

# Black Sexuality, Social Construction, and Research Targeting 'The Down Low' ('The DL')

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**PURPOSE:** The purpose of this commentary is to explain how social constructions of black sexuality are relevant to research targeting black sexual behavior and the ostensibly new and race-specific phenomenon known as "the Down Low" (the DL). The term "the DL" is widely used to refer to black men publicly presenting as heterosexual while secretly having sex with other men and presumably spreading human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS) to unsuspecting women.

**METHODS:** We briefly review lay and public health literature from 1998 to 2004 about the DL, describe existing social constructions of black sexuality, discuss two implications for epidemiologic research, and offer recommendations to guide future research.

**RESULTS:** The lifestyle referenced by the term the DL is neither new nor limited to blacks, and sufficient data linking it to HIV/AIDS disparities currently are lacking. Common perceptions about the DL reflect social constructions of black sexuality as generally excessive, deviant, diseased, and predatory. Research targeting black sexual behavior that ignores these constructions may unwittingly reinforce them.

**CONCLUSIONS:** Unaddressed social constructions of black sexuality have implications for epidemiologic research targeting black sexual behavior. Explicit examination of these concerns is necessary to eliminate fundamental causes of health disparities.

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**KEY WORDS:** HIV Infections, Prevention and Control, Epidemiologic Methods, African Americans, Sexual Behavior, Sex.

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## INTRODUCTION

"Ideas about race, gender, sexuality, and black people as well as the social practices that these ideas shape and reflect remain intricately part of the new racism, but in changed ways."

—Patricia Hill Collins (1)

Although racial disparities in human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS) have persisted for more than two decades (2–4) and African Americans account for increasing proportions of infections (5), research typically does not examine relationships between the social context of US racism and the processes and assumptions informing research that targets black sexual behavior. Increasingly, many people attribute racial disparities in HIV/AIDS to an ostensibly new

phenomenon known as "the Down Low" ("the DL") (6–8). This term has been part of black vernacular connoting secrecy of some sort since the early 1990s; for example, someone might say "I will tell you why I am upset if you keep it on the DL." Keeping a thing on the DL did not necessarily connote perceived wrongness; it reflected first and foremost a desire for discretion. The original connotation of the DL with regard to sexual liaisons referred to heterosexual relationships. Recently, however, it has come to be used in variety of overlapping ways to denote: 1) presumed straight black men; 2) who are in primary relationships with women; 3) secretly have sex with other men; and, 4) are presumed HIV-positive as the result of male-to-male sexual contact (9).

The DL gained considerable notoriety from publicity surrounding the publication of popular books and news features on the phenomenon (10–14). Most framed it as black men's deviant immoral sexual behavior and focused on implications for "innocent" women partners as well as higher rates of HIV among black relative to white women to emphasize the DL as a public health emergency (15–17). Public reactions to the existence of a DL phenomenon echo responses in the early 1980s to emergent news of the HIV epidemic and to earlier panics about black men as sexual predators: widespread fear; scapegoating of minorities; and attributing infection to sexual immorality (18, 19). Historically,

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**Selected Abbreviations and Acronyms**

AIDS = Acquired immune deficiency syndrome  
CDC = Centers for Disease Control and Prevention  
DL = “Down low”  
HIV = Human immunodeficiency virus  
MSM = Men who have sex with men

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however, black sexuality has always been considered different than “normal” sexuality, which is associated with whiteness, middle-class status, and heterosexuality (1, 20). During and after the US Reconstruction, for instance, whites lynched thousands of black men for fear of them raping white women (1). Similar fears about black men pervaded the civil rights era and remain imbedded in Americans’ attitudes today (21, 22).

This commentary explores certain social dynamics that epidemiologists are not trained to recognize, which may function when research targets stigmatized minorities such as black men who have sex with men (MSM). Specifically, social constructions of black sexuality may influence research and, in turn, research unwittingly may reinforce the constructions. Social construction connotes that the media and researchers do not merely observe a reality objectively; they also help to create it (23, 24). Our goal is neither to prove nor disprove the DL, its prevalence, or the proportion of HIV infections resulting from straight-identified black men having sex with each other. Rather, we demonstrate that a burgeoning emphasis on behavioral determinants of HIV among minorities necessitates a disciplinary critique (23, 25) of the processes by which this research is conducted. We summarize epidemiologic data related to the DL’s purported contribution to HIV/AIDS disparities, discuss social constructions of black sexuality and illustrate implications for both minority group stigmatization and epidemiologic risk group formation. We conclude with recommendations for conducting research that is attentive to these concerns.

