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Psychosocial Implications of Family and Religious Homophobia: Insights for HIV Combination Prevention among Black Men who have Sex with Men

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Abstract

Black men who have sex with men (BMSM) bear an increasingly disproportionate burden of HIV in the United States. Research demonstrates that psychosocial factors, such as homophobia, are associated with HIV risk. Between June 2013 and May 2014, we conducted three in-depth interviews with each of 31 BMSM and interviews with 17 community stakeholders in New York City to understand the sociocultural and structural factors that may affect adherence to oral pre-exposure prophylaxis (PrEP) among BMSM and to inform an adherence clinical trial. BMSM and community leaders frequently described condomless sex as a consequence of psychological factors and economic circumstances stemming from homophobia from families and religious groups. Negative support from social networks affected self-worth, which community stakeholders believed was crucial for men to engage in HIV prevention, such as PrEP. Our results indicate that addressing psychosocial factors and fostering social support are key elements to improve the effectiveness of combination prevention among BMSM.

Keywords

HIV/AIDS; Combination Prevention; Black MSM; Social Support; Pre-exposure Prophylaxis

INTRODUCTION

From 2008–2010, black men who have sex with men (BMSM) represented only 2% of the US population but approximately 75% of new HIV infections (CDC, 2012). A recent study of BMSM in six US cities reported an HIV prevalence of 21% (Koblin, 2012). New York City has one of the highest infection rates of HIV infection in the US. In 2011, 66.1% of all new HIV diagnoses in NYC were among black men, of which 56.2% were MSM(NYCDOHMH, 2012). Compared to other racial-ethnic groups, HIV-infected BMSM are less likely to know their HIV status (Centers for Disease Control and Prevention (CDC), 2005; MacKellar et al., 2005; Millett, Peterson, Wolitski, & Stall, 2006) and have lower rates

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of retention in HIV care (Calvert & Isaac-Savage, 2013; Christopoulos, Das, & Colfax, 2011; Giordano, Hartman, Gifford, Backus, & Morgan, 2009); they are less likely to be virally suppressed than HIV-infected White MSM (Beer, 2013).

A recent review and meta-analysis among BMSM pointed to contextual factors – structural, social, and cultural – as key drivers of the epidemic (Maulsby et al., 2014; Millett et al., 2012). Mental health problems including depression, stress, substance abuse, and exposure to violence are associated with homophobia and increased social vulnerability to HIV among MSM in the US (Mustanski, Garofalo, Herrick, & Donenberg, 2007; Reisner et al., 2009; Stall et al., 2003). How the roots of homophobia in social support networks can be addressed to reduce HIV risk in interventions among BMSM is underexplored.

Social support is a proven determinant of psychosocial health(Cohen, 1988), and research suggests that the family and religious institutions are critical sources of social support within black communities (Haley et al., 1996; McAdoo, 2007; Utsey, Bolden, Lanier, & Williams, 2007). One recent study among young BMSM in Chicago found religiosity and frequent religious attendance to be associated with fewer instances of unprotected anal sex(Garofalo et al., 2014). Based on what they describe as the "historical tension between certain religious doctrine and sexual minorities" (p.9), study authors called for "qualitative data about the experiences of religious practices and beliefs among YMSM" (Garofalo et al., 2014). Other research has described the homophobia and the HIV-related stigma that BMSM face in religious institutions (Balaji et al., 2012; Valera & Taylor, 2011; Wilson, Wittlin, Muñoz-Laboy, & Parker, 2011) and the family (Balaji et al., 2012; Hussen et al., 2014). We could not identify any studies that explored how these forms of social support (i.e. from family and religious institutions) may affect psychosocial processes, heighten sexual risk, and the uptake of combination HIV prevention.

Our ethnographic study explored the sociocultural and structural factors that could affect adherence to pre-exposure prophylaxis (PrEP) among BMSM in New York City. In this paper, we (1) describe the psychosocial reasons men gave for engaging in condomless sex and (2) connect those reasons to men's experiences of rejection from families and religious organizations. We suggest ways in which important psychosocial factors could be addressed in combination prevention interventions and clinical practice. In the context of widespread and growing enthusiasm for biomedical prevention, we argue that these insights about psychosocial vulnerability are a crucial starting place for building effective combination prevention strategies which include a behavioral component to support PrEP uptake and adherence (Grossman, Purcell, Rotheram-Borus, & Veniegas, 2013; Strathdee, Shoptaw, Dyer, Quan, & Aramrattana, 2012).

