Journal of Homosexuality

Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/wjhm20

The Down Low, Social Stigma, and Risky Sexual Behaviors: Insights from African-American Men Who Have Sex with Men

Maria Knight Lapinski PhD, Mary E. Braz MA & Erin K. Maloney MA

a Department of Communication, National Food Safety and Toxicology Center, and Michigan Agricultural Experiment Station, Michigan State University, East Lansing, Michigan, USA

b Department of Communication Studies, West Chester University of Pennsylvania, West Chester, Pennsylvania, USA

c College of Communication and Arts & Sciences, Michigan State University, East Lansing, Michigan, USA

Published online: 06 May 2010.

To cite this article: Maria Knight Lapinski PhD, Mary E. Braz MA & Erin K. Maloney MA (2010) The Down Low, Social Stigma, and Risky Sexual Behaviors: Insights from African-American Men Who Have Sex with Men, Journal of Homosexuality, 57:5, 610-633, DOI: 10.1080/00918361003712020

To link to this article: http://dx.doi.org/10.1080/00918361003712020

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The Down Low, Social Stigma, and Risky Sexual Behaviors: Insights from African-American Men Who Have Sex with Men

MARIA KNIGHT LAPINSKI, PhD
Department of Communication, National Food Safety and Toxicology Center, and Michigan Agricultural Experiment Station, Michigan State University, East Lansing, Michigan, USA

MARY E. BRAZ, MA
Department of Communication Studies, West Chester University of Pennsylvania, West Chester, Pennsylvania, USA

ERIN K. MALONEY, MA
College of Communication and Arts & Sciences, Michigan State University, East Lansing, Michigan, USA

The “down low” is purported to contribute to social stigma associated with being homosexual and may influence risk behaviors. This article examines communication patterns among stigmatized groups and reports the findings from 32 structured interviews and five focus groups with African-American men who have sex with men. Results indicate negative emotions associated with labels based on sexual practices, the influential role of organized religion in social stigma, and barriers to reaching stigmatized groups. These findings can be used to build culturally appropriate sexual risk interventions for this population.

KEYWORDS  down low, DL, men who have sex with men, stigma, health communication, HIV, AIDS, health risk, AAMSM, MSM

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 authors would like to acknowledge Harry Simpson and Liisa Randall for their assistance with this project.

Address correspondence to Maria Knight Lapinski, Department of Communication, 482 Communication Arts and Sciences, East Lansing, MI 48824, USA. E-mail: lapinsk3@msu.edu
The “down low,” a term that has been used to describe men who are behaviorally gay but do not identify as such and live outwardly heterosexual lives, has received considerable attention in both the popular and scholarly press (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 (Wolitski, Jones, Wasserman, & Smith, 2006). The DL phenomenon is believed to be associated with social stigma related to bisexuality and homosexuality (Herek & Capitanio, 1995).

As has been pointed out elsewhere, addressing the communication needs of stigmatized and hard to reach population groups is a critical challenge for health communicators (Harter, Berquist, Titsworth, Novak, & Brokaw, 2005). The empirical evidence available on the DL phenomenon suggests that persons on the down low might benefit from culturally appropriate health communication interventions that address sexual risk behaviors (Mays, Cochran, & Zamudio, 2004), but the literature holds little empirical information about how best to craft such interventions. Furthermore, the DL phenomenon represents a particularly interesting case with which to address a number of 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 about social stigma? Do people view stigma as an influence on their communication patterns and risk behaviors? This study was conducted to fill an identified gap in the existing literature on these issues (Mays, Cochran, & Zamudio, 2004; Wolitski et al., 2006) and to examine the social context of the DL 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 appropriate interventions for this population, particularly regarding sexual risk behaviors.

This article addresses the functional role of stigma in human social systems and the nature of the DL phenomenon, explicates a series of research questions, and reviews the methodology for testing the above-listed questions. Data from interviews and focus groups with AAMSM are presented, and conclusions are drawn about health communication interventions for AAMSM and DL men in particular.

