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Psychosocial Health of Black Sexually Marginalized Men

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The background of the cover features silhouettes of African-American men. One man is in the foreground, looking to the right, holding a white folder or document. Another man is partially visible behind him. The background is a blurred, warm-toned scene, possibly an outdoor setting. The text is overlaid on this image.

EDITORS

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SOCIAL
DETERMINANTS OF
HEALTH AMONG
AFRICAN-AMERICAN
MEN

Chapter 4

Psychosocial Health of Black Sexually Marginalized Men

Louis F. Graham

Learning Objectives

- Gain awareness of major themes related to the social determinants of black sexually marginalized men's psychosocial health.
- Identify factors related to mental disorder acquisition by black sexually marginalized men.
- Understand the relationships between mental health and attitudes and beliefs, relationship functionality, identity development, and violence discrimination and harassment.

• • •

I could not bear the burden of living as a gay man of color in a world grown cold and hateful towards those of us who live and love differently than the so-called mainstream.

—Joseph Jefferson, 26

Joseph Jefferson

Raymond Chase

Terrel Williams

Austin Aaberg

Asher Brown

Tyler Clementi

Zach Harrington

Billy Lucas

Seth Walsh

These are the names of some of the young gay, same-gender-loving, and bisexual men who committed suicide in 2010. This chapter is dedicated to their lives and memory.

The dead offer no answer. We must question the living.

—Marvin K. White, *Poet*

There is a paucity of research on the psychosocial health of black sexually marginalized men. The little research that exists suggests that black sexually marginalized men (BSMM) are disproportionately burdened by mental health problems and disorders, the most severe of which are depression, anxiety, and **suicidality** (i.e., suicidal ideation, suicide attempts, and completed suicides). A number of theoretical models have been conceptualized to explain health outcomes among both ethnic and sexual minorities, the most comprehensive of which include three primary pathways: internalization of negative attitudes, beliefs, and stigma; structural inequalities; and perceived discrimination and harassment (Clark, Anderson, Clark, & Williams, 1999; Jones, 2000; Krieger, 2001; Link & Phelan, 2001). The **minority stress model**, which has been used with ethnic and racial minorities as well as lesbian, gay, and bisexual communities (LGBs) (Crocker & Major, 1989; Jones et al., 1984; Mirowsky & Ross, 1980, 1989; Pearlin, 1982), posits that minorities who face oppression from a dominant group are likely to experience stress due to this oppression and consequently suffer greater morbidity (Hamilton & Mahlik, 2009).

Meyer (2003) carried out a meta-analytic study that documented the high prevalence of psychiatric morbidity among LGBs and conceptualized a minority stress model to explain the somatic and mental health concerns among gay men, which proposes that gay communities, similar to other marginalized groups, experience stress as a result of oppression and stigmatization (Meyer, 1995). The model casts discrimination and harassment as key elements of harsh social environments that contribute to internalized homophobia, being closeted, expectations of rejection, and experience of prejudice, which then results in compromised mental health (Battle & Crum, 2007). Although evidence supporting constructs and relationships between them delineated in the minority stress model for predominately heterosexual samples of ethnic minorities or predominately white samples of sexual minorities are not readily generalizable to BSMM, there is undoubtedly overlap and some empirical evidence substantiates similarities. Nevertheless, models are needed that address the particular sociocultural context of BSMM's lives in order to better understand how and why minority stress model factors and others contribute to mental disorder occurrence among this specific subpopulation.

