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Exploring Service Provider Perceptions of Treatment Barriers Facing Black, Non-Gay-Identified MSMW

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Abstract

Non-gay-identified men who have sex with men and women and who use alcohol and other drugs are a vulnerable population. Little is known about health and medical service provider interaction with these underserved clients. This article presents a thematic analysis of two focus groups undertaken with social and medical service providers regarding the needs of non-gay-identified men who have sex with men and women. Four emergent themes (labeling, constructions of masculinity, HIV/AIDS awareness, and treatment success) illustrate perceived barriers to HIV/AIDS prevention and treatment, as well as treatment success. Implications for policy, practice, and future research are discussed.

Keywords

HIV/AIDS; men who have sex with men and women; prevention services; stigma

Introduction

While demographic frequencies of non-gay-identified men who have sex with men and women (NGI MSMW) are unknown, Black men who have sex with men (MSM) are more likely than White MSM to have female partners (Muñoz-Laboy & Dodge, 2007). Black MSM are more likely than White MSM to be infected with HIV/AIDS. Despite having similar risk behaviors (Millett, Flores, Peterson, & Bakeman, 2007), the female partners of Black MSM are also at disproportionate risk of contracting HIV/AIDS. A study of MSM in New York City found that Black MSM are less likely than White MSM to disclose their same-sex behavior to health care providers and that MSM with female partners are less likely to disclose than MSM without female partners. In the same study, none of the MSM who self-identified as heterosexual ($N = 5$) or bisexual ($N = 86$) disclosed same-sex behavior to providers (Bernstein et al., 2008). Orellana, Picciano, Roffman, Swanson, and Kalichman (2006) found that MSM who had a primary female partner and who described themselves as "closeted" were less likely than other MSM to enroll in an HIV prevention program, suggesting that stigma was a barrier to participation.

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Goffman (1963) describes stigma as a social process that exposes the theoretically negative characteristics of an individual. A stigmatized individual's entire humanity and societal membership are assumed to be in question (Crocker, Major, & Steele, 1998). This may result in dehumanization and segregation (Dovidio, Major, & Crocker, 2000), impeding the individual's access to care. Black MSM and MSMW encounter simultaneous stigmatizing oppressions (Mays, Cochran, & Zamudio, 2004; Rhodes et al., 2010), including racial discrimination and disproportionate incarceration (Alexander,2010). They may also face rejection in parts of the Black community for violating heterosexist gender norms. There is some evidence of internalized homophobia among Black MSMW (Shoptaw et al., 2009). Men have reported pressure to conceal their same-sex behavior from their female partners and others (Benoit & Koken, 2012; Dodge, Jeffries, & Sandfort, 2008).

For substance-using Black MSMW, experiences with stigma are multi-dimensional and can occur in multiple settings (Minior, Galea, Stuber, Ahern, & Ompad, 2003; Young, Stuber, Ahern, & Galea, 2005). In the case of NGI MSMW, stigmatizing experiences may be related to sex, class, race, HIV status, and/or drug use. Stigmatizing experiences can occur at home with their families, at church, in the workplace, and in the community at large. Perceived homophobia in parts of the Black community and related norms of Black masculinity lead many men to conceal their same-sex behavior (Benoit & Koken, 2012; Bing, Bingham, & Millett, 2008; Kennamer, Honnold, Bradford, & Hendricks, 2000; Operario, Smith, & Kegeles, 2008; Stokes & Peterson, 1998; Ward, 2005). Therefore, these men may not feel comfortable sharing same-sex behavior in service provision settings.

Childhood sexual abuse is another source of potential stigma for this population (Alaggia, 2004; Benoit & Downing, 2013; Widom & Morris,1997), and is associated with substance abuse and high-risk sexual behavior (Brennan, Hellerstedt, Ross, & Welles, 2007; Paul, Catania, Pollack, & Stall,2001). Studies regarding childhood sexual abuse among other populations have also noted its traumatic impact on one's conceptions of his masculinity (Chan, 2014). A history of incarceration presents its own array of stigmas for Black MSMW. Incarceration closes some avenues of employment and can mark one as wholly unemployable, compromising the traditional masculine role of provider (Pass, Benoit, & Dunlap, 2014). Incarceration can also be a source of shame for one's family (Alexander, 2010) and it can foster the presumption that one has sex with other men, given that sex between men is the most common sexual activity behind bars (Gaiter & O'Leary, 2010; Johnson & Raphael, 2006).

