The HIV/AIDS Pandemic in African American MSM: Targets for Intervention

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Abstract

The Centers for Disease Control and Prevention estimated in 2005 that 46% of African American men who have sex with men (MSM) are HIV positive. This review explores the unique factors that contribute to risky sexual behavior and the spread of HIV within this population, suggesting that the disparate prevalence of HIV among African American MSM is rooted in experiences of stigmatization from multiple sources and lack of social support from society at large as well as from within the African American community. Beliefs in HIV conspiracy myths are also thought to hinder HIV education, awareness and prevention for African American MSM. Past interventions to reduce the spread of HIV among African American MSM are reviewed, and suggestions for future individual and community level interventions to reduce stigma, enhance social support, and de-emphasize beliefs in HIV myths are presented.

Key Words: African Americans, HIV/AIDS, risky sex, MSM, stigmatization

African American MSM and HIV: A Health Disparity

African Americans in the United States are disproportionately affected by HIV/AIDS, making up 13% of the population, but over 50% of HIV/AIDS cases. African American men are the largest demographic group living with HIV/AIDS in the United States, accounting for one-third of all cases. Over the last five years, HIV/AIDS has consistently ranked as one of the top three causes of death for African American men aged 25–44 in the United States, and it was the number one cause of death for this demographic in 2001 and 2002. African American men are also 10 times more likely than white men and 3 times more likely than Hispanic men to be diagnosed with HIV/AIDS. The Centers for Disease Control and Prevention (CDC) believe that over 50% of all African American men living with HIV/AIDS contracted the disease.
through male-to-male sexual contact, meaning that these men are engaging in risky, unprotected sex leading to the transmission of the HIV virus.

African American men who have sex with men (MSM) account for around 16% of all HIV/AIDS cases in the United States, and this percentage will grow exponentially as this population continues to have unprotected sex. In fact, a 2005 CDC study of African American MSM in five large cities (Los Angeles, San Francisco, Miami, Baltimore and New York) revealed that 46% were HIV positive, a greater percentage than the worst-hit areas of sub-Saharan Africa. Furthermore, of those who were HIV positive, a striking 67% were not aware that they were infected with HIV. Although statistics vary, research on African American HIV-positive MSM shows that 30%–40% report having unprotected sex in the last 3 months. These statistics support the highly disproportionate HIV infection rates observed for African American MSM and also indicate that unprotected sexual contact is the main contributor to the spread of HIV among this population.

This review explores the unique factors that contribute to risky sexual behaviors among African American HIV-positive MSM, with a special focus on the impacts of stigmatization from multiple sources, lack of social support, and HIV conspiracy beliefs. However, it should be noted that this investigation is hampered by several gaps in the literature. The majority of the research on sexual risk and HIV focuses either on all MSM living with HIV, or on all African Americans living with HIV, with only a handful of studies on African Americans who are also MSM. While it seems surprising that a group so disproportionately affected by HIV/AIDS would be so unrecognized in the literature, major researchers in the field confirm that very little has been written about this group and that only one HIV risk-related intervention for African American MSM had been published as of 2003. In the current review, findings that pertain specifically to African American MSM living with HIV will be utilized wherever possible, and it will be noted if literature cited refers to either African Americans in general or MSM in general. It is important to note these limitations, which highlight the need for more comprehensive and systematic research on prevention and treatment of HIV-related sexual risk behaviors for this population.

There are also a number of meaningful theoretical clarifications which ought to be stated before continuing the current review. First of all, the term MSM (men who have sex with men) is utilized as a behavioral indicator of male-to-male sexual contact. In other words,
participants in the majority of these studies do not self-identify as ‘gay,’ ‘homosexual’ or even ‘bisexual,’ but rather, are measured according to the reported frequency of their sexual behaviors. By utilizing this language instead of more common indicators of sexual identity like ‘gay’ and ‘homosexual,’ researchers in this field are able to avoid the identity meanings that may accompany these labels and focus instead on the actual risk behavior of unprotected male-to-male intercourse, and not a person’s sexuality. Secondly, this review is particularly concerned with the sexual risk behaviors of African American MSM who have already contracted HIV. These HIV-positive individuals are most desperately in need of future interventions as they continue to engage in risky sex, possibly spreading HIV/AIDS and also re-infecting or ‘super infecting’ themselves with a potentially more lethal strain of the virus. Third, the overarching goal of the current investigation is not only to identify and discuss the unique factors that contribute to unprotected sex for HIV-positive African American MSM, but also to use these findings to suggest interventions that might enhance their quality of life and reduce their risky sexual behaviors.