METHODS

Data collection consisted of three methods that took place between June 2013 and May 2014: three in-depth interviews each with 31 BMSM in New York City and 17 key informant interviews with community stakeholders. All in-depth interviewees were aged 15 and older, born as and identified as male, and reported having had anal or oral sex with a man within the past year. Recruitment consisted of outreach and advertising in bars, clubs,

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community health centers, and the Internet. We also worked with a two Community Advisory Boards (i.e., client CAB and provider CAB) to identify community stakeholders (key informants) that have been active in addressing HIV risk among BMSM in New York City. All participants were read a verbal informed consent form: their understanding was assessed with a series of follow-up questions, and data analysis began following verbal consent. The study's lead ethnographer conducted interviews (which were all in person) as described in Table I.

Interviews were digitally-recorded and transcribed verbatim. Interview data were analyzed and triangulated between and across cases using Atlas.ti 7.0 qualitative software. These analyses employed a codebook that was developed based on domains (code families) derived from the interview guides. All procedures were approved by the Columbia University Medical Center Institutional Review Board.

RESULTS

As shown in Table II, the mean age for our sample of BMSM was 29.0 years (SD, 12.3). Of the men who had condomless sex in the last 12 months, most were experiencing precarious housing or homelessness and most were unemployed. In last six months, men had a range of 1–40 male sexual partners (mean = 6.1; SD, 8.6); five men had sex with 1–5 female partners (mean = 2.4).

Explanations for condomless sex

The majority of men explained condomless sex in terms of the need to feel desirable or loved, the want to feel trust in sexual partners, feelings of shame, and moods such as depression or sadness (see Table III.).

In addition, men rationalized condomless sex in relation to satisfying economic needs such as food and housing, and approximately a third of the men made extra money through sex work. For instance, a 24 year-old gay man generated income primarily from sex work (with and without condoms) to "put food on the table," and a 21 year-old gay man exchanged sex for favors, such as having a cell phone bill paid, although he differentiated this from "prostituting" himself. Men with more economic hardship gave less weight to using condoms, and expressed using sex to cope with "uncontrollable" life circumstances.

The community stakeholders we interviewed echoed the psychosocial and economic themes. Many referred to psychological reasons for condomless sex, such as seeking love, feeling "less than," and feeling shame, as well as depression. A community outreach worker and peer educator made these connections, drawing on his experience with clients:

> Black men want to feel desired. They want to feel wanted. They want to feel love, and this is where that whole idea of being corrupt or damaged comes in. I wouldn't even say it's misguided because there really isn't someone to guide them at all, at least for my generation. But sex is a perfect example. There are times where if guys see a sexy, attractive man that they think that they would never have gotten, they may be prone to do things that they would not necessarily want to do: unprotected

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> sex, bottoming, 'cause bottoming is looked at as a very submissive in the negative context.

These explanations for sexual risk-taking underline how men's internal states and affective desires shape practices that render them vulnerable to HIV infection.

Family rejection

Men's intense desires for affirmation and positive affective connections reflect painful experiences of rejection many of them endured from their families. Most men who had condomless sex in the last 12 months had experienced rejection from their families (see Table II). For these men, this rejection occurred either when they disclosed their sexuality or because they displayed feminine gender performance (see Table IV). One young man (22, gay) was homeless because his father became "physically abusive" when he found out his son was having sex with men, a pattern experienced by several homeless youth in the study. Some men claimed that homophobic friends influenced their families, leading their parents to feel that they "failed" at raising them. For others, however, the harm was not that they were taken out of school or forced to leave home, but rather that the disapproval and lack of support from their families caused them stress and shame and left them with enduring feelings of being unlovable.