Based on the literature broadly, key empirical evidence, and drawing from minority stress models, discrimination effects models, and social interaction and norms theory, a model to understand mental health outcomes among

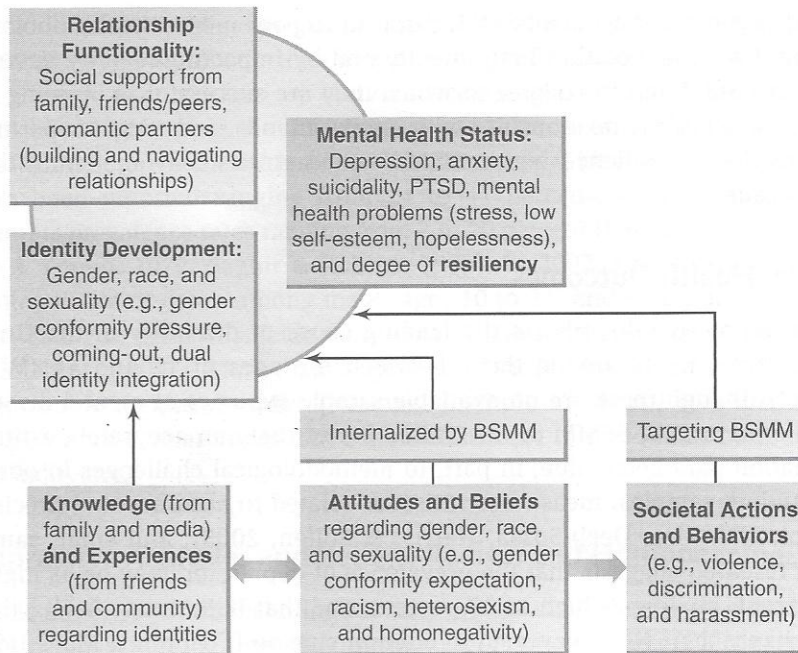


Figure 4.1. Black Sexually Marginalized Men's Psychosocial Health Model

BSMM is expanded in Figure 4.1. A number of constructs across domains of the **socioecologic framework** have been identified as key factors influencing outcomes among this subpopulation. The limited research conducted with BSMM and sexually marginalized and black men in general indicates that ethnic, sexual, and gender **identity development** (intrapersonal); **relationship functionality** (interpersonal); exposure to violence, discrimination, and harassment (institutional/structural); and resilience may play particularly important roles (Graham, Aronson, Nichols, Stephens, & Rhodes, 2011; Graham, Braithwaite, Spikes, Stephens, & Edu, 2009). Researchers have pointed to societal negative attitudes and beliefs regarding gender, race, and sexuality; and policies and practices of community institutions, as forces underlying these factors.

Knowledge produced and shared in families and learned through popular media and experiences with friends and institutions shape the gendered, racial, and sexual terrains community members must navigate, including BSMM. Often this identity landscape and the experience of its inhabitants are imbued with gender conformity pressure, racism, **homonegativity**, and mental illness stigma, among other "isms" and stigma. The effects of these negative attitudes and beliefs regarding gender, race, and sexuality, if internalized by BSMM or if acted on by others in the form of violence, discrimination, or harassment

(VDH) perpetuated against BSMM, can lead to poor mental health outcomes among this subpopulation both directly and by impacting identity development of BSMM and the degree to which they are successful in building and maintaining healthy relationships with family, friends, and romantic partners. The degree of resilience within BSMM communities may moderate these relationships.

Mental Health Outcomes

Major depressive disorder is the leading cause of disability in the United States and Canada among those between the ages of 15 and 44 (WHO, 2008). Although there are no available sample statistics of mental disorder prevalence among BSMM in the United States that can accurately estimate population parameters due, in part, to methodological challenges in obtaining random samples, measurement issues related to accuracy and precision of tools (Perreira, Deeb-Sossa, Harris, & Bollen, 2005), and small sample sizes; research suggests that the prevalence of depression may be as high as 32 percent, anxiety as high as 33 percent, and that BSMM may be 1.2 times more likely than white gay men to attempt suicide (Cochran & Mays, 1994; Graham, Aronson et al., 2011; Meyer, Dietrich, & Schwartz, 2008). Epidemiological research shows that sexual minorities are at significantly greater risk for psychiatric morbidity across a wide range of outcomes, including depression, anxiety, and suicidality, throughout the life course (Cochran & Mays, 2000a, 2000b; Cochran, Sullivan, & Mays, 2003; Fergusson, Horwood, Ridder, & Beautrais, 2005; Gilman, Cochran, Mays, Ostrow, & Kessler, 2001; Sandfort, de Graaf, Bijl, & Schnabel, 2001). In fact, the aforementioned meta-analysis (Meyer, 2003) indicated that sexual minorities are twice as likely as heterosexuals to have a lifetime mood disorder and nearly three times as likely to have a current mood disorder.