The Impact of Stigmatization from Multiple Sources

There is little research, and little consensus across the research, about how and why African American MSM are so disproportionately affected by HIV. The most salient feature of past literature is that African American MSM are both a racial and sexual minority, and this racial/sexual ‘double jeopardy’ leads to experiences of stigmatization and discrimination from society at large and from within the African American community. These multiple sources of stigma are unique to African American MSM and include racial discrimination from social structures like the healthcare system, racial discrimination by white gay men, sexual discrimination from a heterosexist society, stigmatization from fears about HIV, and sexual discrimination from individuals and leaders within the African American community.

African American MSM must cope with discrimination and stigmatization from society on a number of different levels. In general, African Americans in the United States are experiencing major disparities in health care as indicated in a 2005 report by the CDC Office for Minority Health. African Americans trail non-Hispanic whites on many of the major indicators of positive health as outlined by the national health objectives for 2010, including a having a smaller percentage of persons over 65 with health insurance, having fewer adults vaccinated for influenza, and having a greater percentage of adolescents...
and adults who are obese. With respect to obtaining care and resources specifically for HIV/AIDS, African Americans have unequal access to jobs that provide healthcare and/or insurance, must pay higher relative costs of insurance, and are less likely than whites to have health insurance. Roughly two-thirds of all HIV-positive African American men receive their treatment from Medicaid, whose funding has grown more uncertain due to announced 2007 budget cuts in Medicaid funding of $105 billion over the next 10 years. Many African American men living with HIV will struggle to find adequate care when these cuts become effective next year.

In addition to structural inequalities that impede procurement of adequate HIV education, prevention, and care for African American MSM, homophobic and anti-gay attitudes also have a negative impact on the health of MSM in the United States. Both heterosexual men and women (and particularly heterosexual men) have been consistently shown to hold negative attitudes toward homosexual men, homosexual behaviors, and gay rights, suggesting that the stigmatization faced by MSM from the dominant heterosexual discourse in the United States remains very salient. In certain governmental agencies—such as the US Pentagon, for example—homosexuality is still classified as a ‘mental disorder’ alongside mental retardation and other personality disorders. The stigmatization toward homosexuals in the United States extends beyond negative attitudes; many gay men report being victims of violence and abuse because of their homosexuality, and gay-bashing and gay beatings are still common in both rural and urban settings. In fact, over 50% of young gay men of color in the United States report experiencing either harassment or violence perpetrated against them by friends and family because of their sexuality, which often leads to problem behaviors beginning in adolescence.

Stigmatization linking HIV and homosexuality has been rife since the inception of the HIV epidemic in the 1980s, when the disease was initially labeled ‘gay-related immune deficiency’ and considered a ‘gay man’s disease.’ HIV/AIDS is even occasionally referred to as ‘God’s disease,’ suggesting a divine punishment intended to exterminate homosexual men, who are often considered ‘sinful’ in major religious organizations. African American MSM seeking solace from these mainstream anti-gay attitudes may not find support within the white gay male community, which has been shown to objectify and exoticize gay men of minority ethnicities. Negative attitudes about HIV are also rife within the gay community, where a pervasive divide exists between HIV-positive and HIV-negative gay men. In a 2006 study, HIV-positive
MSM reported experiencing negative, stigmatizing attitudes and sexual rejection from HIV-negative MSM. This HIV stigma was shown to have a negative effect on the psychological health of MSM living with HIV.