**SOCIAL STIGMA AND THE DOWN LOW**

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 has been conceptually 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 (Goffman, 1963; Lewis, 1999). 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).

Those who conform to normative expectations are accepted or rewarded by society and those who deviate from the norm are punished (Blum, 2002; Cialdini, Reno, & Kallgren, 1990); stigmatization is one form of social sanction. 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 historically has been stigmatized in the United States is men who have sex with men (MSM; Herek, 1999). AAMSM, in particular, represent a group that has been marginalized within U.S. society; the intersection between race and sexuality for this group cannot be ignored. Importantly, the concept of the “down low” is not a race-based phenomenon; research has demonstrated that it occurs across racial groups (Centers for Disease Control and Prevention, 2003; Ross, Essien, Williams, & Fernandez-Esquer, 2003; Wolitski et al., 2006). It also should be acknowledged that social stigma is only one of several other forces that may be driving DL MSM's failure to disclose (e.g., Decena, 2003; King, 2003). Nevertheless, traditionally, most examinations of the DL discuss it as an African-American phenomenon and stigmatize Black sexuality by portraying it as “…generally excessive, deviant, diseased and predatory” (Ford, Whetten, Hall, Kaufman, & Thrasher, 2007, p. 209). In their commentary regarding how the negative social construction of Black sexuality and research regarding African-American sexuality may be reciprocal, Ford et al. (2003) suggest that future research may avoid this cycle by including stigmatized population groups in the research process and examining culturally based variables. The focus of the current article is to examine the phenomenon of the DL and the social stigma associated with it through the eyes of members of a group that seems to suffer from the stigmatization associated with it.

The marginalization of particular groups (e.g., African-American men; Orbe 1994) can significantly influence their communication patterns with both ingroup and outgroup members (Orbe, 1996, 1997, 1998). Examining the social stigma associated with being an AAMSM can enhance our understanding of the social context in which members of this group enact health behaviors as well as social stigma more generally; it is first necessary to address how social stigma is linked with the DL phenomenon.
Wolitski et al. (2006) explicated the characteristics of the DL phenomenon and stated that the term is inclusive of MSM who do not explicitly identify as homosexual or bisexual and lead an outwardly heterosexual lifestyle (also termed non-gay identified MSM by Martinez & Hosek, 2005). Although this term has most frequently been used in reference to African-American men in particular (c.f., Millett, Malebranche, Mason, & Spikes, 2005, for a discussion of this issue), it has also been used more broadly to define all men who meet the above criteria, regardless of race. Studies of the DL are challenged by difficulties in accessing DL 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), so there is little evidence for the prevalence of DL MSM among particular population groups.

In a notable exception, Wolitski et al.’s (2006) study employed a convenience sample from 12 cities ($N = 455$) and found 20% of MSM in their sample identified as being on the DL; African-American and Hispanic men were more likely to report being DL than White men. The study found that DL men were more likely to be behaviorally bisexual than men not on the DL; DL MSM were more than 10 times as likely as non-DL MSM to report having had a female sexual partner in the previous six months. DL men were less likely than openly gay MSM to have had over seven partners in the previous month and more likely to have had unprotected vaginal sex.

As Wolitski et al. (2006) point out, their study and others to date are limited in that they do not provide a qualitative understanding of how MSM conceptualize the DL and its possible influence on risk behaviors. A better understanding of these perceptions would allow health communicators to appropriately target and tailor interventions for 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, this study was designed to determine whether members of the sample were familiar with the term down low (aka “DL,” “trade,” “cake”; Martinez & Hosek, 2005, p. 1104), and if so, how they conceptualize this phenomenon. Although Wolitski et al. (2006) have clearly documented that the DL phenomenon exists in social systems, it is not known whether scholarly conceptualizations of it accurately represent community perceptions of the phenomenon (see also Martinez & Hosek, 2005). 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. Thus, the first three research questions address these issues:
RQ1: Have AAMSM heard of the term “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?

