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Sexual identity and HIV status influence the relationship between internalized stigma and psychological distress in black gay and bisexual men

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ABSTRACT

Experiences of internalized homophobia and HIV stigma in young Black gay and bisexual men (GBM) may lead to psychological distress, but levels of distress may be dependent upon their sexual identity or HIV status. In this study, we set out to explore the associations between psychological distress, sexual identity, and HIV status in young Black GBM. Participants were 228 young Black GBM who reported on their psychological distress, their HIV status, and their sexual identity. Results indicated that internalized homophobia was significantly related to psychological distress for gay men, but not for bisexual men. HIV stigma was related to psychological stress for HIV-positive men, but not for HIV-negative men. Results indicate a need for more nuanced examinations of the role of identity in the health and well-being of men who have sex with men.

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HIV/AIDS; mental health; substance use; sexual behavior

Introduction

The stigmatization of race and sexual orientation for young Black gay and bisexual men (GBM) has been empirically connected to several health-related problems, including poor mental health (Hatzenbuehler, 2009; Lick, Durso, & Johnson, 2013; Meyer, 2003). GBM, have higher rates of psychological distress than the general population (Cochran & Mays, 1994, 2000a, 2000b; Cochran, Sullivan, & Mays, 2003; Fergusson, Horwood, & Beautrais, 1999; Gilman et al., 2001; Mays & Cochran, 2001). One potential source of psychological distress is internalized homophobia, an individual's direction of anti-gay attitudes toward themselves (Meyer, 1995). Young GBM absorb negative attitudes about same-sex attraction and sexual behavior at an early age (Davies, 1996; Herek, 2009; Isay, 1989). Young Black GBM face additional challenges in managing two subordinate group memberships. They report feeling that their sexual identity is incongruent with their racial identity, but they also experience feelings of rejection and isolation from the white lesbian, gay, and bisexual (LGB) community (Choi, Han, Paul, & Ayala, 2011; Glick & Golden, 2010; Harper & Schneider, 2003; Herek & Capitanio, 1995, 2010; Hunter, 2010; Meyer & Ouellette, 2009; Rosario, Schrimshaw, & Hunter, 2004). The experience of perceived ostracism and isolation from both Black and gay communities can contribute further internalizing stigma.

Although GBM in general are often grouped together in explorations of their sexual behavior and social context, there may be important differences between bisexually identified and gay-identified Black men in these experiences of stigmatization. For instance, the persistent myth of Black bisexual men as vectors of HIV into the heterosexual black community disproportionately affects bisexually identified Black men (Millett, Malebranche, Mason, & Spikes, 2005). Bisexual men who conceal their identity to avoid prejudice may experience mental distress as well as physical health risk (Cole, Kemeny, Taylor, & Visscher, 1996; Wilson, 2008). Conversely, gay-identified Black men may face more direct forms of stigma and prejudice because of their sexual orientation. They are typically less able to conceal their sexual identity (Herek, Widaman, & Capitanio, 2005; Malebranche, 2008). However, little work has explored how sexual identity may differentially affect correlates of felt stigma in young GBM.

Another potential facet of stigma in young black GBM is HIV/AIDS stigma. People with HIV, and those suspected to be infected with HIV, have been the target of social prejudice, discrimination, and violence (Herek, 1999; Herek, Capitanio, & Widaman, 2003). Internalizing AIDS stigma can lead to many of the same consequences

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as internalizing other stigmas, such as self-blame and self-destructive behaviors (Herek & Capitanio, 1999; Klitzman, 1997). People still largely connect AIDS and HIV with the behaviors and identities of men who have sex with other men, and the specter of HIV/AIDS is used as a vehicle to express disdain and prejudice toward GBM (Herek, 1999; Herek et al., 2003). Thus, the stigma assigned to HIV and AIDS has been layered onto the stigma assigned to GBM. Since Black men are disproportionately affected by the HIV epidemic in the U.S., HIV and AIDS have become more closely associated with the sexuality of young black GBM (McKirnan, Houston, & Tolou-Shams, 2007). Thus, even young black GBM who are not HIV-positive could experience HIV/AIDS stigma.

The current study aims to explore the role of sexual identity in understanding the relationship between two forms of internalized stigma – internalized homophobia and HIV/AIDS stigma – and psychological distress in a sample of Black GBM.

Methods

Participants

Participants were a nonprobability sample of 227 young Black GBM recruited in New York. Participants had to be Black men aged 18–35 who identified as gay or bisexual and had oral or anal intercourse with another man in the two months prior to baseline.