Worrisome is the paucity of social support that African American MSM—stigmatized by their ethnicity, sexual orientation, and HIV status—receive within the African American community. HIV/AIDS has been traditionally conceptualized as a white, gay male disease within the African American community, meaning that from the inception of the HIV/AIDS epidemic, African American political leaders have been hesitant to embrace HIV/AIDS as an African American political and social issue, for fear of accepting homosexuality. While research on African American attitudes toward homosexuality and HIV is limited, there is a consensus that African Americans are less permissive of homosexuality than whites, more likely than whites to think that homosexuality is ‘always wrong,’ and more likely than whites to agree that HIV is God’s way of punishing homosexual behaviors. Furthermore, African Americans demonstrate more negative attitudes about homosexuality to the extent that they are religious, which is a concern as over 70% of African Americans in the United States report church membership.

In an eight-year (1988–1996) qualitative study of members of African American churches in New York and Chicago, Fullilove and Fullilove (1999) found strong feelings of stigmatization towards homosexuals, particularly MSM. Most participants said that homosexuality was a ‘great sin,’ indicating that it was symbolically extruded from the church, and citing the holy texts as the reason behind pertinent homophobia. This justified prejudice leads to lowered self-esteem for African American MSM and also is responsible for the African American community’s inability to curb the spread of HIV/AIDS. Even though this qualitative study is limited in its implications for the overall African American community in the United States, it does suggest (at least anecdotally) that the African American church community has negative attitudes toward homosexuality, which has made it very difficult to provide education and social support to individuals engaging in risky MSM sex.

**Stigmatization, Social Support, and Risky Sex**

The research presented here suggests that African American MSM living with HIV are greatly stigmatized and lack social support. The available literature shows that social support and stigmatization are strongly related to risky sexual behavior and also predictive of
psychological correlates of risky sexual behavior for this population.\textsuperscript{46} Lack of social support is a reliable indicator of risky sexual practices, both in African American HIV-positive men\textsuperscript{49} as well among HIV-positive men in general.\textsuperscript{12} In addition, stigmatization has been moderately correlated with risky sexual behaviors for HIV-positive men,\textsuperscript{12} and high stigmatization is predictive of trading sex for money among HIV-positive men.\textsuperscript{53} A preliminary analysis of data from a multi-site HIV volunteerism intervention demonstrated that highly stigmatized African American MSM living with HIV engaged more frequently in risky sex and were less likely to use condoms than HIV-positive white and Hispanic MSM at both high and low stigma levels.\textsuperscript{51} Thus, while research is limited, pertinent findings suggest that high stigma and low social support are uniquely related to risky sexual practices among African American MSM living with HIV.

Social support and stigmatization also predict a number of psychological correlates among African American MSM which are related to risky sexual behaviors, including psychological distress, lowered self-esteem, depression and anxiety, and maladaptive coping.\textsuperscript{12, 27, 52, 53} A 2003 study of African American MSM living with HIV in Los Angeles revealed that psychological distress was the single best predictor of lower condom use for this group\textsuperscript{41} while other research has shown that emotional distress predicts less condom use for HIV-positive men.\textsuperscript{28, 52} Lowered self-esteem, which also relates to stigmatization and lack of social support, is also moderately correlated with lowered condom use in HIV-positive men.\textsuperscript{12} Furthermore, depression and anxiety have been shown to predict greater levels of risky sex for HIV-positive men.\textsuperscript{31, 52} Having a negative or maladaptive coping style is also related to engaging in risky sex for HIV-positive men\textsuperscript{27, 30} as well as among African American HIV-positive MSM.\textsuperscript{41} For HIV-positive men, meta-analyses suggest that avoidant coping in particular is related to risky sexual practices.\textsuperscript{12, 52} In light of the prominent links between social support, stigmatization, their psychological correlates, and risky sex, an intervention incorporating these variables must be created for African American MSM living with HIV.