A study by Cochran, Sullivan, and Mays (2003) found a 31 percent one-year prevalence of major depression and 17.9 percent one-year prevalence of panic disorder among gay and bisexual men in a U.S. population-based random sample using the Composite International Diagnostic Interview Short Form (CIDI) from the MacArthur Foundation National Survey of Midlife Development. This represents a prevalence 3.57 and 5.09 times ($p < .05$) more than that of heterosexual men in the study (10.2 percent, 3.8 percent, respectively). Additionally, the investigators found higher levels of current and past psychological concerns among men who have sex with men (MSM) compared to heterosexual men in the study; 17.8 and 20.4 percent of MSM self-rated their own mental health as "fair" or "poor" at age 16 and at present age, respectively. These percentages were 3.10 ($p < .05$) and 3.47 ($p < .05$) times greater than that of heterosexual men. This study is consistent with other previous studies,

concluding that MSM suffer greater lifetime prevalence rates of major depression and suicide symptoms than men reporting only female partners.

Though mainly based on convenience samples, research indicates that LGBs have higher rates of suicidality than do heterosexuals (Paul et al., 2002). Among adult gay men and lesbians, lifetime suicidal ideation prevalence rates have been reported ranging from 24 to 41 percent, with lifetime suicide attempts prevalence rates ranging from 7 to 20 percent (Bell & Weinberg, 1978; Jay & Young, 1979; Saghir & Robins, 1973). In 2002, suicide was the third leading cause of death among males ages 10 to 24, and males are four times more likely to commit suicide than females (National Alliance on Mental Illness [NAMI], 2007). More than 90 percent of those who die by suicide have a diagnosable mental disorder (National Institute of Mental Health [NIMH], 2005). Oppressive attitudes and beliefs contribute to these rates both directly and indirectly.

Oppressive Attitudes and Beliefs: Racism and Homonegativity

Ethnic minority youth, including sexually marginalized youth, are already confronting racist attitudes, beliefs, discriminatory policies, and practices regularly by the time they reach adolescence and become teenagers (Parks, 2001). Ethnic minority families often intentionally and proactively try to teach their children how to deal with blatant and covert racism experienced in predominately white heterosexual spaces (Jones, 1997), through, for example, imparting race-conscious ethnic relations perspectives that offer children language of critique and views that help insulate them from the harmful effects of racism (Graham, Brown-Jeffy, Aronson, & Stephens, 2011). BSMM also encounter racism and cultural orientation incongruence (Graham, Brown-Jeffy et al., 2011) in sexually marginalized communities. Racism and cultural orientation incongruence in gay communities are present in political and service organizations, social spaces, and in the sexual stereotyping of black men (Parks, 2001) ranging from sexual predator to pornographic object. Racism in sexually marginalized communities is expressed in many ways, including: differential treatment and regard (DeMarco, 1983; Icard, 1986), invisibility, lack of acknowledgement, tokenism (Jackson & Brown, 1996), European derived standards of beauty (Loiacano, 1989), and sexual objectification or perceptions of exoticism (Burstin, 1999; Diaz, Ayala, Bein, Henne, & Marin, 2001). This reality can negatively affect the social relations within community institutions; and, racism is not the only oppressive force BSMM face. Throughout the next three sections, we draw heavily from Battle and Crum's (2007) theorizing and insights on homophobia, parental social support, and identity development.