Participants were recruited from community organizations that catered to, or are frequented by, young Black GBM. Banner advertisements were placed on both general social media and websites as well as online communities targeted at young GBM. Flyers were posted and distributed at gay bars, gay clubs, college campuses, gyms, cafés, and other community locations frequented by young men. Some participants were recruited directly through partnerships with several community-based organizations (CBOs) such as LGBT centers and community health centers. Snowball sampling was also used; participants were encouraged to refer their eligible friends to the study, and could receive up to three $10 gift cards for referring up to 3 friends who ultimately participated in the study. Overall, 10% of the participants were recruited from clubs and bars; 15% were recruited via business cards and flyers hung or passed out in general locations; 18% were recruited through partnerships with CBOs; 21% were recruited from online ads; and 36% were recruited through snowball sampling.

Procedure

Participants were asked to come to one of the two study sites – one located in the Washington Heights neighborhood of upper Manhattan, the other in the Chelsea neighborhood of lower Manhattan – to complete the cross-sectional part of the study. Each participant was taken to a private office and as shown how to navigate the questionnaire, which used a computer-assisted self-interviewing modality. The cross-sectional survey took approximately 45–60 minutes to complete, and participants were compensated $30 for completing the cross-sectional survey and received a $5 MetroCard for round-trip travel to the office. Participants completed a series of measures of internalized homophobia, HIV/AIDS stigma, and psychological distress. This study was approved by the Institutional Review Board at Columbia University Medical Center.

Measures

Demographic and health-related information

This 24-item measure (Wilson, Cook, McGaskey, Rowe, & Dennis, 2008) collected demographic and health-related information. Participants were asked to report on their ethnicity, age, education level, annual income, employment status, health insurance, relationship status, sexual orientation/identity, history of mental illnesses, current psychiatric medication, and HIV status. They also answered questions about past incarceration experiences.

Internalized Homophobia Scale

The Internalized Homophobia scale (IHP; Martin & Dean, 1987) is a nine-item scale developed to measure internalized homophobia in men with same-sex sexual attractions and behaviors. Participants are presented with statements such as "I have tried to stop being attracted to men in general" and "I feel alienated from myself because of being gay or bisexual" and are asked to indicate how often they had these kinds of thoughts or feelings. The scale employed a 4-point Likert-type scale and response options ranged from 1 ("often") to 4 ("never"). Possible scores ranged from 9 to 36. Responses were coded so that higher scores indicate higher internalized homophobia. In this sample, the IHP has a Cronbach's alpha of 0.88, indicating very good reliability.

HIV/AIDS stigma

The HIV/AIDS Stigma scale (Diaz, 2006) is a set of scales designed to measure stigma against HIV and AIDS in men who have sex with men (MSM). There are two versions: a seven-item version designed for HIV-negative and HIV status unknown participants and a five-item version designed for HIV-positive participants. Both scales are scored using a four-point Likert scale.

Responses were coded so that higher scores indicate higher HIV/AIDS stigma. Possible scores ranged from 4 to 20 on the version for HIV-positive participants and 4–28 on the version for HIV-negative and HIV status unknown participants. Because of the different range of scores due to the differing number of items, mean scores are analyzed and presented in this paper, which range from 1 to 4. In this sample, the version of the scale for HIV-negative and unknown participants has a Cronbach's alpha of 0.77, indicating adequate reliability. The version for HIV-positive participants has a Cronbach's alpha of 0.71, also adequate reliability.

Psychological distress

The Kessler Screening Scale of Non Specific Psychological Distress (K10; Kessler et al., 2002) is a 10-item scale designed to measure depressive distress. This scale measures cognitive, affective, and behavioral symptoms of psychological distress. This scale was scored on a four-point Likert-type scale. Participants are presented with statements of feelings and emotions such as "felt hopeless", or "felt tired out for no good reason", and are asked to rate how often they had felt that way over the 30 days prior to baseline. The response options ranged from 1 ("none of the time") to 5 ("all of the time"). Possible scores on this scale ranged from 10 to 50. This scale has been validated with diverse populations of men and women, with Black participants deliberately oversampled in these studies. In the current sample, the K10 had a Cronbach's alpha of 0.92, indicating excellent reliability.

Psychological distress was also assessed using the 53-item Brief Symptom Inventory (BSI; Derogatis & Spencer, 1993). Participants are asked to rate the severity of many different mental health symptoms they may have experienced over the past 14 days on a 0–4 scale, with higher ratings indicating more distress. Mean scores are reported for the BSI. Internal consistency reliability (Cronbach's α) for the global severity index, which measures overall incidence of psychological distress, was $\alpha = .97$ in the current sample. In addition to the global severity index, the BSI yields nine primary symptom scales. Five subscales were used in this study: depression, anxiety, interpersonal sensitivity, somatization, and hostility. Internal consistency reliability (Cronbach's α) for the five measured subscales was .88, .83, .80, .79, and .79, respectively.

