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ORIGINAL PAPER: BLACK AND LATINO MALE BISEXUALITIES SPECIAL SECTION

Sexual Behavior, Sexual Identity, and Substance Abuse Among Low-Income Bisexual and Non-Gay-Identifying African American Men Who Have Sex with Men

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Abstract We examined the role of drug use and addiction in same-sex sexuality among non-gay-identifying African American men who have sex with men or with both men and women (MSM/MSMW). Between July 2005 and February 2006, we conducted seven focus groups with 46 predominately low socioeconomic status African American MSM/MSMW. A total of 29 men self-identified as HIV-infected and 17 self-identified as uninfected. Focus group transcripts were analyzed using consensual qualitative research techniques. Alcohol, crack cocaine, and crystal methamphetamine were the primary drugs mentioned by participants. Drug use was identified as playing a central role in same-sex sexuality for many African American MSM/MSMW. Participants described alcohol use and drug transactions, use, and addiction as motivating sex with men, allowing and rationalizing same-sex activity and unprotected sex, and facilitating access to male sex partners. Some of those in treatment for substance abuse indicated that a readiness to admit their same-sex activity and come to terms with their homosexuality/bisexuality was necessary for recovery. Because successful engagement of non-gay-identifying African American MSM/MSMW is essential to the reduction of HIV transmission and substance abuse in Black communities, findings call for drug treatment approaches that acknowledge and accept diverse sexuality in clients. Service providers and policy-makers may be guided by these findings toward building cultural competency among direct service staff. Future research should examine interrelated dynamics of sexual activity, identity, and drug use as they evolve within individual African American MSM/MSMW and compare the frequency with which sex, condom use, and substance use co-occur with male versus female partners.

Keywords African American men · Bisexuality · Homosexuality · Crack cocaine · Alcohol · Methamphetamine · Substance abuse disorders

Introduction

Over the past few decades, illicit drug use among men who have sex with men (MSM)[1] has become a popular area of research, as it is an important factor associated with high-risk sexual activity (Halkitis, Parsons, & Stirratt, 2001; Heredia, 2003; National Institute on Drug Abuse, 2002; Seidman, Sterk-Elifson, & Aral, 1994; Webster et al., 2003). Certain drugs, such as amphetamines and its derivatives, methylenedioxymeth-amphetamine (ecstasy) and crystal methamphetamine (crystal or ice), as well as ketamine ("special K"), gamma-hydroxbutyrate (GHB), and

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[1] MSM, as used throughout this article, refers to general populations of men who have sex with men, regardless of whether or not they also have sex with women. MSM/MSMW, as used throughout this article, refers to studies that explicitly include and present separate results for men who have sex exclusively with men and men who have sex with both men and women. Bisexual is also used to refer to MSMW. "MSM only" is used when referring specifically to men who have exclusively male partners.

lysergic acid diethylamide (LSD), have been labeled *party* or *club drugs* and their use has increased greatly in the past 10 years (Klitzman, Pope, & Hudson, 2000). Use of club drugs (Klitzman et al., 2000; Patterson, Semple, Zians, & Strathdee, 2005) and powder cocaine or crack cocaine (Campsmith, Nakashima, & Jones, 2000; de Souza, Diaz, Sutmoller, & Bastos, 2002; Maranda, Han, & Rainone, 2004) has been associated with increased risky sexual behaviors among MSM. For example, the prevalence of substance use reported by MSM attendees at a major circuit party in North America was 72, 60, 39, 36, and 28% for ecstasy, ketamine, cocaine, crystal methamphetamine, and GHB, respectively, with unsafe sexual behaviors in these settings being significantly associated with frequent use of ecstasy and ketamine (Mattison, Ross, Wolfson, Franklin, & San Diego HIV Neurobehavioral Research Center Group, 2001). The pharmacological effects of these drugs include physical, emotional, and psychological health consequences (e.g., agitation, anxiety, tachycardia, and hypertension). Additionally, they also affect neurotransmitters and cause euphoria, enhanced feelings of intimacy and sexual libido, and increased energy (Sandowick, 1998; Smith, Larive, & Romanelli, 2002; Worth & Rawstorne, 2005). These effects are particularly relevant to sexual risk taking, as these drugs may act as an aphrodisiac and disinhibit impulse control (Sandowick, 1998; Worth & Rawstorne, 2005).