Homonegativity pervades our society, including black communities. A number of issues have been identified as likely contributing to homonegativity

in black communities, including Christian doctrine and beliefs that often view homosexuality as sinful, the legacy of slavery, and gender conformity expectations that center heterosexuality as an ideal construct of black masculinities, among other issues. Although homonegativity exists in black communities, this is not to say that there is more or a greater degree of homonegativity in black communities compared to white communities or society generally. How it is experienced, what it means, and the impact it has on black sexual minorities may, however, be different.

Homonegativity may hurt more or may be felt more severely when it comes from community members and institutions that are regarded as places of refuge from racism, networks of support, and groups with which black sexual minorities may strongly identify. Loiacan (1989) uncovered through in-depth interviews that black gay men who viewed black communities as "extremely homophobic" did not view them as any more homophobic than white communities. Also, black gay and bisexual men rated their experiences with black heterosexuals in black straight organizations significantly more positively than their experiences with white LGBs in white gay organizations, but agreed more with the statement that "homophobia is a problem within the black community" than with the statement that "racism is a problem for GLBT blacks dealing with the GLBT community" (Battle, Cohen, Warren, Ferguson, & Audam, 2002). In this study, although participants' experiences alluded to racism in gay communities as a more pervasive problem, homonegativity in black communities was deemed more problematic (Battle & Crum, 2007).

Additionally, Herek and Capitanio (1995) found no significant differences between African-Americans and Euro-Americans in heterosexist attitudes toward gay men. Battle comments that homonegativity in black communities is problematic "not because of its magnitude but because of its relevance" (Battle & Crum, 2007, p. 339) in the eyes of black sexual minorities. BSMM cannot afford to lose the social support of black communities because of their role in helping community members contend with racism and discrimination in society writ large. BSMM have, to some degree, been equipped to deal with racism and its consequences, but the same is not true for homonegativity.

BSMM have been taught approaches for managing stress related to racial and ethnic discrimination and violence, albeit not specifically in gay communities. They are not as equipped, though, to be resilient against the alienation and hostility of homonegativity in black communities. Even less is known about how internalized isms may play out in BSMM communities. And controlling and negotiating degrees of being "out" or "closeted" in particular spaces and to particular people contributes to stress and poor mental health outcomes. BSMM may endure high levels of stress because of the aggregate effects of institutionalized racism and cultural orientation incongruence in institutions, homonegativity, and heterosexism.

Relationship Functionality

Mental health outcomes among BSMM are influenced by the degree to which BSMM's interpersonal relationships are supportive, functional, and beneficial. Low levels of social support have been shown to predict depression and slowed recovery from major depressive episodes (Kessler, Price, & Wortman, 1985; McLeod, Kessler, & Landis, 1992). Research with sexual minorities has established the importance of both familial and peer/friendship support in promoting and protecting mental health (M. Goldfried & Goldfried, 2001; Radkowski & Siegel, 1997). Research has shown that sexual minorities report less social support than heterosexuals and that this difference partially explains mental health disparities, including depressive symptoms (Eisenberg & Renick, 2006; Safren & Heimberg, 1999).

Graham and colleagues (2009) found that among BSMM, relationships of support sometimes became relationships of shunning and ostracism. This study defined relationship functionality as the degree to which individuals were able to build, grow, and maintain healthy relationships with family, friends, and romantic partners. Some BSMM in this study reported developing and sustaining unhealthy relationships that contributed to their depression and anxiety. LGBT identities often are viewed by ethnic minority families as being in conflict with "traditional" family structures, value systems, and religious beliefs (Morales, 1990).