Analyses

Descriptive statistics were obtained for all variables used in the analysis. Multiple linear regression analyses were used to examine the interaction between internalized homophobia sexual identity and its association with psychological distress; multiple linear regression was also used to examine the as well as the interaction between HIV/AIDS stigma and HIV status, and its association with psychological distress. A model-building process using hierarchical regression was used; first the relationship between the independent and dependent variables were tested, and then covariates were added to see if the relationship held over and above the influence of covariates. A separate analysis was conducted for each independent variable and psychological distress outcome due to the high covariance between independent variables. The analyses were adjusted for covariates of age, income, education, sexual identity, relationship status, and HIV status. All analyses were conducted using Stata 13 (StataCorp, 2013).

Results

Sample characteristics

Full sample characteristics are presented in Table 1. Participants ranged in age from 18 to 34 years ($M = 23.9$ years, SD = 4.2 years) or higher. Nearly one-fourth of the sample was HIV-positive, which reflects the HIV epidemic in New York (New York Department of Health and Mental Hygiene, 2014). Five participants reported that they did not know their HIV status, with the remaining 74% ($N = 169$) stating they were HIV-negative. Nearly three-fourths ($N = 169$) of the sample identified as gay or homosexual, with the remaining quarter identifying as bisexual.

Means, standard deviations, and ranges of the IHP, HIV/AIDS stigma scale, K10, and BSI analyzed are presented in Table 2. Chi-square tests of independence were used to assess differences in demographic characteristics across groups. GBM were different on educational attainment, $\chi^2(5) = 11.18$, $p = .048$. Examination of adjusted residuals showed that gay men were more likely to have at least some college education, whereas bisexual men were more likely to have a high school diploma or less. GBM were also different on HIV status, $\chi^2(5) = 7.93$, $p = .019$. Gay men were more likely to be HIV-positive, whereas bisexual men were more likely to be HIV-negative. GBM were not different on any other demographic characteristics. Two-way ANOVAs were used to assess comparability of the gay and bisexual groups and the HIV-positive and HIV-negative groups on internalized homophobia and psychological distress. There were no significant differences in psychological distress between gay and bisexual participants or between HIV-positive and HIV-negative/unknown participants. There was also no significant difference in HIV/AIDS stigma scores between the HIV-negative/

Table 1. Demographics of sample ($N = 227$).

Demographic	%/Mean	Gay	Bisexual
Age	24.8 (SD = 4.16)	24.9 (SD = 4.16)	24.2 (SD = 3.85)
Ethnicity			
African American	61.7%	63.8%	52.7%
Black Hispanic/ Latino	19.4%	17.8%	25.5%
Afro-Caribbean/ West Indian	6.3%	6.1%	7.3%
Mixed Race	12.6%	12.3%	14.6%
Education			
Less than high school diploma	8.3%	6.0%	15.5%
High school diploma/GED	28.9%	26.5%	36.2%
Some college	39.9%	43.4%	31.0%
College degree or higher	22.8%	24.1%	17.2%
Annual income			
$0–10,000	53.1%	52.4%	58.6%
$10,001–20,000	20.2%	20.5%	15.5%
$20,001–30,000	37.2%	12.1%	13.8%
More than $30,000	14.0%	15.1%	12.1%
Employment status			
Employed	36.9%	38.2%	33.3%
Student	23.8%	23.6%	25.9%
Unemployed	34.6%	33.8%	35.2%
Disability	4.7%	4.5%	5.7%
Relationship status			
Married/ partnered	26.8%	25.9%	31.0%
Single	73.3%	74.1%	69.0%
Sexual orientation			
Gay or homosexual	74.1%		
Bisexual	25.6%		
HIV status			
HIV-negative	74.1%	69.9%	86.2%
HIV-positive	23.7%	28.3%	10.3%
HIV status unknown	2.2%	1.8%	3.5%
Psychiatric medication			
On psychiatric medication	10.5%	10.2%	12.1%

unknown and HIV-positive participants. However, bisexual participants had significantly higher scores on the IHP than gay participants, $F(1, 221) = 29.9$, $p < .001$.

