understanding of how stigmatized issues are discussed and how normative beliefs are communicated, and it may shed light on mechanisms for the reduction of stigma. Cline (2003) has pointed out that ‘everyday’ communication about health issues, although an understudied area of research, can lend to our understanding of health communication processes. Knowledge of communication patterns also provides insight into the extent to which men in our sample are open (or not) with referent others about their sexuality. Thus, the final research questions ask:

RQ6: With whom do AAMSM feel comfortable discussing their sexuality and why?
Method

Overview of Design and Sampling

In order to answer the above research questions, structured interviews and focus groups were conducted; the focus group participants also completed a short self-report survey. The use of multiple methods can enhance social scientists’ understanding of complex social phenomena by compensating for the weaknesses of any one method (Babbie, 2001). Participants were sampled from six communities around the state of xxxxx (Blinded for Peer Review). Quota and network sampling methodology were used to recruit participants on streets, in parks, community-based organizations, and other venues where the research team members knew gay identified and non-gay identified Black men were likely to frequent. The quotas were set based on the 2000 U.S. Census Bureau estimates of the size of the general population in each of the cities, with the largest number of interviews and focus groups coming from the largest metropolitan area in the state.

Interview Participants

The interview participants \((N=32)\) reported primarily as men (3 reported as Transgendered) and Black or African American (3 reported as mixed race). The average age was 27.65 \((SD=9.74)\) with a range from 17 to 47 years of age. Participants reported as behaviorally MSM \((n=24)\) or bisexual \((n=8)\). All but two of the participants reported completing high school with many participants \((n=13)\) reporting taking some college courses. Most participants \((n=24)\) reported having tested for HIV in the past and 4 reported as HIV positive. When asked the number of times they had tested in the year prior to the interview, numbers ranged from 0-8, with a mean of 1.45 \((SD = 1.78)\).
Focus Group Participants

Five focus groups were conducted with a total of 24 participants. Focus group participants were all men, with the exception of one person who reported as Trans-Gendered, and one person who did not answer the question. All participants reported as Black or African American and were behaviorally homosexual with the exception of 2 men who reported as behaviorally bi-sexual. The average age was 30.14 ($SD= 13.17$) with a range from 17 to 55 years of age. Most of the focus group participants (86%) had been tested for HIV, analysis of the self-report survey indicated that 2 of the focus groups included all people reporting as HIV positive; a caveat for interpretation of the focus group data.

Procedure and Coding

Both the interview (pilot $n=4$) and focus group (1 pilot group, $n=8$) protocols were piloted prior to initiating data collection. The purpose of the pilots was to assess question flow, wording of items, participant willingness and ability to answer the questions, and to allow the interviewers to practice the protocols. The protocols were modified slightly following the pilots. Because the changes to the interview protocol were not substantial, the data from the interview pilot is included in the final analyses. The focus group pilot was not included in the final analysis because of technical problems that occurred during the data collection.

After administering informed consent and requesting consent for tape recording, interviewers completed a semi-structured interview or focus group protocol. The interviews were conducted in a private setting chosen by the participant and took approximately 45 minutes to complete. The focus groups were conducted in local community organizations and lasted approximately 1 hour and 15 minutes. Focus group participants completed a short questionnaire containing demographic and risk behavior items after the focus groups. All interview and focus
group participants received cash compensation for their participation. The interviews and focus groups were audio taped and transcribed. Due to the nature of the questions, the data collection yielded both quantitative and qualitative data. The qualitative data were coded by members of the research team.

The interview data was coded by four independent coders for the responses to each research question. Two members of the research team reviewed a subset of the transcripts to create a coding scheme based on common responses to the interview questions. Coders coded 71% in common. Cohen’s Kappa was calculated to establish intercoder reliability and values ranged from .77 to 1.00. Disagreements were resolved by discussion until 100% agreement was reached.

The focus group data was coded for emergent themes by two members of the research team independently and then as a pair. Agreement was reached on dominant themes through discussion. Data that best represent the patterns of results are excerpted below. In the results section, direct quotes from participants will include the interview (INT) or focus group (FG) in which they participated (where appropriate) and the participant identifying number (P#).