Some ethnic minority families may discuss issues of sexuality frankly, whereas others may have a hard time overcoming taboos, adjusting their attitudes and beliefs positively, or regarding the marginalized identities of family members in healthy ways. In response to a family member's **coming-out**, the negative views of families can vary from considering this a threat to the existing family unit, an unwanted and unworthy distraction from other more urgent problems and stressors they are facing, to unnecessary increased exposure to HIV. BSMM often fear rejection and expulsion from their family when coming-out. Pilkington and D'Augelli (1995) revealed that 10 percent of ethnic minority LGBT youth reported verbal abuse from fathers, 11 percent from brothers, and 7 percent from sisters. Twenty percent characterized the possibility of coming-out to their family as "extremely troubling." Twenty-two percent considered their mothers' reactions to their sexual orientation as "rejecting," 25 percent judged their fathers' reactions as "rejecting," and 8 percent assessed their sisters' reactions as "rejecting."

Identity development commences early and Caldwell and colleagues' study (2002) suggests that families play a purposeful and primary role in instilling positive self-concepts in their children to help buffer the effects of negative external views regarding race, which may partially explain elevated levels of self-esteem found among black adolescents (Jordan, 2004). It is doubtful that

families of BSMM intentionally attempt to impart tactics that protect against the effects of negative external views related to their child's sexuality that do not also harm their identity (Battle & Crum, 2007). In fact, it is more likely that heterosexual families do not recognize, acknowledge, or envision the possibility that their children will grow and develop as anything other than heterosexual, until well after same-sex orientation becomes discernible in desire, action, and/or identity. Given this case, it is largely unavoidable for BSMM to internalize some of their families' and communities' homonegative and heterosexist attitudes and beliefs, whereas black families may work to shield their children from internalizing the larger society's racist attitudes and beliefs; and this is to say nothing of the unique experience and nonadditive considerations of being positioned at intersecting identities. Consequently, budding realization and development of an orientation other than heterosexual is more likely to be initially accompanied at best by confusion, fear, and uncertainty, and at worst by shame and self-hatred, rather than pride; thus all but guaranteeing a difficult and vulnerable adolescence for BSMM (Cochran, 2001). BSMM likely do not possess parallel assets vis-à-vis identity development that facilitate ethnic minorities' well-being (Ryff, Keyes, & Hughes, 2003).

Identity Development

Mental health outcomes among BSMM are influenced by the degree to which they are able to achieve positive integrated ethnic, sexual, and gender identities. Generally, identities, being simultaneously culturally bound and porous, aid in social grouping, a sense of life satisfaction, and self-definition (Howard, 2000; Lewin, 1948; Tajfel & Turner, 1979). Strong, positive, and integrated identities are particularly important for marginalized communities as a core factor in how political, social, and psychological resources for protecting against stressors associated with marginalized status are garnered, developed, distributed, and accessed (Cass, 1979; Cross, Parham, & Helms, 1998; Icard, 1996; Lemert, 1997; Sellers, Smith, Shelton, Rowley, & Chavous, 1998; Troiden, 1989). Our self-concept is in part composed of a reflection of how others view, treat, and regard us (Cooley, 1956; Mead, 1934). Consequently, the attitudes and beliefs of communities about BSMM and societal actions targeting BSMM (e.g., VDH) affect their identity development and by extension their mental health. Identity development includes a number of components (e.g., racial, ethnic, gender, sexual) and they have been operationalized in a number of ways by researchers. We begin this discussion by highlighting the effects of internalized homonegativity and identity achievement and integration on the mental health of BSMM, followed by a discussion of racial and sexual identity development models generally, coming-out, and unique features of identity development among BSMM in particular.

In the survey study by Graham and colleagues (2011), internalized homonegativity (measured using the Internalized Homonegativity Inventory revised for use among BSMM) explained 13 percent of the variance in depression (CESD) and 46 percent of the variance in anxiety (STAI) among BSMM. Also, the study by Crawford, Allison, Zamboni, and Soto (2002) among African-American gay and bisexual men found that BSMM with less-developed racial and sexual identities were significantly more likely to have mental distress and less likely to have greater life satisfaction and self-esteem than BSMM with strong dual identities. Additionally, Graham, Braithwaite, Spikes, Stephens, and Edu (2009) conducted focus groups to shed light on the potential factors influencing mental health outcomes among BSMM. They found that BSMM were challenged in developing a healthy overarching identity. Authors concluded that struggles related to the unique experience of being BSMM, such as negative attitudes and beliefs concerning race, sexuality, and gender conformity expectations, contributed to the burden of depression and anxiety.