For men whose same-sex encounters are prompted by alcohol and other drug use, the stigma of drug dependence is an additional threat to self-esteem (Ahern, Stuber, & Galea, 2007; Appel, Ellison, Jansky, & Oldak, 2004; Benoit, Randolph, Dunlap, & Johnson, 2003; McCoy, Metsch, Chitwood, & Miles, 2001; Room, 2005). Because condom use is often inconsistent in these encounters, the men are also at heightened risk of HIV infection, which carries its own stigma (Nanín et al., 2009; Radcliffe et al., 2010). Black MSMW are also vulnerable to racial discrimination, which can be a barrier to obtaining quality health services, adequate employment opportunities, and equitable treatment from criminal justice institutions (Bogart & Thorburn, 2005; Bogart, Wagner, Galvan, & Klein, 2010; Krieger,

Smith, Naishadham, Hartman, & Barbeau, 2005). If Black MSMW are also living with HIV, their vulnerability to stigma is compounded.

Although stigmatizing attitudes toward chronic illness are not new (Herek, 1999; Yang et al., 2007), the intersection of HIV/AIDS with other identities (i.e., racial/ethnic, drug use, and sexual orientation) may exacerbate society's negative perceptions of those living with the disease (Bogart, Galvan, Wagner, & Klein, 2011; Goldin, 1994; Siegel & Lekas, 2002). Community-level stigma can cause self-stigma (Herek, Saha, & Burack, 2013) among infected individuals. These "dimensions of oppression" (Windsor, Benoit, & Dunlap, 2010) can cause problems in health and social service agencies, where stigmatized clients (such as Black NGI MSMW) must interface with potentially biased systems, which already contain racial and ethnic disparities (Noel & Whaley, 2012). Similarly, these systems may not reflect a climate of diversity (Hyde & Hopkins, 2008). Research with other populations (e.g., Chau, Yu, & Law, 2014) has documented a lack of cultural competence in health care settings. When Black MSMW must interface with social and medical service systems that are not reflective or supportive of their life experiences, they may be averse to engaging in preventive treatment.

Research with Black MSMW suggests this population is in need of better information about the relationship between sexual risk taking and HIV/AIDS infection (Dodge et al., 2008; Friedman et al., 2013; Rhodes et al., 2010). Given that drugs and alcohol also impact risk behavior among NGI MSMW (Benoit & Koken, 2012; Harawa et al., 2008; Operario, Smith, Arnold, & Kegeles, 2011), treating substance abuse may help reduce HIV risk. Yet little is known about whether providers are prepared to meet the needs of substance-using Black MSMW. Current research—recognizing that helping professionals are in a perpetual struggle to adapt knowledge bases to meet community needs (Chau et al., 2014; Graham, Shier, & Brownlee, 2012)— suggests that providers are, in fact, ill prepared to meet the needs of this population. In one recent study, African-American MSMW did not perceive the substance abuse treatment setting as a safe place to discuss their same-sex risk behavior. Many study participants reported discrimination or homophobia on the part of treatment counselors (Washington & Brocato, 2011). The perception of homophobia is compounded by the fact that the affective attitudes of many helping professionals suggest the same discomfort about race that characterizes American society (Green, Kiernan-Stern, & Baskind, 2008). In other words, providers themselves are uncomfortable or unwilling to think critically about ethno-racial dynamics between themselves and their clients. This further marginalizes Black MSMW from the service provision arena, in spite of the population's sustained need for prevention and treatment.