Internalized homophobia and psychological distress

Results of the linear regression analyses of internalized homophobia and psychological distress are presented in Tables 3 and 4. Internalized homophobia was significantly positively related to psychological distress, $B = .46$, $p < .001$; $R^2 = .19$. Further analysis revealed a significant interaction between sexual identity and internalized homophobia, $B = .45$, $p = .006$; $R^2 = .19$. Examining marginal means revealed that internalized homophobia is positively significantly related to psychological distress only for gay/homosexual-identified participants, $B = .66$, $p < .001$. In the gay participants, higher levels of internalized homophobia were related to higher levels of psychological distress. There was not a significant relationship for bisexual participants, $B = .20$, $p = .098$.

Table 2. Means, standard deviations, and ranges of psychological distress and stigma measures.

	Mean	SD	Min.	Max.
Internalized Homophobia Scale (IHP)	15.98	6.31	9	36
Gay/homosexual	14.64	5.28	9	31
Bisexual	19.72	7.59	9	36
HIV/AIDS Stigma Scale	2.30	0.67	1	4
HIV-negative or unknown status	2.25	0.61	1	3.75
HIV-positive	2.44	0.80	1	4
Kessler Scale of Psychological Distress (K10)	17.24	7.58	10	50
Brief Symptom Inventory Global Severity Index	0.64	0.66	0	3.02
Depression	0.72	0.80	0	4
Anxiety	0.71	0.78	0	3.20
Interpersonal sensitivity	0.62	0.74	0	3.25
Somatization	0.60	0.70	0	3.67
Hostility	0.88	0.91	0	2.5

Table 3. Regression results, interaction of internalized homophobia and sexual identity on psychological distress (K10).

Variables	*B*	Std. err.	*t*	Sig. (*p*)
Internalized homophobia	0.21	0.12	1.68	.094
Sexual identity (Ref. group = bisexual)	−5.77	3.14	−1.84	.068
IHP × sex identity interaction	0.45**	0.16	2.75	.006**
Age	0.26	0.13	1.95	.053
Income > $20,000	0.23	1.03	0.22	.825
Education > High school	−0.47	1.09	−0.43	.667
HIV-positive	0.17	1.18	0.15	.884
Single	−1.78	1.09	−1.64	.103

*$p < .05$.
**$p < .01$.

Results of the linear regression analyses examining the relationship between internalized homophobia and five subscales of the BSI are presented in Table 3. Internalized homophobia was significantly related to four of the sub scales: depression ($B = .05$, $p < .001$; $R^2 = .19$), anxiety ($B = .03$, $p = .019$; $R^2 = .13$), interpersonal sensitivity ($B = .14$, $p = .003$; $R^2 = .17$), and somatization ($B = .04$, $p = .002$; $R^2 = .14$). Sexual orientation did not significantly interact with internalized homophobia for any of these subscales. There was no significant relationship between internalized homophobia and hostility, $B = .03$, $p = .064$

HIV/AIDS stigma and psychological distress

Results of the linear regression analyses of HIV/AIDS stigma and psychological distress are presented in Table 5. While the coefficient for the main effect relationship between HIV/AIDS stigma and psychological distress was not statistically significant ($B = -.69$, $p = .490$), there was a significant interaction between HIV status and HIV/AIDS stigma, $B = 4.67$, $p = .005$.

Table 4. Regression results, interaction of internalized homophobia and sexual identity on psychological distress (BSI).

	Depression			Anxiety			Int. Sensitivity			Somatization			Hostility		
Variables	*B*	SE	*p*	*B*	SE	*p*	*B*	SE	*p*	*B*	SE	*p*	*B*	SE	*p*
Internalized homophobia	**0.05**	0.01	**<.001****	**0.03**	0.01	**.019***	**0.04**	0.01	**.003****	**0.04**	0.01	**.002****	0.03	0.02	.064
Sexual identity (ref. = bisexual)	−0.01	0.33	.987	−0.31	0.33	.352	−0.18	0.31	.561	0.02	0.29	.935	−0.51	0.39	.191
IHP × sex identity interaction	0.01	0.02	.563	0.02	0.02	.252	0.02	0.02	.234	0.01	0.02	.618	0.04	0.02	.072
Age	<0.01	0.01	.832	−0.01	0.01	.430	−0.01	0.01	.619	<0.01	0.01	.690	0.02	0.02	.341
Income > $20,000	−0.06	0.01	.595	0.02	0.11	.842	0.07	0.10	.474	−0.08	0.10	.386	−0.09	0.13	.436
Education > High school	0.04	0.12	.704	−0.08	0.12	.463	−0.02	0.11	.800	−0.10	0.10	.300	0.04	0.13	.759
HIV-positive	−0.01	0.12	.835	0.04	0.13	.757	0.05	0.12	.659	0.05	0.11	.631	0.10	0.15	.482
Single	−0.02	0.42	.672	0.10	0.42	.297	−0.07	0.11	.516	−0.03	0.10	.749	−0.03	0.13	.828

Bold entries are statistically significant.
*$p < .05$.
**$p < .01$.