Beyond annual events, such as circuit parties, drug use is common in gay communities and at specific gay venues. In San Francisco, approximately 50% of MSM who frequented gay venues, such as bars, dance clubs, parks, and sex clubs, reported having used crystal methamphetamine in the past three months (Heredia, 2003). In New York City, 52% and 20% of MSM who frequented dance clubs reported using ecstasy and crystal methamphetamine, respectively, in the prior year (Grov, Bimbi, Nanin, & Parsons, 2006; Klitzman, Greenberg, Pollack, & Dolezal, 2002). In the 25-city National HIV Behavioral Surveillance (NHBS) survey of MSM ages 18 and over, 46% of the 10,030 HIV-antibody negative and undiagnosed participants reported having used illicit drugs in the past year (32% with sex) (Sanchez et al., 2006). In contrast, general population drug use rates are much lower, with just 13.8% of adults reporting illicit drug use in the prior year according to the 2005 National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration [SAMHSA], 2006). Additionally, recent studies examining MSM drug users identified a high prevalence of polydrug use, defined as "those using three or more street drugs during the past year" (Greenwood et al., 2001). In a sample of 261 HIV-antibody positive methamphetamine-using MSM, 95% reported polydrug use (Patterson et al., 2005).

Contrary to popular belief, MSM are not at higher risk of developing alcohol use-disorders than men in the general population, although they are less likely to abstain from drinking alcohol altogether (Bux, 1996). Nevertheless, alcohol must be considered when assessing sexual risk behaviors among MSM, particularly in communities of color (U.S. Department of Health and Human Services [US DHHS], 1998), as it tends to put users at elevated risk for HIV infection and other STDs (Irwin, Morgenstern, Parson, Wainberg, & Labouvie, 2006; Weinhardt & Carey, 2000). As with many other groups, alcohol use has also been identified as a means of excusing socially unacceptable or personally desirable behaviors among MSM/MSMW (Dermen, Cooper, & Agocha, 1998; Irwin et al., 2006; McKirnan, Vanable, Ostrow, & Hope, 2001). This may be particularly true for those non-gay identifying (NGI) African American MSM/MSMW who perceive high levels of disapproval of homosexuality and bisexuality in African American communities.

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Surveys on Drug Use and Health (SAMHSA, 2006), Blacks report lower rates of current, binge, and heavy alcohol use and lifetime illicit drug use than do Whites. In recent years, however, Blacks have reported slightly higher rates of current illicit drug use (9.7% vs. 8.1%). Blacks also experience more frequent and more severe consequences of drug and alcohol use, including poorer physical health outcomes and more severe social consequences, such as higher incarceration rates (Ronan, 1987; Staples, 1990; U.S. DHHS, 1991).

Significant differences have been noted regarding drugs of choice and frequency of use among Black versus other race MSM, but few data are available on drug-use patterns within Black MSM subgroups, including NGI and bisexual MSM. According to several different studies, overall levels of drug and alcohol use are lower than or comparable to other MSM (Greenwood et al., 2001; Halkitis, Green, & Mourgues, 2005; Harawa et al., 2004; Heckman, Kelly, Bogart, Kalichman, & Rompa, 1999; Irwin & Morgenstern, 2005; McNall & Remafedi, 1999; Siegel, Schrimshaw, & Karus, 2004; Stall et al., 2001; Sullivan, Nakashima, Purchell, & Ward, 1998). Nevertheless, specific drugs appear to be used more frequently by Black MSM compared to other MSM, at least among older men. These include marijuana (Irwin & Morgenstern, 2005) and non-injected crack cocaine (McKirnan et al., 2001; Sullivan et al., 1998). The latter is significant given the well-documented role that crack cocaine plays in stimulating hypersexual activity and increasing involvement in exchange sex among both males and females (Guss, 2000). Methamphetamine use appears to be much less common among Black than White or Hispanic MSM (Irwin & Morgenstern, 2005; Wilton, Halkitis, English, & Roberson, 2005); however, recent data indicate increasing use in Black MSM populations (Wilton et al., 2005).

Types of drugs used, drug-use patterns, and the sexual and social contexts in which drug use occurs are likely intertwined with a myriad of factors that have implications for HIV prevention and addressing problem drug use. HIV

intervention experts have argued that socio-cultural factors, including racism, homophobia, sexism, and levels of affiliation with gay and ethnic communities, should be critical considerations when developing HIV risk-reduction interventions (Mays & Cochran, 1988; Mays, Cochran, & Zamudio, 2004; Peterson & Carballo-Dieguez, 2000; Williams, Wyatt, Resell, Peterson, & Asuan O'Brien, 2004). For many African American MSM/MSMW, additional factors critical to HIV prevention and issues of drug use include sexual relationships with males, females, and/or male-to-female transgenders, internal conflicts regarding fulfillment of culturally prescribed masculine gender-role expectations (i.e., gender role conflicts), strong identification with and desire for support from African American communities, secrecy regarding same-sex behavior, and the role that illicit drugs can play in stimulating hypersexual activity and increasing involvement in exchange sex among both males and females (Kraft, Beeker, Stokes, & Peterson, 2000; Mays & Cochran, 1988; Mays et al., 2004; Stokes & Peterson, 1998).