Black NGI MSMW are likely to benefit from substance abuse treatment programs that address sexuality and sexual history while incorporating HIV risk-reduction services, but this combination of interventions is not widely available (Substance Abuse and Mental Health Services Administration [SAMSHA], 2010). There are programs for gay-identified men, but NGI MSMW are not likely to use them because they do not identify as gay. Moreover, addiction counselors in regular treatment programs lack training in sexuality, and fear of provider insensitivity discourages some men from pursuing HIV/substance abuse services (Mimiaga, Goldhammer, Belanoff, Tetu, & Mayer, 2007; Orellana, Picciano,

Roffman, Swanson, & Kalichman, 2006; Washington & Brocato, 2011; Wilson & Moore, 2009). Men may also perceive that seeking services would be stigmatizing in itself or would expose their concealed risk behavior (Benoit, Randolph, Dunlap, & Johnson, 2003; Peterson & Jones, 2009; Room, 2005; Stokes & Peterson, 1998). In an international study of services for MSM, Arreola and colleagues (2014) determined that lower access to HIV treatment was, in fact, associated with greater perceptions of sexual stigma. Research also suggests that some Black NGI MSMW see same-sex risk behavior as a consequence of substance use, but conceal their behavior from others and may avoid seeking treatment because of internalized stigma (Benoit & Koken, 2012; Harawa et al., 2008).

These studies indicate that Black NGI MSMW may be reluctant to discuss their same-sex risk behavior in treatment settings, but do not explain why they resist doing so. Some researchers recommend reforms in provider settings that include more culturally inclusive practices (Chau et al., 2014) and the elimination of heterosexist presumptions. For example, in an ethnically diverse sample of MSM and MSMW, Mimiaga, Goldhammer, Belanoff, Tetu, and Mayer (2007) found that including same-sex relationship categories on intake forms (e.g., “gay civil union” or “gay marriage”) and asking about sexuality as a routine matter increased men’s comfort level when discussing sexual behavior with their providers. If not executed carefully, however, some tactics could further alienate men who may feel challenged by routine questions about sexuality. Some Black men who have not formed an identity around their same-sex behavior also feel culturally bound to conceal such behavior (Operario et al., 2008). Moreover, substantial research indicates that sexual orientation is not a fixed identity (see literature review in Savin-Williams & Ream, 2007), which challenges the common provider practice of categorizing clients.

To elicit provider perceptions of Black NGI MSMW and treatment barriers that the population may experience, our research team conducted two focus groups with HIV and substance abuse prevention and/or treatment service providers. The focus groups were conducted as part of a study that resulted in the development of a survey instrument to measure stigma about HIV, substance abuse, and MSM behavior among providers (Windsor, Benoit, Ream, & Forenza, 2013). This article presents exploratory and descriptive analysis of the focus group data.

Methods

Research design and sample

After approval was obtained from the appropriate Institutional Review Boards (IRBs), 18 HIV and substance abuse service providers were recruited via purposive sampling. Purposive sampling is a hallmark of qualitative inquiry, which deliberately invites individuals into a study because of a focal experience or expertise (Patton, 2001). Sampling occurred through the New Jersey HIV Planning Group (a statewide advisory board pertaining to HIV/AIDS prevention and treatment) and the Training Institute at National Development and Research Institutes, Inc. (NDRI; a nonprofit research and educational organization that specializes in areas related to HIV/AIDS) in New York City. We chose the two locations because previous experience and contact with service providers made it clear that many men who wish to conceal same-sex behavior and live in New Jersey seek partners

in New York City, and vice versa. Both organizations build professional capacity for HIV/AIDS service providers working in myriad contexts, and the samples were similar with regard to their professional experiences. The sampling frame included approximately 70 providers from the following practice areas: HIV/AIDS testing and prevention, outpatient counseling, residential treatment, harm reduction, detox, medical treatment, and the like, with both general and specific populations (for example: young adults living with, or at risk of, HIV/AIDS; people living with addiction as well as, or at risk of, HIV/AIDS; gay men living with, or at risk of, HIV/AIDS, etc.). All members were invited to participate, and the 18 included in this study ultimately self-selected because of their desire to contribute to the research process and their availability. Participants were not remunerated for their time, although light refreshments were served at both focus groups.