Examination of the marginal means shows that the relationship between psychological distress and HIV/AIDS stigma are significant for HIV-positive men ($B = 3.84$, $p = .004$) but not for HIV-negative men ($B = -.58$, $p = .545$). The relationship for HIV-positive men is positive, indicating that higher levels of HIV/AIDS stigma are related to higher levels of psychological distress in this sample of men.

Discussion

Young gay and bisexual Black men are at the intersection of multiple marginalized identities, and thus may be at increased risk of poor mental health. The current study advanced the research in this area by exploring differences in associations between internalized stigma and psychological distress due to sexual identity and HIV status. Our results indicate that gay-identified men who experienced greater internalized homophobia experienced greater psychological distress. Most previous studies of the relationship between stigma and psychological distress have focused on instances of enacted stigma, such as discriminatory experiences. Our findings suggest internalized stigma is also an important facet of mental health for young gay Black men.

However, the relationship only persisted for gay men, and not for bisexually identified men. This difference could exist for a variety of reasons. In particular, the ability to conceal their same-sex sexual behavior – or at least push it beyond the minds of those in their community through relationships with women – may give Black bisexual men the ability to seek the support and resources necessary to deflect the distress often induced by internalized homophobia.

Table 5. Regression results, interaction of internalized homophobia and sexual identity on HIV/AIDS stigma.

Variables	*B*	Std. Err.	*t*	Sig. (*p*)
Internalized homophobia	0.71	0.82	0.87	.386
HIV status (Ref. group = HIV-neg/unk)	−3.88	3.19	−1.21	.226
IHP × HIV status interaction	0.38**	0.10	3.95	<.001**
Age	0.31*	0.14	2.14	.034*
Income > $20,000	0.27	1.09	0.25	.803
Education > High school	−1.01	1.17	−0.86	.390
Bisexual	2.24	1.24	1.79	.074
Single	−2.36*	1.16	−2.03	.044*

*$p < .05$.
**$p < .01$.

Although there was a relationship between HIV/AIDS stigma and psychological distress, this relationship only existed for HIV-positive men. We expected that there might be an association for HIV-negative young men as well, because of societal associations of HIV and AIDS with the sexual identities and behaviors of GBM, even if they are HIV-negative (McKirnan, Ostrow, & Hope, 1996; McKirnan, Vanable, Ostrow, & Hope, 2001). However, young Black GBM might not perceive this societal association between their sexual identity and HIV within their communities, and may thus feel psychologically unaffected by stigma against HIV-positive people. It is also possible that within the communities and social circles that these young Black GBM travel, HIV/AIDS stigma does not have a strong connection with gay or bisexual identity at all. Another possible explanation is that even if HIV/AIDS stigma does have a small negative impact on the psychological well-being of these young men, the HIV-negative young men have personal and community resources to reduce its impact. In contrast, the internalization of HIV/AIDS-related stigma seems to be detrimental for HIV-positive GBM, who are more directly affected by the socially driven negative evaluation of their HIV status.

Our study did have some limitations. One potential limitation is the small sample size of our study. The sample of 228 did not allow us to examine, for instance, the 2 × 2 interaction of sexual identity and HIV status. Another limitation is the generalizability of our findings. This work was done specifically with young Black GBM living in an urban area; the results are thus not intended to be widely applicable to all MSM. In particular, we only had one participant in the sample who identified as

heterosexual; therefore, it was not possible to compare heterosexually identified MSM to gay- and bisexual-identified men. Patterns and experiences of stigma are very likely to be different for MSM who identify as heterosexual. Future research should make an effort to include heterosexually identified MSM in studies of identity and examine how their identity and behavior may moderate the effects of stigma.

The internalization of stigma against the sexual identity of young GBM may contribute to mental distress. The different relationship between internalized homophobia and sexual identity may impel public health workers to tailor programming and messaging within interventions and in psychological care for the differing needs of GBM. More empirical work examining differences in outcomes among Black GBM is necessary to fully elucidate these differences. Furthermore, it appears that HIV/AIDS stigma may not affect HIV-negative GBM as much as previously thought. However, HIV stigma does seem to have a powerful impact on the psychological well-being of HIV-positive men, so public health interventions should focus on this kind of stigma when attempting to improve the physical and mental well-being of GBM.

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