Cross's Nigrescence Model and Troiden's Sexual Identity Development Model

Although racial and sexual identity development models have been theorized separately, no models have been theorized that consider the simultaneous development of racial and sexual identities. **Cross's Nigrescence model** was one of the first racial identity models conceptualized. In accordance with this model, individuals begin with low race salience. Next, consequent to a race-related "encounter," individuals recognize the oppressed nature of their race and begin to contemplate their racial identity. Following this, in the immersion/emersion phase, there is a heightened awareness and sensitivity to racial identity, and assessments of the dominant external or white communities are inclined to be negative. The last phase, called *internalization/commitment*, is marked by a positive complete identity wherein race is seamlessly integrated with other identities, such as gender, age, and religious affiliation (Cross, 2001).

Troiden (1993) proposed the most well-received model of sexual identity development, which suggests that the healthiest stage of functioning is the **Committed state**. The Committed state exemplifies embracing an identity that matches sexual desire and emotional feelings, perceiving a "nontraditional" or "alternative" identity as legitimate and not inferior to a heterosexual orientation and straight identity, thus commencing and sustaining same-sex romantic relationships—divulging this identity to the general public. This process, commonly known as coming-out, is especially difficult for BSMM and often contributes to psychological distress until successful and complete sexual

identity is achieved (Troiden, 1979). Grov, Bimbi, Nanin, and Parsons (2006) found that only 61.8 percent of African-American MSM in their sample were "out" to their parents, compared to 76.8 percent of white MSM ($p < .001$). Given findings in the Meyer study on the relationship between being closeted and suicidality, evidence suggests that BSMM may be at increased risk. Additionally, a study by Mills et al. (2004) found that nonqueer (i.e., no sexual identity indicated or straight identified) sexually identified MSM in their sample had a 39 percent depression prevalence rate ($CES-D > 15$) that was statistically significantly different from queer sexually identified MSM who had a 28 percent depression prevalence rate ($p < .001$). These results are suggestive in that those MSM who have not reached the committed state may be at increased risk for depression. However, the developmental trajectories of BSMM, with respect to coming-out processes, may vary considerably from the Euro-centric standard.

Coming-Out and Unique Features of Identity Development among BSMM

Most models of the coming-out process in the LGB identity literature are Euro-centric. Limited investigation of the coming-out process among black sexual minorities suggests that BSMM's experiences differ from that of white sexually marginalized men. A study by Dube and Savin-Williams (1999), for example, showed that older BSMM came to recognize and self-identify as gay much later than current models suggest. Socially, psychologically, and politically BSMM cannot afford exclusion from or rejection of homonegative heterosexist communities that is frequently theorized as a stage or phase in LGB identity development, because homophile communities often do not provide parallel sociopolitical or psychological resources for them as they do white sexually marginalized community members (Eliason, 1996). This may also partially shed light on the rejection of gay identity among many BSMM (Icard, 1996), choosing instead to identify as Same Gender Loving.

A few have suggested that BSMM may be challenged in simultaneously developing a healthy sexual identity while preventing damage to their ethnic identity (Akerlund & Cheung, 2000). Akerlund and Cheung (2000) found, in reviewing literature on sexual minority issues from 1989 to 1998, that oppression, discrimination, rejection, assimilation, and lack of social support were major factors contributing to the challenge of healthy identity development. In spite of the acknowledged homonegativity in African-American and other communities, BSMM maintain a strong connection with their ethnic cultural heritage and to their communities, and often cite their ethnic identity as primary (Acosta, 1979; Mays, Cochran, & Rhue, 1993). Even so, BSMM allude to feelings of conflicting loyalties between African-American communities and gay

communities, when challenged by homophobia in African-American communities or racism in gay communities (Greene, 1994). There are realistic concerns about rejection by both communities (Dyne, 1980; Icard, 1986; Mays & Cochran, 1988), and consequently, there is the potential for negative effects on the health and psychosocial well-being of gay men who are members of ethnic minority groups.

