

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

CHANDRA L. FORD, PhD, MPH, MLIS, KATHRYN D. WHETTEN, PhD, MPH,
SUSAN A. HALL, PhD, MS, JAY S. KAUFMAN, PhD, AND ANGELA D. THRASHER, MPH, PhD

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.

Ann Epidemiol 2007;17:209–216. © 2007 Elsevier Inc. All rights reserved.

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

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,

From the Departments of Social Medicine (C.L.F.), Epidemiology (S.A.H., J.S.K.), and Health Behavior and Health Education (A.D.T.), University of North Carolina, Chapel Hill, NC; and the Departments of Public Policy and Community and Family Medicine (K.D.W.), Duke University, Durham, NC.

Address correspondence to: Chandra L. Ford, Department of Epidemiology, Mailman School of Public Health, Columbia University, 722 West 168th Street, New York, NY 10032. Tel.: 212-304-6424; fax: 212-544-4221. E-mail: cf2264@columbia.edu.

Received June 12, 2006; accepted September 29, 2006.

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

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 [†]	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 [‡]	Bisexual, Heterosexual, or Homosexual	Heterosexual or bisexual	Presumed heterosexual
Closeted bisexual B [§]	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).

[†]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.

[‡]Closeted bisexual A: keeps homosexual partnerships secret.

[§]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.

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).

The authors wish to acknowledge Kara Keeling for her provocative comments and close readings of manuscript drafts. The authors also acknowledge John Sweet, Johari Jabir, Greg Millett, and Leisa Meyer for their suggestions about relevant resources and Rachel Whetten for editorial assistance. This work was supported in part by the National Institute of Allergy and Infectious Diseases (NIAID) (Grant # 5 F31 AI058914-02), the W.K. Kellogg Foundation's Kellogg Health Scholars Program and the Department of Epidemiology at Columbia University. Support also was received from the National Institute of Mental Health (NIMH), the National Institute of Drug Abuse (NIDA), and the National Institute of Nursing Research (NINR) (Grant # 5401MH061687-05).