**Epidemiology of HIV/AIDS Among Blacks**

Although HIV/AIDS rates among US blacks decreased from 2001 to 2004, blacks represent 50% of diagnoses in the 35 areas reporting HIV infection and 40% of cumulative AIDS diagnoses (26, 27). Among US households from 1999 to 2002, 1.4% of blacks ages 18 to 39 years and 3.6% of blacks ages 40 to 49 years were HIV-positive (28). Blacks represent 74% of heterosexual diagnoses and 69% of HIV/AIDS diagnoses among women (29). Among HIV-positive women, 67% of whites and 80% of blacks acquire HIV through heterosexual contact (30, 31). Among HIV-positive men, 77% of whites and 49% of blacks acquire HIV through MSM contact. Black MSM are less likely than white MSM to know their serostatus (32–34). Greater

proportions of black MSM also identify as heterosexual and have sexual partnerships with women (35).

More complete population-based information on heterosexual transmission of HIV is necessary, however, before the DL can be linked epidemiologically to HIV/AIDS racial disparities (36). Black women carry a heavier burden of heterosexually acquired infection than do whites; however, evidence is incomplete on how the partners of these women became infected. The Centers for Disease Control and Prevention (CDC) collects data on subtypes of heterosexual contact (sex with an injection drug user, a bisexual male, a hemophiliac, an HIV-infected transfusion recipient, or an HIV infected person, risk not specified); however, 80% of women who contracted HIV through heterosexual contact in 2002 did not know or specify the risk category of their heterosexual contact (37). Completeness of reporting of transmission risk has been decreasing over time (38). Further, due to a paucity of qualitative behavioral research, what constitutes risk may not always be clear (39, 40). Although several studies (41–43) have reported high-risk behaviors among black MSM, others (44–47) have found black MSM to have comparable or lower levels of behavioral risk than other MSM.

**Relevant Discourses and Common Assumptions About the DL**

We reviewed popular (7, 10–12, 48–55) and scholarly sources about the DL identified through the use of Lexis/Nexis, Medline, CINAHL, Sociological Abstracts, and Google searches for the period 1998 to 2004 containing the following sets of terms in the titles, abstracts or as key words: HIV, HIV/AIDS, or HIV infection; down low, men who have sex with men (MSM), men who have sex with men and women (MSM/W), or bisexual; and blacks, African Americans, race, or racial disparities. Most characterized straight-identified MSM as a new, race-specific phenomenon, implied links to HIV disparities (56–59) disproportionately emphasized HIV-related implications for women relative to men (12, 16, 35, 58, 59). With some exceptions (60–63), public health discourses emphasized implications for women and conceptualized sexuality as fixed and categorical (e.g., heterosexual vs. homosexual) rather than as fluid (i.e., contextually, temporally, situationally dependent) (see References 64 and 65) (66). In addition, two common but erroneous assumptions about the seeming discordance between behavior and orientation signified by the term the DL were that it is new and limited to blacks.

**Is the Seeming Discordance New?**

While the term “the DL” is relatively new, activists and researchers have long known about the lifestyle it references. Sexual behavior may or may not correlate with sexual