IRB approval for implicit consent (in which informed participation constitutes consent) was received in exchange for not collecting any potentially identifying information. In accord with IRB protocol, ethno-racial self-reports, demographic frequencies, and other identifying information were not recorded, but the overall sample ($N = 18$) was observably diverse in age, gender, and race. Because focus groups are not appropriate for generalizing to populations (Morgan & Krueger, 1993; Sim, 1998), participant demographics are less important than for other research methods. The purpose of our focus groups was to inform the development of survey questions that could be tested with a larger sample (Desvousges & Frey, 1989; Lobdell, Gilboa, Mendola, & Hesse, 2005). Participants represented a variety of occupations including social work, case management, prevention and outreach services, HIV testing and counselling, and substance abuse counseling. Their work settings included residential and outpatient treatment facilities, testing and prevention services, harm reduction organizations, and services for gay, lesbian, bisexual, and transgender (GLBT) young people. All but one participant (who self-identified as new to the field) were seasoned providers. All of the providers reported having some experience working with non-gay-identified MSMW. In most cases, the clients' same-sex encounters were situational—e.g., trading sex for drugs or shelter, or having sex with other men while incarcerated—although providers also described cases in which men who considered themselves heterosexual were involved in steady relationships with men or with male-to-female transsexual partners.

The authors conducted two focus groups: One took place in New Brunswick, New Jersey; the other took place in New York City (Manhattan), New York. While study participants worked in service provision throughout the metro-NYC area, these locations (New Brunswick and Manhattan) were selected because of their proximity to the New Jersey HIV/AIDS Provider Group and the NYC-based NDRI, which—as previously mentioned—provided the sampling frame. At the focus groups, 18 total providers responded to open-ended questions eliciting their previous experiences serving NGI MSMW and their beliefs about the unique challenges these men face in accessing care.

Data analysis

The focus groups were recorded and transcribed. In qualitative research, the researcher must consider himself or herself part of the research instrument, because all data collection and analyses pass through the researcher and, as such, the researcher interprets data through his

or her subjective reality. To enhance this study's rigor and objectivity, two additional scholars assisted with qualitative analysis of the transcribed focus group data (a total of four research analysts). In the realm of reflexivity, it should be noted that two members of the four-person analysis team are doctorally trained and considered subject matter experts in the fields of HIV and substance use; another analyst is a doctoral candidate specializing in qualitative research methods, who has practice-oriented experience in human service policy and provision; the final analyst was an MSW candidate completing a research internship.

With the aid of qualitative analysis software (NVivo), each of the four analysts conducted her or his own content analysis, which was comprised of basic and axial coding, to derive emergent themes. This process yielded individual coding paradigms (Corbin & Strauss, 2008). All four analysts met in person to reconcile differences (for example, some analysts identified multiple themes that, upon discussion, were collapsed into broader themes) and synthesize findings into one set of mutually agreed upon thematic dimensions.

Results

The dominant themes relevant to service provider perceptions of treatment barriers facing Black, non-gay-identified MSMW are (a) labeling, (b) constructions of masculinity, (c) HIV/AIDS awareness, and (d) treatment success. They are described at length here.

Labeling

"Labeling" transcended the data most frequently; this theme pertains to service providers' beliefs that NGI MSMW neglected to seek services for fear of being labeled "gay" or "bisexual." Those terms were thought to be Eurocentric and to imply a lifestyle orientation, as opposed to an isolated, behavioral act. As several service providers noted, NGI MSMW may avoid or decline services because they fear agencies labeling them:

> They (NGI MSMW) don't feel the comfort level of going to an agency and speaking to a person that is going to identify them as gay, which is part of why we use the term MSM. You don't have to classify yourself as gay to be an MSM … I think that, honestly, a big barrier is the term "gay" for homosexuals. If I am a non-gay-identified man who is having sex with men and if I'm straight, as soon as you say that I'm homosexual or gay … that shuts the door between us. You judge me—you put me in a category that I don't feel that I'm comfortable with.

> You have to understand the word gay. … It's a label and it makes you feel weak. This client already has this image in his mind and you say "gay," and he thinks of some feminine guy, just really out in the open—rainbows, pinks everywhere. … So when you say that to a man that doesn't identify as gay, he's totally just like, "No! No way!"

In addition to interpersonal or agency-level labeling, other service providers indicated that NGI MSMW may perceive being labeled by the community at large, and consequently may not utilize services:

> If [the agency] has AIDS in the title, as soon as I go there, somebody is going to say that I have AIDS or somebody is going to believe that I'm gay. No one is going to believe that I'm a straight man going into that office.