Loiacano (1989) conducted a qualitative study in which black gay men were interviewed about their sexual identities. One of the salient themes delineated was an expressed need to integrate better multiple identities, namely ethnic and sexual identities. The author describes this as a strong desire to acquire simultaneous and inclusive validation and support for black gay men's diverse identities. Most people have multiple components of a collective identity, each of which can assume lesser or greater importance or prominence in disparate circumstances. When two or more of those identities are marginalized, one could become the target of multiple prejudices in majority group contexts (e.g., as black, gay, low socioeconomic status) but could also experience prejudice in minority community environments (e.g., racial prejudice from white gay men, sexual prejudice from black heterosexuals) (Herek & Garnets, 2007). Possessing multiple minority identities raises an individual's likelihood of experiencing marginalization and subjugation (Diaz et al., 2001; Greene, 1994), which could lead to mental disorders like depression and anxiety.

Violence, Discrimination, and Harassment

Black sexually marginalized men face unique challenges in managing a double minority status (i.e., facing racism and heterosexism), putting them at risk for negative life events (e.g., loss of employment, home, or custody of children) and chronic daily hassles due to discrimination. Perceived unfair treatment or discrimination contributes to psychiatric morbidity among BSMM. Both qualitative and quantitative studies have found significant relationships between racial and sexual discrimination, violence, and perceived racist events, and the life satisfaction, anxiety, depression, and general mental health status of BSMM. The most recent was an observational, cross-sectional study that examined the relationships between depression and anxiety; ethnic and sexual identity development; violence, discrimination, and harassment; and coping skills (Graham, Aronson et al., 2011). In this study, 95 percent of BSMM reported experiencing violence, discrimination, and harassment (VDH) in the past year at least once; and of those experiencing any VDH in the past year, 40 percent indicated their race as being primarily involved, and 32 percent indicated both race and sexuality as being primarily involved. Fifty-two percent of participants reported experiencing VDH in public places, 43 percent in retail, customer

services, or other business settings, and 35 percent in the criminal justice system. VDH accounted for 52 percent of the variance in depression and 7 percent of the variance in anxiety among respondents.

In regard to the prevalence of hate crimes in African-American communities targeting ethnic minority LGB youth because of their racial or sexual identities, Pilkington and D'Augelli (1995) found that 48 percent of ethnic sexually marginalized youth reported experiencing one form of victimization, and 33 percent experienced two or more forms of victimization. These same authors documented that 56 percent of sexually marginalized youth experienced more than one occurrence of verbal assault, 26 percent of sexually marginalized youth were threatened once, and 10 percent were threatened three or more times. In this same study, 8 percent of LGB ethnic minority youth had objects thrown at them, 7 percent were physically assaulted twice or more, and 5 percent had been a victim of assault with a weapon. LGB adolescents are more likely than their heterosexual peers to be victims of peer violence. Physical and verbal abuse are related to suicide, school problems, and substance abuse among LGB youth.

Sexually Marginalized Men

Research on minority stress among gay men has shown that discrimination and experiences of negative treatment in society are associated with more mental health problems. Meyer (1995) found that gay-related discrimination corresponded with a threefold increase in risk for severe mental distress. Similarly, Huebner, Rebchook, and Kegeles (2004) found that among young MSM those who experienced discrimination within the past six months were 2.13 times more likely to have suicidal ideation within the past two months ($p < .001$) than those who had not experienced discrimination. Likewise, those who were victims of physical violence within the past six months were also 2.06 times more likely to have suicidal ideation in the past two months than those who had not. Hate crimes are common among this population.