Religious rejection

Most men who had condomless sex in the last 12 months felt rejected, guilty or shamed by religious institutions due to their sexuality (see Table II). Many of those who experienced homophobia from their churches maintained their ties to churches, chose to be secretive about sexuality, and continued to believe that homosexuality was wrong; they had taken on, in their own self-image, the identity of the sinner. Others expressed unease and confusion about the moral status of their sexual practices, hoping to change their homosexual behaviors and desires (see Table IV). A clinician described a patient who endured a relationship with a violent partner because he "felt so awful about himself, felt so guilty about his homosexuality, felt so much shame" that he believed that he "deserved punishment." According to the clinician, this sentiment was further reinforced "every Sunday, as he dutifully went to church to be flogged." In fact, several men were told HIV was a form of punishment, instilling fatalism about the inevitability of HIV infection. Many men in our sample internalized homophobia due to religious and family rejection, and community experts indicated that this social stigma challenged HIV prevention.

Challenges for combination HIV prevention

We documented several barriers to PrEP acceptance and adherence. The widespread stigmatization of HIV and homosexuality within families, among peers and within the gay community made PrEP off-putting to many participants. For example, a 22 year-old gay man who would be afraid that his friends and family found out he was on PrEP explained:

> If people were to hear that one was taking medications to help prevent, some people would think that the person was risky – have risky behavior. Some people may think that the person's a whore or a hoe or a escort, that they're gay off-the-bat.

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Many men thought that PrEP was not socially acceptable within their peer groups. One 21-year-old gay man suggested that the "normalization" of PrEP among peers would be most effective for addressing stigma and social pressure:

> I think a big part of it, like I said, is normalizing it, making it part of just what is expected, what is routine…If it's the kind of thing where you feel like everyone else is doing it, I think that makes it easier to do it, if not putting that social pressure to, oh, well, why wouldn't you do it? Everyone is doing this. That will have a big impact on people.

In fact, most men thought people were not able to be "responsible enough" to take PrEP as directed, signaling a lack of perceived self-efficacy, which the literature on health promotion relates closely to issues of self-worth and self-esteem (43,44).

> I think that it [PrEP] is ludicrous. I think it promotes unsafe sex. I believe that as a country and as the GBLT community and the promiscuous behavior, which is in fact practiced on a day-to-day basis, I don't think that people are mature enough to handle such a pill. (39, same-gender loving)

As a 27-year-old gay man explained, safe spaces in community-based organizations (CBO) helped him to start thinking about safer sex as "self-love:"

> Before that I was more so excited that somebody was interested in me… I went through this complex where I just felt like people wouldn't like me. Like, I just never had that exposure to knowing how to appreciate my body when it comes to sex. That was something I learned once I started going to the CBOs and stuff and hearing that message of how it's, you know, of self-love, to just love your body. But, before that, it was just like I was just excited a guy is into me. I'm not thinking about all that other stuff.

Many emphasized that the dedicated, daily, self-care that adherence to PrEP is contingent on a host of other personal resources, including self-esteem and having a sense of control over one's life. Current and past experiences with homophonic families and religious institutions were related to men's mistrust of medications and medical institutions, psychosocial factors which challenged most (55% of sample) men's acceptance of biomedical prevention.

> So how you were socialized would prevent you from taking the [Truvada] pill… It's how you were taught about these things. You know what I mean? For the black community, the Caribbean community, Latinos – home remedies are a part of the culture, pretty much. You would hear growing up that pills are not good for you. (20, discreet)

Community stakeholders underlined that family and religious rejection created psychosocial vulnerability, and that addressing social support networks was essential for PrEP acceptance and adherence. A social worker told the story of a young man who hid his medication from his mother in a trombone to avoid stigma, and highlighted the importance of a "supportive environment" where men can develop "courage" and "agency" to manage their own health; for him this will require overcoming "a lot of the self-esteem and self-worth issues tied to some clients not feeling that they matter." Clinical psychologists, social workers, community clinic physicians and administrators all had "many" clients who lacked emotional support

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from families or who had been "kicked out," which led to them being "shamed;" key informants associated this with "low self-worth," "attachment problems in relationships," and "low self-care." As a community-based organization coordinator explained, rolling out PrEP and reducing sexual risk behaviors requires "mentoring" young men on "how to develop a healthy relationship when they've never seen one" because "a lot of these guys don't have a father figure." One clinical psychologist claimed that, like consistent condom use, for PrEP to work as part of the HIV toolkit, group training in "self-love" was necessary to overcome feelings of shame and rejection, suggesting:

> What you want to do is help them have some ownership. This PrEP is not like a Rolaids: when you take it, your acid is gone. This is a daily commitment to something. This is a commitment to health, to longevity…To loving yourself, okay?