This provider, speaking in the voice of a hypothetical client, highlights the fact that HIV-related stigma also can deter MSMW from seeking service. In general, provider comments about labeling corroborate findings in the literature about the multidimensional ways in which perceived stigma can discourage care-seeking. They reveal sensitivity to distinctions between behavior and identity that may not be widely appreciated, either in the community or by some service providers themselves. The observation that certain commonly used terms for MSM are considered Eurocentric highlights a subtle but important cultural barrier for Black men.

Constructions of masculinity

A second emergent theme included service providers' perceptions that NGI MSMW are reluctant to seek services because of pressure from certain cultural constructions of masculinity, which may cause some NGI MSMW to view help-seeking and prevention/treatment as anti-masculine. For example, NGI MSMW are often fearful of being perceived as effeminate, weak, or in need of help. Such characteristics stand in stark contrast to key constructs of Black masculinity including independence, self-sufficiency, and being a provider for one's (heterosexual) family (Operario et al., 2008; Pass, Benoit, & Dunlap, 2014). As two service providers indicated:

> The average black man won't go to the doctor because something is wrong with him and they don't believe in marriage counseling and things that are the norm in certain families or cultures. So education, in general, and making it okay to go to a doctor, and making it okay to talk about sex and okay to talk about emotional issues [will help normalize treatment].

> In the Black-Latino community, the male identity is very, very—I won't say confused—but is focused in the church and machismo and a man can't really cry … that is very much what I've seen when it comes to [HIV] testing.

Cultural constructions of masculinity, sometimes intensified by ethnic traditions, also may drive MSMW to conceal their same-sex attraction and relationships:

> Some of the clients that I have worked with … those who are from a West Indian or Caribbean heritage. … One told me that he doesn't go to anyone on the street. … He goes to married men because when he goes to a married man, his identity will not be revealed. The married man has a wife at home and she will not know anything about his sexual orientation; neither will anybody that he talks to.

> I have had patients who are from the Caribbean and the stigma there is so harsh and so high that one of my guys told me directly that he has had sex with both men and women and he is not really sure who to choose to be his lifelong partner. … The stigma is so great, that you just have to continue to keep it under the carpet.

Concealment is an important consequence of stigma not only because it may discourage men from seeking care, but because it may put their female partners at increased HIV risk. The

preceding comments on masculinity were made by providers who understand that Black culture is not monolithic and whose clients felt comfortable enough to share their perceptions of and experiences with stigma. They suggest potential benefits that may accrue when providers are attuned to the consequences of varied cultural pressures on Black MSMW.

HIV/AIDS awareness

A third theme was the perception among service providers that NGI MSMW were unaware of the need for safe-sex practices and prevention, misinformed about risk, or perhaps allowing fear of stigma to trump concern for safety:

> They [NGI MSMW] would rather keep their image … their image is more important. … [W]hat they label themselves internally is more important than actually protecting themselves.

Advancements in treatment have made HIV/AIDS a treatable illness as opposed to a terminal disease (Balderson et al., 2013; Siegel & Lekas, 2002). These medical breakthroughs have led to decreased risk perception, especially among young people (Kalichman, Nachimson, Cherry, & Williams, 1998; United States Department of Health and Human Services, 2012):

> I had a young MSM come to me that knew he was already infected before he was tested. After speaking to him a little bit more, the reality is he knew he was engaging in risky behavior, but didn't think that being HIV positive was that much of an issue anymore. Therefore it was just a matter of time for him … he was so accepting of the situation … a lot of people are engaging as if there is a cure.

Some service providers noted that many NGI MSMW do have safe sex with male partners, but that this alone is insufficient:

> They [same-sex couples] are engaging in protective sex and they are using that as a way not to discuss HIV. … No positive gay man wants to self-identify, even at the point where they [the couple] are both probably understanding that they are both positive.

The provider suggests that using condoms is a way to avoid the stigma associated with positive HIV status. Through focus group findings, this section illustrates the extent to which risk awareness and coping are complicated by other worries concerning intersecting stigmas related to sexual identity and HIV status.