REFERENCES

1. Hill Collins P. *Black Sexual Politics: African Americans, Gender, and the New Racism*. New York: Routledge; 2004.
2. Karon JM, Rosenberg PS, McQuillan G, Khare M, Gwinn M, Petersen LR. Prevalence of HIV infection in the United States, 1984 to 1992. *JAMA*. 1996;276:126–131.
3. Selik RM, Castro KG, Pappaioanou M. Racial/ethnic differences in the risk of AIDS in the United States. *Am J Public Health*. 1988;78:1539–1545.
4. Jenkins B, Lamar VL, Thompson-Crumble J. AIDS among African Americans: a social epidemic. *J Black Psychol*. 1993;19:108–122.
5. Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report, 2003*. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention; 2004.
6. Osborne D. The down low goes down: CDC researcher debunks statistical basis of reporting on black bisexual men spreading HIV. *Gay City News*. New York, NY: Community Media, LLC; 2004.
7. King JL, Hunter K. *On the Down Low: A Journey into the Lives of 'Straight' Black Men Who Sleep with Men*. New York, NY: Broadway Books; 2004.
8. Wikipedia contributors. Down-low. Wikipedia, the Free Encyclopedia. January 10, 2007. Available at: <http://en.wikipedia.org/wiki/Down-low>. Accessed January, 12, 2007.
9. Boykin K. *Beyond the Down Low: Sex, Lies and Denial in Black America*. New York, NY: Carroll & Graf; 2005.
10. Wright K. *The great down-low debate. A new black sexual identity may be an incubator for AIDS*. New York, NY: The Village Voice; 2001;23.
11. Harris EL, Roberts T. Passing for straight. *Essence*. 2004;156–162.
12. Hooper E. Black men on 'the down low' and AIDS are scary trends. *St Petersburg, FL: St Petersburg Times*; 2004.
13. Centers for Disease Control and Prevention. HIV transmission among black college student and non-student men who have sex with men—North Carolina, 2003. *MMWR - Morbidity & Mortality Weekly Report*. 2004;53:731–734.
14. Harris EL. *Invisible Life [Invited Lecture]*. Durham, NC: Duke University; 2004.
15. Smiley T. Segment with Jeff Obafemi Carr. *Tavis Smiley Show: National Public Radio*, 2004.
16. Sternberg S. The danger of living 'down low': black men who hide their bisexuality can put women at risk. *USA Today*. 2001:1.
17. Roberts S, Lindsey CD. Down low buzz may drown message: public health educators see pitfall in author's exposure of some black men's secret sex lives. *Raleigh, NC: News and Observer*; 2004;1, 12.
18. Weeks J. *Sexuality*. New York, NY: Routledge; 2003.
19. Treichler PA. AIDS, Africa, and cultural theory. *Transition*. 1991;5:86–103.
20. Roberts D. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. New York, NY: Pantheon Books; 1997.
21. Graves JL. *The Race Myth: Why We Pretend Race Exists in America*. New York, NY: Penguin Books Ltd; 2005.
22. Davis AY. Race and criminalization: Black Americans and the punishment industry. In: Lubiano W, ed. *The House that Race Built*. New York, NY: Pantheon; 1997:264–279.
23. Wing SB. Whose epidemiology, whose health? *Int J Health Serv*. 1998;28:241–252.
24. Fee E, Krieger N. Understanding AIDS: historical interpretations and the limits of biomedical individualism. *Am J Public Health*. 1993;83:1477–1486.
25. Adam BD. Sociology and people living with HIV/AIDS. In: Huber J, Schneider BE, eds. *The Social Context of AIDS*. Newbury Park, CA: Sage Publications; 1992:3–18.
26. Centers for Disease Control and Prevention. *Fact Sheet: HIV/AIDS among African Americans*. Atlanta, GA: Centers for Disease Control and Prevention; 2006:6.
27. Centers for Disease Control and Prevention. Diagnoses of HIV/AIDS – 32 States, 2000–2003. *MMWR - Morbidity & Mortality Weekly Report*. 2004;53:1106–1110.
28. McQuillan GM, Kruszon-Moran D, Kottiri BJ, Kaminoto LA, Lam L, Cowart MF, et al. Prevalence of HIV in the US Household Population: the National Health and Nutrition Examination Surveys, 1988 to 2002. *J Acquir Immune Defic Syndr*. 2006;41:651–656.
29. Centers for Disease Control and Prevention. Heterosexual transmission of HIV–29 states, 1999–2002. *MMWR - Morbidity & Mortality Weekly Report*. 2004;53:125–129.
30. Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report, 2003. Cases of HIV infection and AIDS in the United States, 2003*. Atlanta, GA: Centers for Disease Control and Prevention; 2004.
31. Centers for Disease Control and Prevention. *HIV/AIDS among Women*. Atlanta, GA: Centers for Disease Control and Prevention; 2004:5.
32. MacKellar DA, Valleroy LA, Secura GM, Behel S, Bingham T, Celentano DD, et al. Unrecognized HIV infection, risk behaviors, and perceptions of risk among young men who have sex with men: opportunities for advancing HIV prevention in the third decade of HIV/AIDS. *J Acquir Immune Defic Syndr*. 2005;38:603–614.
33. MacKellar DA, Valleroy LA, Secura GM, Behel S, Bingham T, Celentano DD, et al. HIV prevalence and associated risks in young men who have sex with men: Young Men's Survey Study Group. *JAMA*. 2000;284:198–204.
34. Anonymous. Unrecognized HIV infection, risk behaviors, and perceptions of risk among young black men who have sex with men—six U.S. cities, 1994–1998. *MMWR - Morbidity & Mortality Weekly Report*. 2002;51:733–736.