**HIV-Related Conspiracy Myths**

Another potential barrier to receiving social support and HIV education from within the African American community is the reported prevalence of HIV conspiracy myths among African Americans. Telephone samples\textsuperscript{19} indicate that 20% of African Americans and only 4% of whites agree with the statement that ‘the government is using
AIDS as a means of killing off minority groups.’ Community-based samples demonstrate that over 70% of African Americans believe that ‘the government is not telling the truth about AIDS’ and 25% agree that AIDS was “intended to wipe black people off the face of the earth.” While data on these HIV-related conspiracy myths is limited and varies across telephone, door-to-door and community-based samples, the consensus indicates that around 20% of African Americans endorse the belief that HIV/AIDS was designed by the government to systematically exterminate the African American population, and more than 50% believe that the government is lying about HIV/AIDS or withholding a cure.

Research has shown that these kinds of HIV/AIDS-related conspiracy beliefs are undeniable barriers to HIV/AIDS education, prevention and treatment. For African American MSM living with HIV, obtaining social knowledge, social support and HIV/AIDS education and treatment from within their community is going to be unlikely, as these myths continue to permeate and confuse understandings of HIV/AIDS within this context. Of even further concern is the assertion that endorsing HIV/AIDS-related conspiracy beliefs leads not only to being less open to HIV prevention messages, but also less open to birth control. The possibility that individuals who endorse HIV/AIDS conspiracy theories may also be less likely to practice safe sex is especially worrying, given the incidence of HIV/AIDS in the African American community. More empirical research should be conducted to determine the strength of this relationship.

Past HIV-Related Interventions for African American MSM

These findings clearly indicate a need to reduce risky sex among African American HIV-positive MSM by decreasing perceived stigma, increasing social support, and providing HIV/AIDS education and awareness to combat HIV conspiracy myths in the African American community. Unfortunately, high-risk populations have been critically undeserved in HIV/AIDS intervention research, particularly African American MSM. Three separate reviews have confirmed that only one HIV-related intervention specifically for African American MSM, by Peterson in 1996, has ever been published.

This study sought to reduce HIV risk behaviors through group-based counseling sessions that addressed assertiveness training, AIDS risk education, and development of self-identity and social support. While this intervention was successful in reducing the prevalence of unprotected sex, the social support component sought to build
social support within the counseling group, but did not address the already existing social support relationships in the participants’ lives. Participants in this study were not HIV positive, meaning that no interventions have ever been published concerning reducing the prevalence of risky sex for African American MSM who have already contracted HIV. Given that HIV is spread primarily through unprotected sex with an HIV-positive individual, future interventions clearly must attempt to halt the risky sexual behaviors of African American MSM who are already HIV-positive. Of the 54 published HIV-related interventions for MSM, as identified by a 2005 meta-analytic review, only 15 of those targeted MSM who were HIV-positive. Estimated effect sizes showed that these interventions reduced unprotected sex by around 20%, with the most effective interventions using small, group-based counseling sessions.

Similarly, few HIV stigma-related interventions have been published, and to date, no interventions have been conducted that address stigmatization for African American HIV-positive MSM. A 2003 meta-analytic review identified 23 HIV stigma-related interventions divided into three categories: changing attitudes towards HIV in the general population (14), increasing willingness of health care workers to treat people with HIV (6), and finally, helping people with HIV cope with perceived stigma (3). Of this last category, only one intervention specifically addressed coping with perceived stigma for HIV-positive individuals, while the other two looked at perceived stigma of individuals who were being tested for HIV. In this one study, conducted with The AIDS Support Organization (TASO) of Uganda, participants received one-on-one counseling designed to help them disclose their HIV-positive serostatus to a close other or family member, and help them and their family cope with HIV-related stigma and gain acceptance from their community. This counseling intervention was successful in encouraging both disclosure of HIV status and perceived family and community acceptance. The authors contended that counseling is an appropriate response to the emotional needs of people living with HIV/AIDS and their families.

Suggestions for Future Interventions

Given the dearth of interventions targeted specifically at the unique health barriers faced by African American MSM living with HIV, perhaps health care professionals should not be surprised that such a huge percentage of African American MSM have already contracted the disease. More effort, time, and resources must be devoted to alleviating
this health disparity by addressing the obstacles to prevention, treatment, and care faced by African American MSM in our society. The one HIV-related intervention for African American MSM demonstrated that participants from this population could be recruited, an intervention could be tailored specifically for them, and the prevalence of risky sex could be successfully reduced, even at an 18-month follow-up. The current review has sought to identify three unique factors that contribute to risky sex and the spread of HIV among this population: experiencing stigmatization from multiple sources, lack of social support, and belief in HIV conspiracy myths within the African American community. Each of these factors can be targeted on individual and community levels. Individual-level intervention suggestions are discussed first.