**TABLE 1.** Selected identity/behavioral groups illustrative of the heterogeneity of the term, the DL, as widely used\*

Group	Behavior	Identity	Key characteristics
Heterosexual	Heterosexual or bisexual	Heterosexual	Sole or primary partnerships are with women May have sex with men in certain social situations (e.g., experimental sex) May have sex with men in other contexts (e.g., in prison)
Men on the DL	Bisexual or homosexual	Heterosexual or DL <sup>†</sup>	Perceives self as straight Identifies as “on the DL” Often successful in career and considered a “good catch” Hides homosexuality
Closeted Gay	Homosexual	Varies	Sex with men is not for relationships; it’s just for sex Presumed or presents as heterosexual May or may not have women sex partners May or may not have men sex partners
Closeted bisexual A <sup>‡</sup>	Bisexual, Heterosexual, or Homosexual	Heterosexual or bisexual	Presumed heterosexual
Closeted bisexual B <sup>§</sup>	Bisexual, Heterosexual, or Homosexual	Homosexual or bisexual	Hides any homosexuality Presumed homosexual
Out bisexual	Bisexual or homosexual	Bisexual	Hides heterosexuality May partner with one or the other sex serially May partner with one or the other sex concurrently
Homothug	Homosexual	Homosexual	Heavily involved in a specific hip hop culture Out about sexuality through this hip hop culture Strong masculine identity
Queer	Varies	Not heterosexual or not conventionally sexed	Disfavors expressions of femininity by men A broad category that encompasses various homosexual or bisexual identity groups Generally more commonly used among whites and certain politically active groups May have negative connotations among older lesbian or gay-identified persons
Two Spirit	Homosexual or bisexual	Two Spirit	Embodies the essences of both genders Historically has been considered strongly spiritual Concept is American Indian in origin but it often is adopted by other racial/ethnic minorities
Pomosexual	Varies	Varies	Does not identify as a fixed sexual orientation or sex Seeks partners without regard for their sex or sexual orientation

\*Adapted in part from Boykin (2005) and Mays VM, Cochran SD and Zamudio A (2004).

<sup>†</sup>Increasingly, out gay men also identify as “on the DL.” This may be a result of the increasing currency and cache associated with the category.

<sup>‡</sup>Closeted bisexual A: keeps homosexual partnerships secret.

<sup>§</sup>Closeted bisexual B: keeps heterosexual partnerships secret.

orientation, which is an individual’s self-perception as gay, lesbian, bisexual, or heterosexual (67). Both behavior and orientation may vary over time (67). For decades, gay rights advocates have considered secret networks, mostly of white men, evidence of the resiliency with which individuals survived societal homophobia (68–70). African American public intellectuals also have described historically secret networks of black MSM (71–74). Some public health researchers also have known that men who identify as heterosexual may engage in sex with other men (75–79). Fifteen years ago, Bell (75) described research conducted by Exoo in the Deep South among MSM of unspecified racial/ethnic backgrounds; most self-identified as straight or bisexual and nearly all who routinely visited public venues for sex with

other men maintained primary relationships with women. More than 10 years ago, Diaz and colleagues (77) reported in 1993 that Latino MSM in 11 US states were much more likely than white MSM to be married and to perceive themselves as heterosexual. Similar findings from outside the United States also have been reported (76, 79, 80). A more recent study of black men who self-identified as heterosexual found that 31% of HIV-positive men and 16% of HIV-negative men recruited from streets and parks near cases’ homes reported ever having anal sex with a man between 1978 and the date of HIV diagnosis (or matched date, for control subjects). Although the selection strategy probably overrepresented men with histories of MSM contact, that 61% of cases consistently disclosed their HIV

status to women partners suggests that some proportion of women partners know of their elevated HIV risk.

### Is the Seeming Discordance Limited to Blacks?

As previous research (47, 81–83) indicates, discordance between sexual behavior and sexual identity is not limited to blacks. MSM across race/ethnicity reported heterosexual identity in the CDC's Young Men's Study (47). Similarly, Ross and colleagues (82), in 2004, surveyed nearly 1,500 African American, Hispanic, Asian and white adults in public venues such as bus stops to determine whether individuals' sexual identities were concordant with their reported sexual behavior (82). They found considerable discordance for every racial/ethnic group, with highest levels of discordance among whites and lowest among Asians. That discordance was highest among persons reporting stigmatized (homosexual) behavior but normative (heterosexual) identity suggests homophobia exerts considerable pressure on people of all racial/ethnic groups to identify as heterosexual. The CDC also recently reported identifying DL men from across racial/ethnic groups (84). As we discuss later, however, how the study assessed DL status reflects mutual influence between socially constructed identity categories and research question formulation.