35. Montgomery JP, Mokotoff ED, Gentry AC, Blair JM. The extent of bisexual behaviour in HIV-infected men and implications for transmission to their female sex partners. *AIDS Care*. 2003;15:829–837.
36. Millett G, Malebranche DJ, Mason B, Spikes P. Focusing 'down low': bisexual black men, HIV risk and heterosexual transmission. *J Natl Med Assoc*. 2005;97(Supplement):52–59.
37. Centers for Disease Control and Prevention. Cases of HIV infection and AIDS in the United States, by race/ethnicity 1998-2002. HIV/AIDS Surveillance Supplemental Report. 2003;10.
38. Lee LM, McKenna MT, Janssen RS. Classification of transmission risk in the national HIV/AIDS surveillance system. *Public Health Rep*. 2003;118:400–407.
39. Malebranche DJ. Black men who have sex with men and the HIV epidemic: next steps for public health. *Am J Public Health*. 2003;93:862–865.
40. Lichtenstein B. Secret encounters: black men, bisexuality, and AIDS in Alabama. *Med Anthropology Q*. 2000;14:374–393.
41. Heckman TG, Kelly JA, Bogart LM, Kalichman SC, Rompa DJ. HIV risk differences between African-American and white men who have sex with men. *J Natl Med Assoc*. 1999;91:92–100.
42. Wohl AR, Johnson DF, Lu S, Jordan W, Beall G, Currier J, et al. HIV risk behaviors among African American men in Los Angeles County who self-identify as heterosexual. *J Acquir Immune Defic Syndr*. 2002;31:354–360.
43. Siegel K, Schrimshaw EW, Karus D. Racial disparities in sexual risk behaviors and drug use among older gay/bisexual and heterosexual men living with HIV/AIDS. *J Natl Med Assoc*. 2004;96:215–223.
44. Bingham TA, Harawa NT, Johnson DF, Secura GM, MacKellar DA, Valero LA. The effect of partner characteristics on HIV infection among African American men who have sex with men in the Young Men's Survey, Los Angeles, 1999-2000. *AIDS Educ Prev*. 2003;15:39–52.
45. Harawa NT, Greenland S, Bingham TA, et al. Associations of race/ethnicity with HIV prevalence and HIV-related behaviors among young men who have sex with men in 7 urban centers in the United States. *J Acquir Immune Defic Syndr*. 2004;35:526–536.
46. Easterbrook PJ, Chmiel JS, Hoover DR, Saah AJ, Kaslow RA, Kingsley LA, et al. Racial and ethnic differences in human immunodeficiency virus type 1 (HIV-1) seroprevalence among homosexual and bisexual men: the Multicenter AIDS Cohort Study. *Am J Epidemiol*. 1993;138:415–429.
47. Centers for Disease Control and Prevention. HIV/STD risks in young men who have sex with men who do not disclose their sexual orientation—six U.S. cities 1994-2000. *MMWR - Morbidity & Mortality Weekly Report*. 2003;52:81–86.
48. Tucker C. Homophobia among black churches is taking dangerous toll. Atlanta, GA: Atlanta Journal-Constitution; 2004.
49. Harris EL. *Invisible Life*. New York, NY: Anchor Books: A Division of Random House Publishing; 1994.
50. Harris EL. *Just As I Am*. New York, NY: Doubleday; 1994.
51. Denizet-Lewis B. *Double Lives on the Down Low*. New York, NY: New York Times Magazine; 2003:1.
52. Winfrey O. *A Secret Sex World: Living on the "Down Low"*. The Oprah Winfrey Show. Chicago, IL: King World; 2004.
53. Wright K. AIDS and black New Yorkers: Homophobia, racism, and rejection fuel rising infections - Part 2: black, gay, at-risk. New York, NY: The Village Voice; 2000:32.
54. Vargas JA. HIV-positive, without a clue: Black men's hidden sex lives imperiling female partners. Washington, DC: The Washington Post; 2003: B01.