Thus, community stakeholders emphasized improving the quality of emotional and social support networks to instill self-worth, which they considered essential for acceptance and adherence to PrEP as part of the HIV prevention toolkit.

DISCUSSION

The importance of social support from family and religious institutions in black communities in the US, and the role it plays in HIV risk behaviors, as well as homophobia from religious groups are well-documented(Balaji et al., 2012; Haley et al., 1996; Valera & Taylor, 2011; Wilson et al., 2011). Our findings go further to suggest that these forms of social rejection can shape men's sexual risk behavior and commitment to self-care. Men in our sample explained engagement in condomless sex through reference to their internal affective states and emotional histories, including feeling shame and low self-worth, and needing validation from desirable men. Men's narratives suggest that psychosocial factors are related to their relationships with their families and religious institutions. Many BMSM associated shame and guilt related to their homosexuality, as well as to their struggles to find love and self-care, with family and religious rejection. Key informants agreed that rejection from families and from religious institutions contributed to men's self-worth and attitudes toward self-care. Stakeholders identified these psychosocial factors as determinants of acceptance of and adherence to combination HIV prevention.

Low self-worth has been documented in other studies, suggesting that these psychosocial factors negatively affect engagement with HIV prevention in community-based clinics (Wilson & Moore, 2009). Research has also suggested that a desire for intimacy and love, even in casual sexual relationships, is associated with condomless sex among MSM(Bauermeister, Ventuneac, Pingel, & Parsons, 2012; Blechner, 2002; Carballo-Diéguez et al., 2011; Moskowitz, 2010). Through triangulation with stakeholder interviews, we found that service providers and outreach workers had similar explanations for condomless sex, including psychosocial factors such as mental health problems, shame and low self-worth. Consistent with our findings, some have called for "sex-positive" approaches to HIV prevention, in which health promotion is valued over placing negative normative judgment on sex (Blechner, 2002). The CDC has keenly reframed the notion of safer sex and protection, replacing "unprotected sex" with condomless sex, which acknowledges PrEP as a

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form of efficacious protection. Further stigmatization of sex could be counterproductive for the effectiveness of PrEP as an element of combination prevention.

Structural factors were also relevant to condomless sex: several men who lacked fulltime employment and were unstably housed or homeless also described not using condoms in relationships they maintained for the purpose of having a place to live, food to eat, and money. High rates of homelessness among young BMSM have been documented (Halkitis & Figueroa, 2013; Rosario, Schrimshaw, & Hunter, 2012), and consistent with other studies, for men in our sample family rejection often took the form of being forced to leave home. Other studies have indicated that socioeconomic issues related to homelessness and unemployment create a context of vulnerability for HIV infection (Aidala, Cross, Stall, Harre, & Sumartojo, 2005; Marshall et al., 2009; Millett et al., 2012). However, men in our sample used psychosocial factors to explain instances of condomless sex far more frequently than socioeconomic issues. This suggests that HIV prevention aimed at the social roots of sexual risk should address both the internal affective states which reflect multiple dimensions of social inequality, as well as the material dimensions of those social inequalities.

Our study documented the historical arc of men's lifelong experiences with social support networks, but our conclusions are limited because our findings cannot be generalized to describe all BMSM. Our sample, however, closely reflects the situation of BMSM who are most vulnerable to HIV and other health problems, and their stories provide insight into the specific community context experienced in New York City, one of the epicenters of the US epidemic. Our sample is largely composed of men on public assistance or without insurance, indicating our success at recruiting individuals with lower socioeconomic status. Furthermore, finding and describing the lives of MSM who are not open about their sexuality was inherently difficult because this is a "hidden population." A third of our sample identified as discreet, straight or bisexual. These men's ability to talk about stigmatizing subject matter in interviews suggests that qualitative research gives us particular insight about socially marginalized BMSM. Thus, this analysis presents key themes that emerged about the relationship between social support, psychosocial health, and sexual risk among men that are highly vulnerable to HIV.