The fourth research question examines AAMSM’s perceptions of the role of organized religion in the DL. The church has been considered a strong normative force in the African-American community and has been criticized as slow to respond to the growing HIV/AIDS epidemic among African-American men and women (Denizet-Lewis, 2003) in part because of linkages between HIV/AIDS and homosexual sex. Among the general public, high religious intensity and ideology has been linked to more negative attitudes toward and unwillingness to interact with people with HIV/AIDS (Greene & Banjeree, 2006). As Walton (2006) observed, “[t]he notion that homosexuality is immoral and unnatural has thus become axiomatic in societies that are dominated by Christian values, even among people who are not actively Christian themselves.” (p. 15) To the extent to which organized religion can be considered a cultural force in African-American communities, understanding AAMSM’s beliefs about the role of the church in social stigma can enhance our understanding of institutions’ role in shaping normative perceptions.

RQ4: What do AAMSM see as the role of organized religion in the down low?

Social norms more broadly, and social stigma in particular, have been implicated as a driving force behind sexual risk behaviors (Lapinski & Nwulu, 2008; Wolitski et al., 2006) because of perceived lack of access by AAMSM and DL men to appropriate prevention services (Mays et al., 2004) and secrecy and shame, making communication about safe sex with partners less likely. A recent examination of correlates to nonparticipation in an HIV prevention program for MSM indicated that men who refused to enroll in such program were less educated and more closeted. This group, as well as those who enrolled, but did not show up for the program, reported engaging in more sexual risk behaviors than those in attendance (Orellana, Picciano, Roffman, Swanson, & Kalichman, 2006). The fifth research question examines this linkage by asking participants about how, if at all, the DL relates to sexual risk behaviors.

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

Theoretical work has recently addressed how 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. Communication Privacy Management Theory (CPMT; Petronio, 2002) discusses why and how a person makes the decision to disclose or not disclose information such as sexual orientation to different people. People make decisions on whether or not to share private information based on weighing the rewards and costs. Choosing to disclose makes the person vulnerable to others because the person no longer controls the information. The information becomes co-owned and other people can choose to share the information or engage in exploitation of the person who disclosed, making disclosure risky.

These risks create a dialectical tension between privacy and disclosure, and prompt people to make decisions about what is public information and what is private information. CPMT (Petronio, 2002) suggests, based on these distinctions, people then decide who has access to what information and establish expectations for co-ownership of information. Information is considered private to the extent that someone wishes to maintain control over the information. Understanding how AAMSM disclose information about their sexuality can add to our understanding of how stigmatized issues are discussed and how normative beliefs are communicated, which may shed light on mechanisms for the reduction of stigma. 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 sixth and final research question asks:

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

METHODS

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 Michigan. Quota and network sampling methodologies 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 African-American 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 transgender) 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 over one third of participants \( (n = 13) \) reporting taking some college courses. Most participants \( (n = 24) \) reported having tested for HIV in the past and four reported as being HIV positive. When asked the number of times they had tested for HIV in the year prior to the interview, numbers ranged from 0 to 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 transgendered, 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 two men who reported as behaviorally bisexual. 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 two of the focus groups included all people reporting as HIV positive; a caveat for interpretation of the focus group data.

Focus Group and Interview Protocols

Both the focus group and interview protocols followed a semistructured format and were designed to address the research questions above as well as other questions about HIV risk perceptions that are beyond the scope of this article. The semistructured format, which included probing questions, allowed 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. Importantly, the participants were not asked whether or not they were DL because inadequate conceptualization of the term made it immeasurable. The questions designed to answer the research questions for this article are presented in Appendix A.

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 and because a number of questions were modified in the focus group protocol following the pilot.

After administering informed consent and requesting consent for tape recording, interviewers completed a 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 monetary compensation for their participation. The interviews and focus groups were audio taped and transcribed by a professional transcriptionist. 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 were coded by four independent coders for the responses to each research question. Two of the study authors 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 of the study authors 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 include the interview (INT) or focus group (FG) in
which they participated (where appropriate) and the participant identifying number (P#).