Focus Group and Interview Protocols

Both the focus group and interview protocols followed a semi-structured format and were designed to address the research questions above as well as other questions about HIV risk perceptions. The semi-structured format, which included probing questions, allows for aggregation across individuals and groups while giving participants the freedom to express their thoughts on each question. The focus group and interview protocols followed the same general structure but differed on two dimensions. First, the focus group questions asked about issues at a general level as opposed to the interview questions which asked about specific risk behaviors of
individuals. Second, the focus group questions asked specifically about the term the “down low” and the interview questions did not specifically mention the term but asked about stigma and discrimination and their relationship to the interviewees risk behaviors. Participants in both groups were asked about the people with whom they discuss issues related to sexuality and HIV/AIDS. The protocols are available from the first author.

Results and Discussion

Conceptualization of the Down Low

The first research question asked about whether or not participants had heard of the term the “down low”. When focus group participants were asked whether they had heard of the term, all but one focus group participant reported that they had previously heard of it. Two participants offered other terms that were relevant to understanding the way people talk about the DL.

Several participants explained that the term DL is not used ubiquitously by members of the gay community. When these individuals refer to a man who they think has sex with other men but is not “out”, they use the word trade, “…the queer community has kind of stayed away from using DL as much and the new term is ‘trade’. Oh he trade girl…within the queer community we have gadar, so, so, um, we be like, oh they trade.” (FG A, P# 4). Another mentioned the term “cake” used to distinguish men who are not on the DL from those who are, “When you don’t want the man, you have the DL you call him and you have your other man that you feel you should be able to go out with and cake with…Be seen. Hold hands and kiss, you know.” (FG B, P#4)

When asked how they defined the DL and to whom the term applied (RQ2), focus group participants reported conceptualizations that had two global components: behavioral and psychological. That is, participants provided definitions that both described particular behaviors and identified social-psychological processes driving those behaviors. In terms of behaviors,
previous literature has defined the DL as applying to men who have sex with both men and women (Woltiski et al., 2006), but many participants in this study indicated that being on the DL does not necessitate having sexual relationships with women. The only requisite is that these men have sex with other men but are not open about it. One man stated, “The down low applies to you know…people that doesn’t necessarily have to mean guys that sleep with women. It could be guys that just haven’t come out yet and then probably um…play it off straight…” (FG C, P#3) Another person defined it as, “Men that appear to be straight but they mess around with gay men.” (FG D, P#5).

Participants also reported different social-psychological conditions that men on the DL might exhibit including self-deception and denial, other-deception, and yielding to normative conformity pressures. One psychological theme to emerge from the data was that participants defined DL men as men with homosexual tendencies who do not admit it to themselves or are in denial about the existence of their attraction to other men. One respondent in Focus Group A stated, “…being down low is where you’re completely denying that aspect [homosexuality] of your sexuality.” Several participants also suggested that men on the DL may know they are gay but do not want to disclose their sexual orientation to others for a variety of reasons. Behaviorally, these men may have sex with women as well as men, and may even have girlfriends or wives, and otherwise lead publicly heterosexual lives. One man said, “It applies to the so called guys out there who don’t want anyone to know that they’re gay.” (FG D, P#1). A third social-psychological theme to emerge from the data was the psychological pressure to conform to perceived normative pressure to be masculine. Participants discussed how media portrayals of Black males may influence how people behave in public. One participant said:
…you have to be a thug…And then I think the media um…music, television, Destiny’s Child *I Need a Soldier*, it keeps perpetuating like the stereotype thing. Um…it just makes black men who…who are really gay feel like they have to conform and you know, live these heterosexual lives. (FG A, P#4)

Another participant reflected similar concerns about the importance of masculinity, speculating that some men on the DL might say:

I don’t like boys or nothing like that then don’t want nobody to know…they get this thug appeal you know…but really they want to wear some tight pants and um a little…small jacket and stuff like that. (FG C, P#3)