One-on-one counseling provides the first step to breaking down the barriers to health and well-being faced by African American MSM. In a series of recommendations for clinical psychologists who counsel African American MSM with HIV, So (2003) calls for empowerment through social support, acceptance, and integration of racial and sexual identities. In general, this one-on-one counseling should be culturally sensitive, provided by African American men, and contextualize HIV and treatment in terms of the racism, poverty and homophobia that African American HIV-positive MSM experience. It is crucial that clinical psychologists understand, identify, and effectively address these specific needs of this population and its specific sources of stigmatization. Meeting these basic criteria for treatment is necessary for building trust with African American HIV-positive MSM and will allow for an open environment to effectively discuss and treat stigma, low self-esteem, psychological distress, anxiety, maladaptive coping, and enhance feelings of social support.

One-on-one counseling to reduce stigmatization and increase feelings of empowerment has been effective for HIV-positive MSM in Africa and should also be effective for HIV-positive African American MSM. This empowerment ‘training’ should incorporate disclosure of HIV status and acceptance of this disclosure, provide skills for negotiating safe sex, and help clients break down and re-create their social identity to reflect their multiple memberships as an African American man, who is also MSM and HIV-positive. There are a number of creative and thought-provoking ways of helping African American MSM reconcile their multiple identities, including analyzing family trees, looking at photographs, putting on African masks, making drawings, writing short stories, and listening to music as a means of understanding and expressing their feelings about stigma and HIV. Crucially, this
therapy designed to empower HIV-positive MSM must also incorporate an educational component which will help dispel HIV myths that are rampant in the African American community. Among African Americans, those most likely to believe in HIV conspiracy myths are traditional, college-educated men who have experienced racism, and these individuals in particular should be targeted through one-on-one educational counseling.

In addition to empowering African American MSM living with HIV by reducing stigma, reconciling identity confusion, and providing safe sex skills and HIV knowledge, enhancing feelings of social support is also crucial to reducing risky sexual behavior among these individuals. While building support among African American HIV-positive MSM is important for prevention and will be discussed shortly, another area that has received little to no attention in the intervention literature is enhancing the quality of already existing social support relationships in clients’ lives. This is especially important as African American HIV-positive MSM report feeling isolated and alienated from their families. By counseling African American MSM with HIV and their close friends, relatives or partners, the support giving and receiving process can be more effective and beneficial for African American MSM. These existing relationships can be tailored to better accommodate the needs of HIV-positive individuals, and such improvements will increase clients’ self-esteem and reduce social isolation and shame. Another possibility is to combine individual therapy for social support and stigma reduction, such that a client can utilize therapy to disclose his HIV status to a close other, receive acceptance for this disclosure, and go on to establish a rapport for seeking and providing help.

As mentioned earlier, building social support among HIV-positive African American MSM should also contribute to reducing sexual risk behaviors and increasing self-esteem. These types of HIV ‘support groups’ have been shown to be effective in reducing the risk of HIV infection among at-risk men, with support group members reporting less emotional distress and fewer avoidant coping strategies than non-support group participants. Support groups should be especially important to African American HIV-positive MSM then, as psychological distress and avoidant coping are the two largest predictors of risky sex in this population. The best approach to creating support groups for African American MSM living with HIV is to incorporate them into small-group cognitive behavioral therapy (CBT). In fact, a recent meta-analysis shows that small-group CBT is clearly more favorable than individual-level interventions for reducing risky sex among HIV-positive
MSM. Small, group-based counseling sessions with around ten African American MSM with HIV should allow for individuals to build social support and dispel HIV myths in a comfortable, open forum. In addition to the benefits of enhanced social support, this small-group therapy will also allow African American HIV-positive MSM to set the norms of safe sex behavior, and practice negotiating safe sex through a variety of role-play simulations and rehearsals. Furthermore, these individuals share the same experiences of stigmatization and will be able to assist each other in the coping process by discussing constructions of ethnic identity, sexual orientation, racism, poverty, and discrimination.