RESULTS AND DISCUSSION

Conceptualization of the Down Low

Research Question 1 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 gaydar, so, so, um, we be like, oh they trade” (FG A, P#4). Another mentioned the word “cake,” which is 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. Several men stated the belief that 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 norms of masculinity. Participants discussed how media portrayals of Black males may influence how people behave in public. One participant noted, “…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 “…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, participants reported that they themselves and DL men more generally 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, although 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. 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.

Focus group participants were probed about their feelings associated with the down low term and, in general, participants voiced negative emotions. They discussed a range of negative emotions including anger, bitterness, depression, frustration, inner turmoil, and rage, although 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, which was primarily associated with normative perceptions about gay men. One man recalled a time when he was 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 that 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. As noted, interview participants were never explicitly asked about the DL. Yet, several responses to a probe regarding the stigma associated with homosexuality among African American suggest that stigma and discrimination are key factors contributing to the down low. One interviewee noted:

…they may remain in that little box or mode or continue to live that accepted lifestyle, number one is because of fear and they become frustrated and that’s why bath houses make money. They continue to make money. You have straight men leaving one state and going to another state if they want to have fun because they don’t know anybody, that’s why these truck stops are busy after hours or when the sun go down. They hate the fact that they have to have sex with someone they don’t know, a total stranger but why take the risk of dating someone who lives in your own backyard and information is getting back to his wife. (INT Y, P#11)

Focus group participants also 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, or 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 attacks and, therefore, must hide their sexuality as a defense mechanism. 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” (FG D, P#5).

When asked about whether gay and bisexual men are discriminated against in the Black community, focus group participants generally felt that some members of the Black community discriminate against gay people but that this was not a uniform trend and that social pressure also comes from other sources. 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 and bisexuality is highly stigmatized in the Black community:

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 D, P#3)

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 bisexual 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 response to a specific
focus group question (RQ4), but many participants 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 DL, 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 primary ways: participants believed that churches are 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 DL 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). An interview participant noted that many members of the congregation form their opinions based on cues they take from the church: “My feeling is just church doctrine. It’s just the way they’ve been taught and unfortunately that kind of ignorance stays with you” (INT Y, P#11).

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 this reputation attracts 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 actually came out in church” (FG C, P#5).

Participants stated that a church with the reputation of being “gay friendly” has a potential drawback for the church and attendees, indicating that because 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. 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)

Sexual Risk and Stigma

Research Question 5 dealt with the relationship between the DL and sexual 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—that men who are receptive during anal intercourse (bottoms, “being done”) cannot transmit sexually transmitted disease, “...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). One interview participant discussed his reluctance to become properly informed for fear of being associated with the homosexuality and HIV within the community: “Yes, there’s been a couple of programs around (city name) that you can attend, but my feeling (is) that I’m going to get judged or be discriminated against so I didn’t show up to them” (INT L, P#21).

The second behavior mentioned by participants was communication about health concerns and sexual practices. Participants reported that disclosing sexual history to health care providers and female sexual partners, as well as seeking information about potential health concerns, are things that they themselves and men on the DL are reticent to do. As one participant stated:

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 and 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)
While not representative of the sample as a whole, one interview participant noted that there may be some positive affects of stigma associated with homosexuality as well:

...you don’t want to prove those stereotypes they have to be correct. You don’t want to prove that every gay person has AIDS so you protect yourself. You don’t want to be a victim, you don’t want to be somebody that they look down on and say ‘well I was right you do have AIDS.’ You want to protect yourself and if anything for yourself and also prove them wrong, prove that the stereotypes and these assumptions that they have about you are totally false. (INT GR, P#4)

Finally, a number of 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, supposed 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 most frequently talked about one or two people among their family and friends with whom they felt free to converse about the issue. The interview data allowed 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 male sexual partners) but I don’t go and talk about them. They’re like, Christians” (INT F, P#15), 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 BH, P#4).