This study provides insights about the kinds of support that men may need to feel the kind of 'self-love' that might lead them to seek out and adhere to combination HIV prevention modalities such as PrEP. Few studies have focused on the psychosocial factors that could affect PrEP acceptance among BMSM, such as medical mistrust, client-provider relationships, and substance use (Eaton et al., 2014). Social support could help men feel deserving and valuable, which may both reduce condomless sex and increase men's motivation to engage in self-care, for example by using PrEP. Increasing combination prevention, and thus PrEP uptake and adherence, means working at the individual level and with men's existing social support networks and, where necessary, providing alternative sources of social support. Combination prevention strategies could be configured to target social networks that create barriers to HIV prevention. Our findings suggest that desire to use PrEP is contingent on self-love which necessitates social support.

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Among a highly socioeconomically vulnerable sample of men, combination HIV prevention could include community-level interventions to address homophobia in families and religious institutions. Combination prevention could include individual and behavioral approaches that help men deal with the psychosocial health problems related to those rejections. Our findings suggest that noting experiences with homophobia in social support networks in clients' medical histories could be important for risk management. Further research is necessary to evaluate how social support could be effectively incorporated into the practice of assessing individual readiness for PrEP and combination HIV prevention.

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Table I

Methods

Data collection method	Specific data elicited	Sample description
In-depth Interviews	Session 1: History of family relations, coming of age, education, housing, making money, friends; groups belong to; community engagement; Session 2: Sexual history, including desire, casual and steady relations, sexual identity and racial identity Session 3: Perceptions of health and risk; practices and attitudes about medications and seeking health services; knowledge, attitudes and practices about HIV prevention and PrEP.	31 participants
Key Informant Interviews	Organizational mission; role in organization/group/community; knowledge and attitudes about black MSM, HIV vulnerability, institutions and networks available to Black MSM; views on PrEP and other forms of HIV prevention	17 community stakeholders, including 2 physicians; 3 mental health providers; 4 community organization program administrators; 5 outreach workers; 3 community mobilizers

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Table II

Sample characteristics and condomless sex

Characteristic	Total N=31	Condomless sex (12mo)
Age	Mean, 29.0	
15–24	17 (55%)	9 (53%)
25+	14 (45%)	7 (50%)
Sexual Identity		
Gay	15 (48%)	9 (60%)
Same gender loving	3 (10%)	1 (33%)
Bisexual	4 (13%)	2 (50%)
Discreet	4 (13%)	2 (50%)
Straight	3 (10%)	3 (100%)
Other (MSM, None)	2 (6%)	0 (0%)
HIV Status (self-report)		
Negative	23 (74%)	12 (52%)
Positive	5 (16%)	3 (60%)
Undisclosed	3 (10%)	1 (33%)
Housing		
Stable	15 (48%)	5(33%)
Precarious	11 (36%)	8 (73%)
Homeless	5 (16%)	3 (60%)
Employment		
Full time	8 (26%)	1 (13%)
Part time	8 (26%)	5 (63%)
Unemployed	15 (48%)	10 (67%)
Insurance Status		
Private	5 (16%)	1 (20%)
Public	17 (55%)	10 (59%)
Uninsured	9 (29%)	5 (56%)

Characteristic	Total N=31	Condomless sex (12mo)
Family		
Rejection	21 (68%)	12 (57%)
Support	10 (32%)	4 (40%)
Church		
Rejection	16 (52%)	10 (63%)
Support	4 (13%)	1 (25%)
Spiritual, not religious	11 (36%)	5 (45%)