In addition to providing one-on-one counseling to HIV-positive African American MSM and setting up support groups who receive small-group, cognitive-behavioral therapy, also necessary is intervention on a much broader community level to halt the spread of HIV/AIDS. While HIV-positive individuals are engaging in risky sex which is spreading the disease, the community infrastructure is not in place to provide adequate education, care and prevention both for HIV-positive and HIV-negative African American MSM. According to the ecological approach to HIV prevention, reducing the sexual risk behaviors of HIV-positive individuals is only part of the equation; efforts also must be made to enhance the resources in the environment, community and setting in which these risky behaviors are occurring. Within the African American community, attempts to enhance social support, reduce stigmatization, and dispel HIV myths can be undertaken in a variety of contexts and social settings, including within schools, local clinics, HIV policy making administrations, social venues, and from within African American churches.

HIV prevention and education for African American MSM should begin during middle school, when adolescents first learn about sexuality and safe sex. Clearly, the younger generation of African Americans is not being provided with the real ‘facts’ about HIV, as African American teens (aged 13–19) represent only 15% of all teens in the United States, but accounted for around 65% of new AIDS cases reported by teens in 2002. The disparity in the number of African American teens contracting HIV/AIDS shows the desperate need for school programs to educate them about the risks of unprotected sex and dispel the myths associated with HIV. Some of the myths that educators should challenge include the myth that AIDS was invented by the government to exterminate African Americans, that the government has a cure and is withholding it, and that AIDS is ‘God’s disease’ because it kills off homosexuals. Disputing these myths at an early age is crucial—before African American teens
become sexually active so that these conspiracy beliefs do not cloud and contradict HIV knowledge or condom use. This type of HIV awareness program in middle schools is easy, cost effective, and can be taught in addition to the usual sex education curriculum. Not only does such a program have the potential to stop African American teens from contracting HIV, but it also will reduce stigmatization toward HIV-positive individuals as part of the process of discounting HIV conspiracy beliefs.

School-wide HIV education and prevention is absolutely necessary to halt the future HIV epidemic among African American MSM. Such interventions tailored to dispel HIV myths and reduce stigma while providing knowledge about negotiating safe sex should also be available from medical professionals at local clinics within the African American community. Clinicians should provide HIV information sessions and meetings where African Americans can freely discuss HIV conspiracy beliefs with a trusted medical professional who can dispel them. In addition, the treatment of African American HIV-positive MSM and the dissemination of knowledge to African Americans in general must be culturally sensitive and appropriate. Research on AIDS education videos shows that a culturally-specific video with an African American speaker is generally viewed as more credible, more attractive, and of higher quality by African American men than a multi-cultural video with a white announcer. Therefore, the crucial messages regarding safe sex, stigma, and HIV myths should be disseminated by an African American leader or someone who is trusted within the African American community. In addition, administrative and HIV policy-related programs for African Americans should be more culturally relevant and specific to further dispel the conspiracy beliefs about HIV that are unique to the African American community.

Social venues are another excellent arena for trusted leaders in the African American community to debunk HIV conspiracy beliefs, reduce the stigmatization faced by African American MSM, and help enhance feelings of social support from within the community. Social venues can become especially influential for enhancing social support among African American MSM, who often gather at certain bars, restaurants, and social clubs. Messages about safe sex delivered by popular white and Hispanic community activists, bartenders, and bar patrons have been successful in reducing the prevalence of risky sex among white and Hispanic gay men and male prostitutes, but these messages did not reduce risky sex for African American MSM. Given that African American sources are perceived as more credible to African American
African American men naturally were not influenced by messages delivered by white and Hispanic community leaders. Clearly, this intervention should be adapted specifically for African American MSM, targeting their social venues and places of interest with messages about safe sex and condom use. Identifying and soliciting the help of community leaders respected by African American MSM to disseminate HIV knowledge, provide information on practicing safe sex, and dispel HIV conspiracy myths would be very useful. In addition to bars and restaurants, interventions with African American MSM in other venues, like sport facilities, gyms or barbershops, might be useful in disseminating HIV knowledge.