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 likely 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: “…[with] my mother I can’t express that (his sexuality) 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 the men in our sample self-identified as being homosexual or bisexual, 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). Thus, by the definition of DL offered by the men in this sample (as opposed to the definition that has been used traditionally in the literature), many of the men we interviewed consider themselves on the DL to some extent.

Although this study did not seek to provide a direct test of CPMT, the reasons participants offered for not disclosing their sexuality or sexual behavior to others echo the predictions purported by CPMT. CPMT posits people decide to whom to give access to private information about themselves in light of weighing the benefits and risks of disclosing the information. A dialectical tension exists between privacy of information and disclosure, in which disclosing information to another may be risky because shared information indicates a loss of control over that information. Once people disclose private information to another, the other co-owns the information and may decide whether or not to share the information with
additional others. The participants in this study indicated they choose to share the information with those they trust. The people with whom they shared information generally were others who are close in intimacy, others who also engage in sexually risky behavior, and others who are also homosexual or on the DL. Consistent with predictions in CPMT, sharing information with these others may be less risky than sharing the private information with less intimate others or others who are dissimilar from the participants in the same dimensions associated with the stigma.

CONCLUSIONS AND IMPLICATIONS FOR COMMUNICATION PRACTICE AND RESEARCH

It is clear that the DL is a well-known phenomenon among interview and focus group participants sampled for this study. From these data, it appears that AAMSMS 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 recognize intuitively the danger in this and many reject the notion that DL men are in a category distinct from other AAMSMS. Importantly, participants reported other labels such as “trade” and “cake” that appear to be acceptable for use by ingroup members but not external others. Moreover, 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.

Reaction to the priming of stereotypes or labels associated with group membership has been documented in other domains in the literature on stereotype threat (Davies, Spencer, & Steele, 2005; Steele & Aronson, 1995) and stereotype contrast. The literature on stereotype threat indicates that when members of stigmatized groups perceive they are stereotyped and that they run the risk of confirming that stereotype, it can negatively influence performance on tasks related to that stereotype (e.g., intellectual test performance; see Steele & Aronson, 1995) and reduce aspirations and goals related to the stereotype (Davies et al., 2005). In the case of these data, participants reported stereotyped behaviors related to being labeled as gay as being weak, emotional, and feminine. The stereotype threat literature would suggest that gay men who accept these stereotypes may be likely to act in a stereotype consistent fashion. Conversely, research on stereotype contrast indicates that when people are primed with single exemplars of a
stereotype, they react by contrasting their own behaviors with that of the exemplar (e.g., college students shown a picture of an elderly person walking slowly, walked faster; Dijksterhuis, Spears, & Lepinasse, 2001). Our data showed evidence that in some cases, AAMSM, particularly those on the DL, may react to stereotypes about being gay by creating a “homo thug” image—acting overtly masculine, unemotional, and tough in order to contrast the feminine, emotional, and weak stereotype of gay men that members of our sample believe predominates in their communities. Both of these processes have significant implications for stereotype activation and provide insights for communicators.

Specifically, 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, it appears from these data that reaching DL men may be accomplished through networks of identified AAMSM.

Critically, participants were not asked to self-identify as being DL or not because of concerns over the varying conceptualizations of term documented in this study. Although the participants sometimes referred to people on the DL as “they,” this may or may not indicate their own DL status but serve as a social distancing strategy.

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. Our evidence of participants’ discussion of the stereotypes associated with being gay and the stereotype threat and contrast processes suggests that inadvertent activation of stereotypes by health communicators targeting MSM could have negative consequences. This study is limited in that it did not explore this issue in a more systematic fashion. It should be noted that the literature on stereotype threat and contrast does not provide much evidence for the type of messaging that activates these processes, which provides an interesting direction for additional research in this area. At a minimum, health communicators should be mindful of these issues and use formative research to test the use of techniques such as implicit messaging to reach AAMSM. Further, the emotional associations with the concept of DL, in particular, the strong negative emotions, are issues that could be explored in interventions around issues such as sexual risk behavior for both identified and nonidentified MSM.