Two additional themes emerged when participants discussed the reasons they think certain people choose to be on the DL: distancing from a stigmatized group and the desire for privacy. First, participants reported that they believe DL men and they themselves wanted to be viewed differently than how they felt society views homosexual men. One man reported that he did not want to be categorized as gay, and another noted that gay men “get so many bad names.” (FG B P#1) This participant said that because gay men are viewed negatively by society and can never truly be themselves, he had no reason to disclose his attraction for other men, stating, simply “…what am I going to come out for. I can’t shine.” (FG.B P#1) A number of participants indicated that some men prefer to be on the DL because it allows them privacy and that they believe that their sexual behaviors should be of no concern to others. One man said, “There’s nothing wrong with it. They don’t have to come out for me. If we connect eye to eye, and you peeping what I’m peeping and we doing what we doing, that is nobody’s business but ours.” (FG B, P#2) In these cases, DL men do not disclose their sexual practices because they do not wish for others to know what they are doing.
It should be noted that participants never explicitly stated that the DL was an African American or Black phenomenon, though it was brought up by participants in response to subsequent questions. Race is generally a component of the definition of the DL when it is discussed in research (e.g., Millett et al., 2005). Importantly, although the participants in the interviews were not asked explicitly about the DL, a number of participants mentioned it spontaneously in their interviews; particularly when asked about the issue of stigma about homosexuality in the Black community. This highlights the fact that this term is integrated into discussions about sexuality among the AAMSM sampled in this study. Thus, the focus group and interview participants were largely aware of the DL phenomenon and focus group participants defined the DL as a combination of social-psychological and behavioral factors. Most men in our sample did not make a distinction between “closeted” and “down low” and did not see the DL as a behavior unique to the Black community.

Participants were probed about their feelings associated with the down low term and in general, participants voiced negative emotions. Participants discussed a range of negative emotions from anger, bitterness, depression, frustration, inner turmoil and rage, though most discussion focused around three general themes: anger, embarrassment and frustration. Anger was discussed in two different contexts. First, a number of participants reported being angry at society because of the unfavorable media portrayals of gay men and the lack of acceptance of the gay community by the public in general which they felt drove men to the DL. One participant said:

It makes me feel angry only in the sense that um…when our society makes them (DL men) feel that way. Because they’re in denial about themselves. Our society says that men should be quote-un-quote masculine. They have to make the money, they can’t have
emotions, they can’t…they can’t be themselves. They must be this perfect being and they’re not. They have feelings, they are real people, and there are different facets of men. And so…because they’re on the DL they can’t be themselves. So, that’s why they’re on the DL. (FG A P#3)

Anger was also expressed at people on the DL for the way participants perceive DL men behave; in one case this issue was discussed in terms of race. One participant stated, “…it [the DL] makes the gay community and especially the um…the African American community look weak by comparison of heterosexual couples. It makes it look like we don’t have our shit together. That we can’t come together in healthy relationships without having to have some sort of secrecy behind it.” (FG A, P#5)

Embarrassment was a second common emotion expressed by participants; primarily associated with normative perceptions about gay men. One man recalled a time when he embarrassed about being attracted to another man when he was on the DL:

…when I first started coming, coming around to my senses that I was attracted to boys…it embarrassed me because…society says that’s crazy, why would you be attracted to another guy. And you know what I’m saying…you got all these pretty girls around you, what you want to go with a n----r. …it actually embarrassed me… (FG C, P#3)

Explicit in this sentiment is that the DL invokes feelings of embarrassment on the part of men who are on the DL because they experience discrepancy between their feelings of attraction toward other men and their perceptions of societal expectations of how they should behave. The term DL also made some participants feel frustrated because of past experiences interacting with men on the DL. According to participants, partnering with a DL man constrains the amount and
quality of time spent together in public venues. One man reported that the term DL made him feel frustrated because many potential dating partners were not available to him because they were on the DL, stating, “…those are usually the boys I’m so attracted to. The ones who would not come out of the closet until they are 45, with a wife and three kids, it’s just so frustrating.” (FG A, P#2)