Churches provide support to many people in the African American community, but research suggests that some African American churches exclude, shame and/or isolate HIV-positive MSM. Outsiders (like clinical psychologists) will find it very difficult to change homo-negative attitudes within the African American church, unless clergy members and church leaders want to change these attitudes and welcome MSM. Acceptance of African American MSM living with HIV into African American church organizations has the potential to provide huge benefits to their psychological health and well-being by ending the debilitating stigma and utilizing the church as a site to provide social support, as well as HIV education and knowledge, to MSM. Ideally, an intervention to change negative attitudes in African American churches should begin with a church that already accepts and does not stigmatize MSM or HIV-positive individuals. This church could operate as a base for the healthy integration of HIV-positive African American MSM into religious life, teaching about spirituality, ‘loving thy neighbor,’ and helping with HIV-related pain management. Assuming that such a church exists, activists, church members, and psychologists would be the primary means of spreading the word and teachings of that church to other African American churches in the area. Churches with homo-negative ideologies could be presented with an alternative, holistic model of religiousness, accepting of people regardless of their sexual orientation. While not guaranteed to be effective, presenting a model of a successful church that integrates African American HIV-positive MSM with regular parishioners might convince other church leaders to open their minds and their doors.

Concluding Thoughts

Just as changing attitudes in African American churches will prove extremely difficult, changing society’s attitudes about HIV and MSM will
be equally challenging. Knowledge-based advertising campaigns aimed at the general public and aired on popular youth stations like MTV and VH1 may be effective in reducing the stigma that the younger generation in America has about HIV. Introducing characters into popular television shows who also suffer from multiple stigma (i.e., racial discrimination, sexual orientation discrimination, HIV-status discrimination) might also help to humanize and demystify the struggle of African American HIV-positive MSM in the eyes of the American public. While these measures to make our society more sympathetic toward African American MSM living with HIV might be somewhat effective, they may not necessarily end the stigma, or reduce risky sexual behaviors for this population. As stated by the Black AIDS Institute in 2006, ending the stigmatization toward African American MSM living with HIV begins at home, within the African American community. According to their recommendations, ending the stigma will only happen when each person in Black America stands up and declares that the era of silence and shame about HIV is over. The Black AIDS Institute calls for African American MSM to return home and build community unity by refusing to live in shame and isolation, so that together they can ‘stand up and demand to be counted.’

The HIV pandemic among African American MSM will worsen so long as those affected by it are invisible to their families, friends, churches, and communities. Without these sources of social support, HIV-positive African American MSM are left with little ammunition to fight the stigma raging in their own communities and in society at large. Not surprisingly, living with low self-esteem, psychological distress and maladaptive coping styles, HIV-positive African American MSM are continuing to engage in risky sexual behavior and spreading the disease to extreme proportions. While there is little consensus about the ‘best’ way to reduce risky sex for African American MSM living with HIV, the current review suggests that individual counseling, small-group CBT and community level interventions in schools, clinics, social venues and churches are all equally necessary to target the multiple dimensions of HIV-related stigmatization. Empowering African American MSM living with HIV to ‘stand up and be counted’ through assertiveness training, support building, and community-based knowledge initiatives will make this pandemic a visible public health issue which can no longer be ignored. For every day that passes without an attempt to intervene, the risks of contracting and spreading HIV will increase. The infection rate for African American MSM is nearing 50%, which is greater than the infection rate in some of the worst-hit areas of sub-Saharan Africa. Rather than wait until this pandemic worsens beyond treatable levels,
psychologists, activists, community leaders, health practitioners and policy makers also must ‘stand up and be counted’ by conducting research in this area, designing and evaluating interventions, creating culturally-specific programs, and providing counseling, treatment, and care for African American MSM living with HIV.

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