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Table III

Psychosocial explanations for condomless sex

Theme	Representative Quotes
Self-worth	So if the condom doesn't happen, it just didn't happen….I was more so excited that somebody was interested in me. I went through this complex where I just felt like, because of my size, people wouldn't like me. (27, same gender loving) What's going on within the black gay community as far as the risk… people are still converting and becoming positive. I think what it has a lot to do with is issues of self-worth, self-esteem, perception, economic struggle. (31, gay)
Trust	I guess I just felt comfortable with him…I felt safe with him…So it was just like I didn't think that he was talking to other people or whatever or sexually active with other people. But I think in July or August last year, he contracted HIV. So he told me like the day he found out or whatever. Then I went and got tested. I tested negative. (17, gay) If my partner and I, we go get tested and I feel like we're only having sex with each other, then I would stop using them [condoms]. (21, bisexual)
Love	Some people will sit up here and say and think they're in love with you, when it's not you they're in love with, they're in love with the sex. So they want to start doing other things as far as I don't really care about if I catch HIV from this person, because I love them. (24, gay)
Guilt	Well, no, the guilt came after having the sex. Like, "Oh, man. I can't believe it." Yeah, I thought it was wrong, what I was doing… having sex with another guy." (47, discreet)
Mood	When I'm stressed, or depressed, or whatever, I'm like, let's do something. How I got into contracting the disease, the virus, I had a really bad month of depression after I broke up with somebody…I was spending money, going to hotels, getting drunk, doing this, doing that. I wound up like – not like I was totally unaware that that dude didn't have a condom on. I was aware. I was in the depressed mode. (29, gay)

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Table IV

Narratives of feeling rejected by family or religious groups

Theme	Representative Quotes
Family rejection	[When I came out as gay,] I got like pulled out of school because of it, like – and my parents also like, they didn't like my gay friends and like the people I was hanging around… And then that affected me like a lot. That was really rough for me. Like, I didn't do that well towards the end of the year 'cause I had a lot going on, and like being home was really stressful. (17, gay) Their friends or whatever was saying something and they thought you know that I was gay so they asked my brother and like oh, how your father failed … He said, "I don't want you to come in and embarrass me and shame me or whatever… you could have kept to yourself and don't say anything to anybody." (22, gay) But I got kicked out [of my parents' house] because … I was getting real comfortable with being gay and stuff like that, so I was starting not to care. (24, gay) And all of the negativity that comes with being homosexual from heterosexuals, from religion, from your grandma, from your aunt, from your uncle's buddy, from your uncle – they could say everything about faggots and lesbians… It's not supported in the black community; it's definitely not supported through church. (46, discreet) I think if my father would have been around, maybe my life would have changed. Maybe I wouldn't be having sex with men. Maybe that wouldn't have happened…from drug dealing to sex work and everything. (24, gay)
Religious rejection/guilt	One thing I noticed about religious people, they could be hypocrites and some of them are even fake, like they'll just tell you such and such to just bring you down. [Q: What would they tell you?] Like, "Oh, that's wrong or that's not the way. Or God made Adam and Eve, not Adam and Steve." They will just tell you all different types of things when you're supposed to be a good image yourself, when they're just saying a whole bunch of negative things. (16, bisexual) We know the Bible is the word of God and it's right, that homosexuality is wrong, and we all know this whether they want to accept it or deny it or not… Be a man and own up to what you're doing. Talk about, "oh, we're not doing it, that ain't right, it's right, who's to say?" God said it, that's who, that's the top person right there. God said it's wrong so it's wrong…. Fornication, adultery, homosexuality, all that shit, bestiality, all that shit is wrong, it's wrong but we do it. I know I do it 'cause I'm selfish… Sometimes you got to man up. (45, straight) It's really something that I don't discuss [religion and homosexuality] because it's really mind boggling and right now. I really don't want to deal with that, okay… I believe in God – but the interpretation of the Bible, it's just so much, and it's really confusing… It's not something I discuss. I'm like, okay, homosexuality is wrong. (20, discreet) A lot of times I feel bad about it and saying, "God, why couldn't I be attracted to Mary instead of Mark?" And it's just frustrating, I feel bad about it. I try to change, but at the end of the day, who am I fooling… So if I am to change this [homosexual] lifestyle and do something else, He will direct me from there, in His time, and it's perfect. (17, gay)