In contrast to the negative sentiment expressed above, however, not all focus group participants saw the secrecy required by men on the DL to be a drawback. One participant explained that the different expectations exist for dating men on the DL and dating other people can be quite beneficial because men on the DL do not want to date. One man suggested relationships with DL men are strictly sexual and lack a romantic component altogether: “They’re cool because you know, if you really are not looking for a relationship, you’re only looking for off and on to just chill you know. I am not going to call you every day. I can call you whenever, and you are going to be there or whatever. That’s what’s up.” (FG B, P#1)

*Stigma and Discrimination*

When asked specifically about the relationship between stigma and discrimination and decisions to be on the DL (RQ3), many participants viewed the down low phenomenon as linked to stigma around being gay. Focus group participants identified a number of the issues above as central to how being part of a stigmatized group relates to the down low (e.g., men may be embarrassed to be openly gay, are in denial and are fearful of being known as gay). Some participants reported that gay people are viewed as weak and are the targets of verbal and physical attack. One participant stated, “…they’re just scared and don’t want anybody to know. They’re scared they’re going to look weak if somebody calls them out on the street.”
When asked specifically about whether gay and bi-sexual men are discriminated against in the black community, focus group participants generally felt that some members of the Black community discriminated against gay people but that this was not a uniform trend and that social pressure also comes from outside the Black community. As one person said:

I think it’s equal too, it’s like there is discrimination because I mean you being Black is a strike against you, you being a man is a strike against you and then you being gay on top of it. That’s too many, but then again there a lot of people that like gay Black men that will help them out just because you’re gay and black.” (FG D, P#5)

Another participant was more emphatic in his belief that homosexuality is highly stigmatized in the Black community. He said:

Because you can’t just come out and tell a black, “oh, I’m bisexual, dawg.” You got to be straight, and don’t let them know. You can’t tell people that. You can’t tell a straight man that he’s gay. You always got to talk to him and say “man, I know you ain’t gay, it’s just something you like - that’s what you want, that’s your fantasy.” (INT#3D)

Physical and verbal abuse was discussed in connection with discrimination against gay men. Participants believed it is common for gay men to get in fights with straight men in public, and as a result participants reported that cohesion had increased among gay men to help protect themselves and each other from such attacks. When interview participants were asked specifically if they think bi-sexual and gay men are discriminated against in the Black community, 21 interview participants indicated that they believe gay men are discriminated against and 5 participants said they are not, with missing values for two participants.

Organized Religion and Stigma
The role of organized religion in perpetuating stigma and discrimination of people on the DL was raised by participants in a specific focus group question (RQ4), but participants often brought up the issue of the church without prompting before the question was asked. Although participants had differing views and experiences involving the church in relation to the down low, almost all agreed that the church can be a very powerful normative force regarding sexuality. The role of churches related to the DL was discussed in three discrete ways. Participants reported that churches were judgmental of gay people, did not address homosexuality at all, or were sources of support.

Some participants indicated they feel that pastors and church congregations may be a driving force behind the down low because they openly discriminate against gay people, as one participant said: “Just like I heard a minister the other day on the radio say ‘I’m not gay and I don’t like gay people’ and reverend from down south who said ‘I will kill a gay man who looks at me the wrong way.’” (FG. B, P#2)

Others believed that although the church may not blatantly discriminate against the gay community, it may encourage men to go on the DL by refusing to discuss homosexuality as an issue altogether and encouraging homosexual people to keep their sexuality to themselves. In fact, some participants believed many important members of the church are themselves on the DL. One participant said, “I believe that the churches are….have been a very instrumental part in creating men on the “down low” because of the stigma that’s associated with homosexuals and because of the fact that a lot of ministers are ‘down low’ men”. (FG E, P#2) Participant #3 in the same group concurred, noting, “The whole choir is (on the DL). Well maybe three quarters of the choir”.