55. Forney A, Campanella J, De Segonzac J, Makris C, Shill S, Zakrzewski A, et al. *Law & Order: Special Victims Unit, Low Down (Episode E4424)*. Law & Order: Special Victims Unit. USA: Wolf Films in association with Universal Network Television; 2004.
56. African-American men hide bisexuality. *AIDS Patient Care STDS*. 2001;15:342.
57. Bisexual partners behind HIV risk. *AIDS Patient Care STDS*. 2003; 17:489.
58. Wolfe WA. Overlooked role of African-American males' hypermasculinity in the epidemic of unintended pregnancies and HIV/AIDS cases with young African-American women. *J Natl Med Assoc*. 2003;95:846–852.
59. Lehner T, Chiasson MA. Seroprevalence of human immunodeficiency virus type 1 and sexual behaviors in bisexual African-American and Hispanic men visiting a sexually transmitted disease clinic in New York City. *Am J Epidemiol*. 1998;147:269–272.
60. So DW. Psychosocial HIV/AIDS prevention for high-risk African American men: guiding principles for clinical psychologists. *Clin Psychol*. 2003;10:468–480.
61. Mays VM, Cochran SD, Zamudio A. HIV prevention research: are we meeting the needs of African American men who have sex with men? *J Black Psychol*. 2004;30:78–105.
62. Brooks R, Rotheram-Borus MJ, Bing EG, Ayala G, Henry CL. HIV and AIDS among men of color who have sex with men and men of color who have sex with men and women: an epidemiological profile. *AIDS Educ Prev*. 2003;15:1–6.
63. Hart T, Peterson JL. Predictors of risky sexual behavior among young African American men who have sex with men. *Am J Public Health*. 2004;94:1122–1124.
64. Dudley MG, Rostovsky SS, Korfhage BA, Zimmerman RS. Correlates of high-risk sexual behavior among young men who have sex with men. *AIDS Educ Prev*. 2004;16:328–340.
65. Dumke NM. African-American college students at risk for HIV. *J Natl Med Assoc*. 2004;96:1264.
66. Lewis LJ, Kertzner RM. Toward improved interpretation and theory building of African American male sexualities. *J Sex Res*. 2003;40:383–395.
67. Health care needs of gay men and lesbians in the United States: Council on Scientific Affairs, American Medical Association. *JAMA*. 1996;275: 1354–1359.
68. Howard J. *Men Like That: A Southern Queer History*. Chicago, IL: University of Chicago Press; 1999.
69. Sears JT. *Lonely Hunters: An Oral History of Lesbian and Gay Southern Life, 1948-1968*. Boulder, CO: Westview Publishing; 1997.
70. Howard J. *Carryin' on in the Lesbian and Gay South*. New York, NY: New York University Press; 1997.
71. Beam J. *In the Life. A Black Gay Anthology*. Boston, MA: Alyson Publication; 1986.
72. Hemphill E, Beam J. *Brother to Brother: New Writings by Black Gay Men*. Boston, MA: Alyson Publications; 1991.
73. Riggs MT. *Tongues Untied. Frameline's Lesbian and Gay Cinema Collection*. New Almaden, CA: Wolfe Video; 1996.
74. Julien I. *Looking for Langston*. USA: Waterbearer Films. 1992.
75. Bell NK. Social/sexual norms and AIDS in the South. Ethics and the politics of AIDS: lessons for small cities and rural areas throughout the U.S. *AIDS Educ Prev*. 1991;3:164–180.
76. Bloor M. *The Sociology of HIV Transmission*. London: Sage Publications; 1995.
77. Diaz T, Chu SY, Frederick M, Hermann P, Levy A, Mokotoff ED, et al. Sociodemographics and HIV risk behaviors of bisexual men with AIDS: results from a multistate interview project. *AIDS*. 1993;7:1227–1232.
78. Doll LS, Petersen LR, White CR, Johnson ES, Ward JW. Blood Donor Study Group. Homosexually and nonhomosexually identified men who have sex with men: a behavioral comparison. *J Sex Res*. 1992;29: 1–14.