Participants in this study viewed organized religion as a powerful source for communicating stigma and normative expectations around sex and sexuality. Participants talked of the church as both a discriminatory and supportive force in their communities; some discussed their perceptions of a conundrum faced by churches afraid to condone homosexuality but concerned with alienating a portion of 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 continue efforts to work with organized religious groups to reach DL AAMSM and communicate appropriate health messages to AAMSM by identifying religious organizations that are perceived as gay friendly by community members and working with those organizations to reach membership. Moreover, these data indicate the role of organized religion as a perpetuator of stigma highlights the need for education or persuasive efforts targeting religious leaders on issues of sex and sexuality.

Participants very clearly linked stigma and discrimination against gay and bisexual 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. Past research indicates a strong connection between misinformation about transmission and treatment of AIDS, alcohol and drug use, and sexual risk taking (Halkitis, Zade, Zerm, & Marmor, 2004). Therefore, each of these issues bolsters the need for sexual health interventions targeting DL and AAMSM men and provides explicit intervention content related to the issues of transmission risk, sexual risk taking, and substance use.

The normative issues addressed by these data paint a complex picture and provide some insight into the ways in which normative information is communicated. It is clear that anticipation of social sanctions (i.e., injunctive norms) hindered men in this study from discussion of sex and sexual risk with referent others including sex partners, family members, and providers. The persons in this sample appear to be anticipating reactions from others: creating a set of normative beliefs for a given referent based on previous interactions with this person about other issues. Moreover, these participants perceive their sexual orientation and sexual activities to be a largely private endeavor; a factor that is likely to attenuate normative influence (Lapinski & Rimal, 2005). These issues taken together suggest that health communication strategies that rely on normative influence might meet with limited success with this particular population on issues of sexual health.

Thus, these data provide a glimpse into the ways in which social stigma, or fear of it, impacts communication about health information and information seeking behaviors among AAMSM, including those on the down low. The findings provide important theoretical and practical implications as well as challenging directions for future research.

REFERENCES


APPENDIX A: FOCUS GROUP AND INTERVIEW QUESTIONS

Focus Group Questions

- Have you heard of the term “down low” or “DL”?
- What does it mean?
- Who does it apply to?
- What does this term make you think about or feel?
- What are the reasons you think certain people choose to be on the DL?
- What do you see as the relationship between the DL and stigma about being gay?
- What do you see as the role of churches in this community related to the down low?
- How do you think, if at all, being on the DL influences people’s behaviors related to HIV/AIDS?
- Do you think gay people are discriminated against in the Black community?
- Do you think this discrimination is different for men and women?
- Do you think bi-sexual and gay men are discriminated against in the Black community?
- If yes, why do you think this is the case?
- How, if at all, do you think it impacts the things people do?
- How, if at all, do you think discrimination influences the way people talk about sex and sexuality in the Black community?

Individual Interview Questions

- Are there people among your family, friends, and acquaintances that you feel comfortable talking with about your sexuality?

If there are people

- Why do you feel comfortable talking to these people about your sexuality?
- Why do you talk to these particular people and not others?
- What are the kinds of things you talk about?

If there are not people

- Tell me more about this. Why do you think this is the case?
- What keeps you from talking to people?
- Are there things that you wish you could talk with people about but can’t?
- Are there people that you definitely would not talk to about your sexuality?
- If so, who are they?
- Why wouldn’t you talk to them?
- Are there people among your friends and family that you talk to about HIV/AIDS?
If there are people

- Why do you feel comfortable talking to these people about this?
- What are the kinds of things you talk about?
- Do you talk seriously or not?
- Do you ever talk about things that can be done to protect oneself from HIV? If so, like what?
- Do you ever think about things that your family and friends have said when you are in situations where you could be putting yourself at risk for HIV?
- What do you think about?

If there are not people

- Tell me more about this. Why do you think this is the case?
- What keeps you from talking with people?
- Are there things that you wish you could talk to people, but can’t?