### Social Construction of Black Sexuality

By its very nature, research linking HIV/AIDS disparities to black men on the DL relies on social constructions of black sexuality in ways that may influence both individuals' attitudes and behaviors as well as how researchers conceptualize, measure, and strive to address disparities. According to scholars of race and sex, social constructions of black race include that black sexuality is hypermasculine, hyperheterosexual, and, for black men, aggressive (85–93). Typically, these characterizations make homosexuality among black men difficult to perceive because the concept of black MSM does not fit neatly into stereotypes of blackness (i.e., hypermasculine) or of homosexuality (i.e., not black). When threats of stigmatized disease arise, however, other aspects of black sexuality's social construction—its presumed excessiveness, deviance, and proximity to disease—conspire to magnify perceptions that links exist between black sexuality and observed disease patterns (1). Implications exist for HIV prevention as evident from research detailing African America's response to the HIV/AIDS epidemic. As the epidemic unfolded, many people attributed HIV/AIDS to immorality. African Americans, sensitive to how similar the emerging characterizations were to those historically ascribed to blacks, redrew its boundaries to exclude homosexuals. Ostensibly homophobic, this action was fundamentally an attempt to forestall attributing the new plague to black race (94). As Williams writes:

“Black gays and lesbians are a potential anathema to straight African Americans, whose resistance to racist narratives inspires them to ‘clean up’ images of black sexuality. When these African Americans publicly reject homosexuality, they do so in a social context that persistently regenerates public images and discourses of sexual perversion and familial damage” (85).

Research that does not adequately account for these intersecting dynamics may obtain ostensibly new understandings (e.g., about the salience of black men on the DL to HIV infection) that merely reproduce common assumptions inherent to the social constructs (e.g., black sexuality). We discuss implications of these constructions for potential stigmatization of minority groups and for epidemiologic risk group formation.

### Stigmatization

Stigma is a “negative social label that identifies people as deviant” (95). How researchers define socially marginalized groups and conduct research among them can exacerbate their stigmatization (96). For members of certain multiply oppressed groups, HIV-related stigma represents just an additional layer of stigma reinforcing ways in which they already are stigmatized (97–99). Profound stigmatization of black sexuality is a defining aspect of racial stratification (86, 87, 100) and any discourse that stresses black sexual deviance as the key explanation for disparities taps into earlier discourses linking stigmatized diseases (such as syphilis) to race. Indeed, stigma may be a fundamental reason for African Americans' slow response to the HIV epidemic in the first place (66, 94, 101). At-risk persons who fear stigma more than they fear infection may continue to be at risk or spread disease while seeking better ways to hide from partners, researchers, and providers (102–104). As DL stigmata reflect stigmatization of black sexuality more broadly, research that reinforces DL stigmata also may exacerbate stigmatization of blacks in general. A second concern is social construction's relevance to risk group formation.

### Risk Group Formation

To estimate risk, researchers designate and compare specified risk groups on the basis of factors they deem potentially relevant to disease occurrence. When socially constructed identities are the sole basis for defining epidemiologic risk groups, however, the resultant risk categories inherently include meanings and values the social groups are assumed to represent (105). To the extent that influential aspects of the social context (e.g., sensitivity to stereotypes about promiscuity) are not accounted for, the specified groups contain potentially relevant but unmeasured social meaning (106, 107). Conceptual or methodological limitations may result.

For example, risk may be attributed to proxy rather than actual causal factors or the constructed categories may not be mutually exclusive, a basic assumption necessary to compare groups (25, 108). Understanding how social construction can influence epidemiologic risk group formation is particularly important when research targets socially marginalized groups because considerable social distance often separates researchers from the groups and prevailing assumptions about the groups (on which research unwittingly may rely) often are inaccurate or negative.

Research that conflates sexual orientation, itself a complex psychosocial identity construct, with behavioral risk groups makes it more difficult to identify groups at elevated risk of HIV infection (109). Researchers use the concept “men who have sex with men” because not all men at risk of acquiring HIV through sex with other men identify as gay or bisexual. Likewise, black MSM is a heterogeneous category comprising subpopulations with varying levels of HIV risk (61, 62, 110). Table 1 lists selected diverse groups sometimes considered on the DL, depending on the term’s usage. Although the table is not comprehensive, within-group behavioral and identity variations are apparent for nearly every group regardless of identity.