79. Parker RG, Carballo M. Qualitative research on homosexual and bisexual behavior relevant to HIV/AIDS. *J Sex Res.* 1990;27:497–525.
80. Taylor CL. Mexican male homosexual interaction in public contexts. *J Homosex.* 1985;11:155–163.
81. Caceres CF. HIV among gay and other men who have sex with men in Latin America and the Caribbean: a hidden epidemic? *AIDS.* 2002;16:S23–S33.
82. Ross MW, Essien EJ, Williams ML, Fernandez-Esquer ME. Concordance between sexual behavior and sexual identity in street outreach samples of four racial ethnic groups. *Sex Transm Dis.* 2003;30:110–113.
83. Centers for Disease Control and Prevention. Supplement to HIV/AIDS Surveillance Project: Demographic and Behavioral Data from a Supplemental HIV/AIDS Behavioral Surveillance Project 1997 to 2000. HIV/AIDS Special Surveillance Report, Vol. 1(2). Atlanta, GA: Centers for Disease Control and Prevention; 2004.
84. Wolitski RJ, Wasserman JL, Jones KT, Jenkins J. Down-low identity among at-risk men who have sex with men. National HIV Prevention Conference. Atlanta, GA, 2005.
85. Williams RM. Living at the crossroads: explorations in race, nationality, sexuality, and gender. In: Lubiano W, ed. *The House that Race Built*. New York: Pantheon Books; 1997:136–156.
86. Hyde A. *The Racial Body: Bodies of Law*. Princeton, NJ: Princeton University Press; 1997:222–240.
87. Stevenson HC. The psychology of sexual racism and AIDS: an ongoing saga of distrust and the 'sexual other'. *J Black Stud.* 1994;25:62–81.
88. Hill Collins P. *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*. Boston, MA: Unwin Hyman Ltd; 1990.
89. White DG. *Ar'n't I a woman?: Female Slaves in the Plantation South*. New York: W.W. Norton & Co; 1987.
90. Smith B. *Home Girls: A Black Feminist Anthology*. New York: Kitchen Table Women of Color Press; 1983:377.
91. Moraga C, Anzaldúa G. *This Bridge Called My Back: Writings by Radical Women of Color*. Watertown, MA: Persephone Press; 1981:261.
92. Riggs MT. *Black Is... Black Ain't: A Personal Journey Through Black Identity*. San Francisco, CA: Independent Television Service; 1995.
93. Hull GT, Scott PB, Smith B. *All the Women Are White, All the Blacks Are Men, But Some of Us Are Brave: Black Women's Studies*. Old Westbury, NY: Feminist Press; 1982.
94. Cohen CJ. *The Boundaries of Blackness: AIDS and the Breakdown of Black Politics*. Chicago, IL: University of Chicago Press; 1997.
95. Johnson AG. *Stigma. The Blackwell Dictionary of Sociology: A User's Guide to Sociological Language*. Malden, MA: Blackwell Publishers; 2000:313.
96. Guttman N, Salmon CT. Guilt, fear, stigma and knowledge gaps: ethical issues in public health communication interventions. *Bioethics.* 2004;18:531–552.
97. Berger MT. *Workable Sisterhood: The Political Journey of Stigmatized Women with HIV/AIDS*. Princeton, NJ: Princeton University Press; 2004.
98. Parker R, Aggleton P. HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. *Soc Sci Med.* 2003;57:13–24.
99. Reidpath DD, Chan KY. A method for the quantitative analysis of the layering of HIV-related stigma. *AIDS Care.* 2005;17:425–432.
100. Weisbord RG. *Black Sexuality and the Racial Threat: Genocide?: Birth Control and the Black American*. Westport, CT: Greenwood Press; 1975:25–40.
101. Dalton HL. AIDS in blackface. *Daedalus.* 1989;118:205–227.
102. Whetten-Goldstein K, Nguyen TQ. *'You're the First One I've Told': New Faces of HIV in the South*. New Brunswick, NJ: Rutgers University Press; 2002.
103. Fullilove RE. HIV prevention in the African-American community: Why isn't anybody talking about the elephant in the room? *AIDS Science.* 2001;1:1–7.
104. Harawa NT, Williams JK, Ramamurthi HC, Bingham TA. Perceptions towards condom use, sexual activity, and HIV disclosure among HIV-positive African American men who have sex with men: implications for heterosexual transmission. *J Urban Health.* 2006;83:682–694.
105. Plant AJ, Rushworth RL. 'Death by proxy': ethics and classification in epidemiology. *Soc Sci Med.* 1998;47:1147–1153.
106. Little M. Assignments of meaning in epidemiology. *Soc Sci Med.* 1998;47:1135–1145.
107. Kaufman JS, Cooper RS, Mcgee DL. Socioeconomic status and health in blacks and whites: the problem of residual confounding and the resiliency of race. *Epidemiology.* 1997;8:621–628.
108. Pagano M, Gauvreau K. *Principles of Biostatistics*. Belmont, CA: Duxbury Press; 1993.
109. Kelly BC. On encompassing sexuality. *Am J Public Health.* 2001;91:1731–1732.
110. Crawford I, Allison KW, Zamboni BD, Soto T. The influence of dual-identity development on the psychosocial functioning of African-American gay and bisexual men. *J Sex Res.* 2002;39:179–189.
111. Goldbaum G, Perdue T, Wolitski R, et al. Differences in risk behavior and sources of AIDS information among gay, bisexual, and straight-identified men who have sex with men. *AIDS Behav.* 1998;2:13–21.
112. Silvestre AJ, Arrowood SH, Ivery JM, Barksdale S. HIV-prevention capacity building in gay, racial, and ethnic minority communities in small cities and towns. *Health Soc Work.* 2002;27:61–66.
113. Malebranche DJ, Peterson JL, Fullilove RE, Stackhouse RW. Race and sexual identity: Perceptions about medical culture and healthcare among black men who have sex with men. *J Natl Med Assoc.* 2004;96:97–107.
114. Airhienbuwa CO, DiClemente RJ, Wingood GM, Lowe A. HIV/AIDS education and prevention among African-Americans: a focus on culture. *AIDS Educ Prev.* 1992;4:267–276.
115. Wallace RG. AIDS in the HAART era: New York's heterogeneous geography. *Soc Sci Med.* 2003;56:1155–1171.
116. Auerbach JD, Coates TJ. HIV prevention research: accomplishments and challenges for the third decade of AIDS. *Am J Public Health.* 2000;90:1029–1032.
117. Adimora AA, Schoenbach VJ. Social context, sexual networks, and racial disparities in rates of sexually transmitted infections. *J Infect Dis.* 2005;191:S115–S122.
118. Lane SD, Rubinstein RA, Keefe RH, et al. Structural violence and racial disparity in HIV transmission. *J Health Care Poor Underserved.* 2004;15:319–335.
119. Mackenzie S. Scientific silence: AIDS and African Americans in the medical literature. *Am J Public Health.* 2000;90:1145–1146.