In a national probability sample of sexual minorities, Herek (2009) found that nearly 25 percent of participants reported a person or a property crime, and more than 50 percent had been verbally harassed; and Badgett, Lau, Sear, and Ho (2007) found that gay men earn 10 to 32 percent less than equally qualified heterosexual men with the same job. Mays and Cochran (2001) found that a nationally representative sample (Midlife Development in the United States—MIDUS) of MSM were 4.30 times more likely to be fired from a job and 1.82 times more likely to experience any type of discrimination than heterosexuals ($p < .05$). Authors also reported that 42 percent of MSM attributed lifetime discrimination to their sexual orientation, in whole or part, and 76 percent reported any personal experience of discrimination. In comparison, 98 percent of heterosexuals attributed lifetime discrimination to factors other than

sexual orientation, and 65 percent indicated that they had ever experienced discrimination.

Black Men

A 2000 review of the literature on racial/ethnic discrimination and mental health not bound by sexuality criteria identified 13 studies (Williams & Williams-Morris, 2000). Four investigations (Brown et al., 2000; Karlsen & Nazroo, 2002; Kessler, Mickelson, & Williams, 1999; Siefert, Bowman, Helfin, Danzinger, & Williams, 2000) explored the relationship between a diagnosis of major depression and perceived discrimination, and three showed a positive association. None of the investigations revealed a negative association. One investigation (Kessler et al., 1999) explored the relationship between generalized anxiety disorder and perceived discrimination, which showed a positive association.

Another study conducted by Jackson and colleagues (1996) reported a relationship between a negative perception of whites' intentions and mental health distress among a national sample of black Americans, while Landrine and Klonoff (1996) reported a relationship between perceived racism and mental distress among black university sub-populations. Additionally, Sellers, Caldwell, Schmeelk-Cone, and Zimmerman (2003) reported direct and indirect longitudinal associations between perceived discrimination and mental distress among black youth. Generally, racial discrimination is associated with poor mental health outcomes; however, we do not yet understand the degree to which exposure to perceived discrimination contributes to increased risk of illness, disorder, or problems, the circumstances in which this may happen, or the processes and mechanisms that may be implicated. Study of ethnic discrimination and mental health in this regard is still in a formative phase.

Summary

BSMM appear to learn and become aware of what it means to exemplify manliness, blackness, and gayness from their families, friends, through popular media, and in community institutions. This knowledge and experience are often infused with oppressive attitudes and beliefs surrounding identity designations, which may include racism, homonegativity, heterosexism, and hegemonic gender conformity expectations that may be both internalized by BSMM and lead to societal actions and behaviors perpetuated against BSMM, such as violence, discrimination, and harassment. These constructs: knowledge/experiences, attitudes/beliefs, and societal actions/behaviors, can influence and affect BSMM's core sense of self, ability to sustain healthy relationships, and their mental health status. Additionally, there may exist bidirectional relationships between these constructs: identity development, relationship

functionality, and mental health status. Resilience may moderate these factors' influence on mental health outcomes.

The unique standpoint and experience of BSMM adds a layer of complexity, problematizes current conceptions and presents disparate challenges and opportunities for expanding theoretical frameworks to better understand pathways to mental health problems and disorders among this subpopulation and others. From a standpoint theory perspective, BSMM are of particular interest because they are positioned at the intersection of multiple marginalized identities. We stand to learn the most from those most marginalized among us. Theoretical suppositions and recent research findings have been drawn on to expand a model that highlights social factors likely playing important roles in mental health outcomes among BSMM.

Key Terms

coming-out	minority stress model
committed state	relationship functionality
Cross's Nigrescence model	socioecologic framework
homonegativity	suicidality
identity development	

Discussion Questions

1. What institutional policies and practices contribute to the violence, discrimination, and harassment that black sexually marginalized men experience?
2. How might the concept of intersectionality influence how mental health disorders are diagnosed and measured among black sexually marginalized men?

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