Treatment success

In a number of ways, service providers expressed the belief that NGI MSMW fear being judged by providers themselves. When probed for how to successfully treat NGI MSMW, providers were almost unanimous in their desire to "meet the client where he is at":

> It's very important in doing one-on-one that we create the safe space for the client, whoever they may be, and meet them where they are at. … We need to meet the person exactly where they are at and talk their language—talk their slang—look them in the eye, make them feel comfortable, because a lot of times they are

> looking to express something they haven't been able to express before, especially when it comes to men … they have nowhere to go to express the feelings they are having so … you have to be that safe space … meet them where they are at and talk their language.
>
> I was in a training. … When we were discussing men who have sex with men and [another service provider] said, "Oh, you mean bisexual …" I said, "No … not unless they say they are. … And it doesn't matter what they say. They can say they're an elephant with pink polka dots … and what does that mean as far as their risks?" And she kept saying, "But they are bisexual!" I said, "You can think anything you want to think but you can't just say anything you are thinking. … Because you won't be able to move forward in your risk counseling with a participant. …" People are saying this in their out-loud voice. It is okay to say it and then realize, "I have a feeling about this." Then take it to your supervisor. … Recognize you have the feeling … just don't show it [in session].
>
> You don't have to classify yourself as gay to be an MSM. If you want to say that you're straight and you're MSM we will still talk to you and still give you the same information.

As evidenced by these quotes, meeting the client "where he is at" carries special meaning for service providers who may work with NGI MSMW. These providers must take special care to focus on client needs as opposed to client identity; interventions work best when they meet the specific needs of focal populations (Jones, Hopson, & Gomes, 2012). Treatment must be facilitated in a way that is respectful of individual client circumstances, his social location, and the dimensions of oppressions that he may face.

Discussion

To date, there is almost no literature on drug-treatment experiences among NGI Black MSMW or on what treatment setting characteristics would best meet their needs. Findings in this study explore four emergent themes pertaining to service provider perceptions of treatment barriers facing Black NGI MSMW. Emergent themes include (a) labeling, (b) constructions of masculinity, (c) HIV/AIDS awareness, and (d) treatment success.

The authors recommend that agency administrators and policymakers work with intervention researchers to create and maintain cultural sensitivity training around issues specific to Black NGI MSMW: issues such as cultural definitions of masculinity, service utilization, and stigma as it pertains to multiple dimensions of oppression. Specific findings from formative and intervention research can inform new courses and update existing material. Agency administrators and policymakers could collaborate with researchers on funding opportunities to develop and test such curricula. Such sensitivity training can introduce social and medical service providers to the psychosocial ecology that Black NGI MSMW live in; to this end, providers will be best able to meet these clients "where they are at."

While meeting the client "where he is at," social and medical service providers must also be trained to relieve clients from their own self-stigmatization. This includes normalizing same-

sex attractions and behaviors in terms that are independent from identity. In addition, service providers must not work in silos. A substance abuse counselor serving Black NGI MSMW must be proficient in addressing sexual risk behavior, much as someone working in the field of sexual health must be equally proficient identifying and addressing substance use concerns. To this end, providers would benefit from training in complementary substantive areas. Relevant courses may be found through the Addiction Technology Transfer Center (ATTC) Network, the National Network of STD/HIV Prevention Training Centers, and other programs supported by federal agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control and Prevention (CDC).

Limitations

Like all qualitative research, these findings are context-bound; we cannot generalize beyond the 18 substance abuse and HIV service providers who agreed to participate in one of the two focus groups. In addition, lack of specific demographic data such as race and ethnicity may have limited our understanding of provider attitudes. Our research also may have benefited from a more general understanding of service providers' attitudes toward, and exposure to, same-sex attraction. We should also note that the NGI MSMW whose situations are most difficult to understand may be the ones who never interact with service providers in the first place. Their experiences are not included in these service provider perceptions. A final limitation of our research is that our sample may be biased, as research participants felt strongly enough about NGI MSMW to volunteer their time for the study. They were recruited through an advisory group and a training institute, which may inherently consist of open-minded constituencies. Finally, this research was conducted in the metro-NYC area, a generally tolerant and historically liberal enclave of the United States. Future research that elicits service provider perceptions of NGI MSMW would benefit from more representative geographic sampling.

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