As explained by Mays and colleagues (61) in 2004, conflation of risk groups and identities can affect HIV prevention research in a variety of ways. It may belie heterogeneity of risk within specified categories. Goldbaum and colleagues (111) found bisexual-identified MSM (which, as defined by former DL men excludes DL men) more likely than heterosexual- and homosexual-identified MSM to have both unprotected anal sex with men and intercourse with women, whereas straight-identified MSM were more likely to engage in oral sex and most likely to exchange sex for drugs. Studies may attribute risk to MSM contact but fail to distinguish between higher (e.g., unprotected receptive anal intercourse) and lower (e.g., oral sex) risk behaviors (for example, see Reference 64). Additionally, because sources of prevention information differ for gay-, bisexual- and heterosexual-identified MSM, this conflation may influence intervention success. In the Goldbaum study, straight-identified men were least likely to have recent exposure to HIV preventive information, suggesting prevention messages targeting gay men are unlikely to reach heterosexual-identified MSM. Lastly, in the CDC study mentioned earlier, the term “on the DL” was used in a manner that contradicted its meaning among the black men who originated the term to demarcate a social category. For the black men, black identity is a necessary component of DL status (7). The study, however, asked men of various racial/ethnic backgrounds to define themselves in terms of the DL. In so doing, it demonstrated that straight-identified MSM exist across races/ethnicities; however, it also muddied the DL’s social and research-related connotations.

To summarize, social construction holds relevance for HIV prevention research in at least two ways. Failure to address it may unintentionally lead to further stigmatization of groups and social construction may influence the appropriateness and generalizability with which researchers specify epidemiologic risk groups.

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## CONCLUSION

The term “the DL” is widely used to refer to various primarily black MSM populations; however, the seeming discordance to which it refers is neither new nor race-specific, and the burden of HIV attributable to it remains unknown. Perceptions that the DL explains HIV/AIDS disparities reflect broader social constructions of black sexuality. Research targeting black sexual behavior that does not account for these social constructions may unintentionally rely on or reinforce them. To put it metaphorically, our public health categorizations are like Rorschach tests—they reveal something about our thought processes, but not necessarily something about the real world. That we can identify networks of men on the DL and perhaps do some good in that process does not mean that it necessarily is the most effective or only way to address HIV/AIDS disparities. Emphasizing the DL does not consider ways that this particular approach can perpetuate stereotypes, exacerbate already high rates of HIV/AIDS, or confuse and divert the next generation of researchers.

Although this commentary has focused on the implications of social construction to DL-related research, the principles apply to any research targeting black sexual behavior. We offer five recommendations for addressing these concerns:

1. Conceptualize sexuality as fluid to account for both compositional (e.g., physiological sites of exposure) and contextual (e.g., behavior influenced by the social context in which it occurs) factors (81).
2. Involve members of socially marginalized populations in formulating and directing research that targets their communities to identify and understand salient cultural factors (60, 112–114). If it is not possible to do so, involve persons with less social distance from the target populations than interested researchers (e.g., if it is not possible to identify hidden populations of MSM, it may be possible to identify lesbian or gay organizations already aware of these networks).
3. Incorporate strategies into study design to systematically assess and proactively address any stigmatization that may result from the research (96). This is important because research sometimes traumatizes or further stigmatizes communities.

4. Examine structural factors (e.g., disproportionate imprisonment of blacks) that may influence both behaviors and risk because they may explain fundamental causes of persistent disparities better than do individual level factors (115–118).
5. Examine the research process itself to understand how social context (e.g., media representations of black men as sexual predators) influences not only disease occurrence but also research processes through which knowledge about determinants and populations is produced. For instance, how do research hypotheses regarding stigmatized behavior differ by study populations' races/ethnicities? These types of questions are important because "we must also consider that scientific knowledge both reflects and perpetuates social inequalities" (119).

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