Conversely, some churches were seen by participants as potential sources of support for gay men and men on the DL. Participants reported that certain churches have developed a reputation for being friendly to gay men, and attracted openly gay men and DL men to the congregation. One participant discussed a certain church in which several people in the ministry are known to be gay. Churches that offer acceptance of a homosexual lifestyle were noted to be very supportive: “A lot of people…I know came out actually came out in church” (FG.C, P#3)

Several participants noted that there are churches that get the reputation for being “gay friendly.” Participants stated that this has a potential drawback for the church and attendees, indicating that since most churches disapprove of homosexuality, the churches that are accepting of a homosexual lifestyle may develop a reputation for drawing gay men and men on the DL. This may eventually cause men on the DL to stop attending this church for fear of being found out, as noted by one participant,

I really don’t think that the ones that are “down low” that are in church are too much down low because there are plenty of gay churches here and all those ‘down low’ ones are the main one walking through that church door and it’s fully known and made clear that, that is a gay church, so this ‘down low’ thing I think it’s just a phase too because if you’re ‘down low’ then you wouldn’t be going in that church because it’s out in the open and people can see you and eventually you’re going to be up high. (FG D, P#1)

Stigma and Sexual Risk

The fifth research question dealt with the relationship between the DL and risk behaviors. The responses to this question dealt with people who do not openly acknowledge their MSM behaviors (both on the DL and closeted). Three main themes emerged related to how this lack of openness influences people’s behaviors related to sexual risk generally and HIV/AIDS
specifically. The first was misinformation about gay sex risks; several men expressed the fact that men who are unwilling to acknowledge their sexuality (as either on the DL or closeted) are likely to have inaccurate information about transmission risks for HIV and sexually transmitted diseases (STDs). One participant expressed a common confusion about STD transmission, “…then most men on the down low are not doing the other people. They are the ones that are being done. Again they feel that because of that, they think they can’t transmit the disease. Again because of ignorance of the disease.” (FG E, P#2)

The second behavior mentioned by participants was communication about health concerns and sexual practices. Disclosing sexual history to health care providers and female sexual partners, as well as seeking information about potential health concerns, were identified as influenced by being on the DL.

I think it’s to be honest with the doctors I mean because if you, if you’re going to be honest with anybody it should be your doctor. You know what I’m saying…and then it makes it harder for them simply because the down low and um…you know…when they tell their doctor they’re actually telling someone for the first time that they’re messing around, that he’s messing around with a man but he’s not strong enough to um…realize that well…it’s not about whether or you want to lose your rep or nothing not when your life is on the line. (FG.C, P#3)

Finally, participants discussed drug use in association with sexual risk taking among men on the down low. Several men indicated their belief that being high allows DL men to attribute their sex with men to their altered mental state. For example, one participant remarked that in his experience, men on the DL often have to get high to have sex. Another member of this focus group explained, “Yeah, but that’s just an excuse to do it. A lot of them that supposed to be,
suppose to get so high, they’re not high, they’re just like I said more reason to do it. If you got up and walked out of my house and got in the car and drove home straight better than you did, you are not drunk”. (FG C, P#3)

Communication about Sexuality

When asked if there were particular people among their family and friends (RQ6) with whom they felt comfortable discussing their sexuality, participants in the focus groups and interviews talked about at the most one or two people among their family and friends with whom they felt free to converse about the issue. The interview data allows for a more precise picture of communication patterns; interview participants reported that they were more likely to talk with friends \( n =19 \) than family members \( n =14 \) about their sexuality. One interview participant said: “My friends, not necessarily my family. My family knows (about his sexual orientation) but I don’t go and talk about them. They’re like, Christians.” (INT#15F), and another addressed why he talks with his friends: “Because I have some friends that …have the same sex preference as me. We can talk about a lot of different things versus talking to my father.” (INT#4BH)

Focus group data helped to provide more insight as to why some participants felt comfortable talking about their sexuality with particular people. One reason provided in both the interviews and the focus groups was similarity in sexual preferences. One man explained, “I talk to my brother and my sister because my brother that I talk to he’s gay too and my sister is bisexual, so we talk a lot.” (FG D, P#4) One person pointed out that he talks to his straight friends about his situation because they are “promiscuous” (FG C, P#3) and he feels that they are not in a proper position to criticize him about his sexual behavior.
Along with perceived similarity, the vast majority of people noted relational closeness to another person as the primary reason for their comfort in discussing their sexuality with them. As one man stated:

I come from a very close knit family and the few friends that I do have, it’s nothing that we can’t talk about… Well my mother has been a part with me all my life so I don’t have no problem talking to her about nothing. The friends that I have, I trust in their confidence. (FG E, P#1)

The data from both the focus groups and interviews indicated that anticipated reactions to talking about sexuality can both facilitate and deter discussions about sexuality. Participants typically had a much longer list of people with whom they did not feel comfortable discussing their sexuality than those with whom they felt comfortable often because of fears of hurting the other, having the other disclose their sexuality to outsiders, and other negative reactions. For example, one man felt a need to hide his sexuality from his mother: “…but my mother I can’t express that with her because if I do I can just see the hurt that’s in her. She will ask and everything and I’m nonchalant, everything is fine. There’s nothing for you to worry about. But my godmother, that’s the one I spill my guts to.” (FG E, P#3)

This information indicates that with the exception of one participant who stated that there was not a single person with whom he would not feel comfortable discussing his sexuality, every focus group participant in this study reported that there were many referent others with whom he would not discuss his sexuality. Many of these men self-identify as being homosexual or bi- sexual, but not to everyone. “It’s a select few that you can tell because it’s only a certain people that you can trust.” (FG D, P#4)

Conclusions and Implication for Health Communication Practice and Research
It is clear that the DL is a well-known phenomenon to the interview and focus group participants sampled here. From these data, it appears that AAMSM have a less restrictive conceptualization of the DL than is found in the scholarly research; for many it is inclusive of any man who has sex with other men who hides his behaviors (and in some cases his sexual identity) from others. Our sample expressed negative emotions related to the issue of the DL and rejected the label of the DL; a practice consistent with other research on this issue (Martinez & Hosek, 2005). The literature on social stigma would suggest that the labeling process is a critical step in stigmatizing a group (Link & Phelan; 2001); members of our sample seem to intuitively recognize the danger in this and many reject the notion that DL men are in a category distinct from other AAMSM. This appears to stem, in part, from the fact that respondents saw being labeled as gay as having negative social implications and some rejected that label as well; citing a desire for privacy regarding their sexual behaviors.

Health communicators can draw several lessons from these findings. First, it is clear that many AAMSM who are willing to identify as such, have strong connections with people who the health establishment have traditionally defined as DL men. Thus, reaching DL men may be accomplished through networks of identified AAMSM. Once DL men are reached, however, these data would suggest that convincing them to engage with the health system may be the more challenging task. An additional lesson from these findings is the outright rejection of labels associated with the DL and in many cases being gay, because of the perceived stigma associated with these terms. Health communicators should be mindful of these issues and use implicit messaging techniques to reach AAMSM.

Participants in this study viewed organized religion as a powerful source for communicating stigma and normative expectation around sex and sexuality. Participants talked
of the church as both a discriminatory and supportive force in their communities; some exhibited a nuanced understanding of the conundrum faced by churches afraid to condone homosexuality but concerned with alienating their membership. Participants also believed that many DL men play integral roles in the church. These data taken together suggest that health communicators need to redouble efforts to work with organized religious groups to communicate health messages to AAMSM.

Participants very clearly linked stigma and discrimination against gay and bi-sexual men with the enactment of a number of sexual risk behaviors including: inaccurate knowledge about transmission risk for HIV and STDs, inability to communicate with providers about health issues, and use of drugs and alcohol as a mechanism for DL men to feel safe having sex with men. Each of these issues bolsters the need for sexual health interventions targeting DL and AAMSM men and provides recommendations for potential content.

The normative issues addressed by these data paint a complex picture. It is clear that anticipation of social sanctions (i.e., injunctive norms) hinders men in this sample from discussion of sex and sexual risk with referent others and hinders their ability to discuss sexuality with others including sex partners and providers. The lack of communication about these issues would suggest that AAMSM in this sample have very limited information about the normative beliefs of others; limited by the few people they talk with and by the type of information they discuss. The persons in this sample appear to be anticipating reactions from other: creating a set of normative beliefs for a given referent based on previous experience with this person. This finding suggests that health communication strategies that rely on normative influence might meet with limited success with this particular population on issues of sexual health.
References


psychology of stigma. New York: The Guilford Press.