Black MSM are more likely than MSM of other race/ethnicities to be behaviorally bisexual and non-gay-identified. Furthermore, they are less likely to disclose their bisexual or homosexual activities to others (Kennamer, Honnold, Bradford, & Hendricks, 2000; Millett, Malebranche, Mason, & Spikes, 2005). In the National HIV Behavioral Surveillance Survey (NHBS), 14% of Black MSM, compared to 8% of Hispanic MSM and 4.2% of White MSM, reported sex with females in the prior 12 months (Sanchez et al., 2006). In the six-city Young Men's Survey of MSM ages 15–29, 18% of Black compared to 13% of Hispanic and 8% of White MSM were classified as "non-disclosers" regarding their sexual activity with other men (Centers for Disease Control and Prevention, 2003). Other studies involving men recruited from settings not frequented predominately by gay-identified men have found much higher levels (20–60%) of bisexual behavior and non-gay-identification among Black MSM (Pathela et al., 2006; Simon et al., 1999; Stokes & Peterson, 1998; Wohl et al., 2002), including 34% reporting bisexual behavior in a large national study of people with HIV/AIDS (Montgomery, Mokotoff, Gentry, & Blair, 2003).

Some research indicates that NGI and bisexual MSM may be more likely to use drugs than strictly gay-identifying MSM (Agronick et al., 2004; Newman, Rhodes, & Weiss, 2004; Rietmeijer, Wolitski, Fishbein, Corby, & Cohn, 1998). There are, however, conflicting data on this topic. For example, in their population-based study of 2,172 MSM in four urban centers, Stall et al. (2001) found higher levels of alcohol-related problems and multi-drug use in those MSM who were out to most family and friends compared to those who were not; whereas, Dodge and Sandfort (2007) found higher levels of substance use and abuse in bisexual/MSMW compared to MSM only/gay men in their recent review on the topic. Research has yet to examine in detail how drug-use patterns, frequency of sex under the influence of drugs, and exchange of sex for drugs differ between gay-identified and NGI African American MSM or the meanings attached to drug use by these subpopulations. One analysis examined behaviors among 70 heterosexually identified Black MSM participants in a Los Angeles-based HIV case–control study and found that 64% reported being under the influence of drugs or alcohol during all episodes of anal sex with male partners (Wohl et al., 2002). By comparison, 32% of NHBS participants reported sex under the influence of illicit drugs in the past 12 months (Sanchez et al., 2006). Given the well-documented association of drug and alcohol use with risky sexual behaviors, there exists a need to better understand drug-use patterns, particularly stimulant use, among MSM who are behaviorally bisexual and/or non-gay identifying.

Understanding the psychosocial and cultural issues influencing drug use and sexual identity is also essential. How NGI African American MSM/MSMW form and define their sexuality may have a significant effect on their sexual decision-making and self-concept (Crawford, Allison, Zamboni, & Soto, 2002; Finlinson, Colon, Robles, & Soto, 2006). Identity development within a cultural context, particularly as it relates to sexual development, has been poorly explored for NGI African American MSM/MSMW (Cass, 1984; Johns & Probst, 2004; Myers, Javanbakht, Martinez, & Obediah, 2003). While sexual identity development among ethnic minority MSM/MSMW has not been thoroughly examined, established theories on stages of sexual identity development agree on two important elements, *identity comparison* or the resolution of feelings of isolation and alienation as the difference between self and non-gay/bisexual others become more clear and *identity pride* or the development of positive feelings toward gay/bisexual identity and connection to gay/bisexual members as a group (Cass, 1984; Johns & Probst, 2004). These stages are said to be particularly important to healthy sexual identity development because feelings of isolation may be lessened as individuals realize that they are not alone in their desires and experiences. Without participation in a defined, accepting, and safe community of other sexual minority men, the group identification and cohesiveness that support individual, community, and economic empowerment may not occur, resulting in less resolved sexual identity formation.

It is unclear how lacking a well-defined sexual identity is associated with sexual and drug behaviors and risks. Two large studies have indicated lower sexual risk behaviors and infection rates among MSM who were non-gay-identifying or did not disclose their sexual orientation compared to gay-identifying and disclosing MSM (CDC, 2003; Weatherburn, Hickson, Reid, Davies, & Crosier, 1998). Nevertheless, a number of studies involving predominately marginalized populations of MSM/MSMW have shown higher levels of drug use and sexual risk-taking in the non-gay-identifying and behaviorally bisexual participants (Heckman et al., 1999;

Jimenez, 2003; Rietmeijer et al., 1998; Washington et al., 2006; Wohl et al., 2002), indicating potentially important interactions of socioeconomic status with risk behavior and sexual identity. Drug-use patterns, their contexts, and their interaction with sexual behavior and identity may differ for NGI and bisexual African American MSM compared to gay-identifying MSM (Jimenez, 2003; Rietmeijer et al., 1998). Understanding these dynamics is aptly pertinent and important for African American MSM/MSMW, who bear the largest HIV/AIDS burden of any race/ethnicity and behavioral risk group combination in the United States (Centers for Disease Control and Prevention, 2005) and significant risk of negative outcomes stemming from drug use and addiction.

In summary, the research literature indicates significant levels of drug use and negative consequences in both MSM and general Black populations and points to potentially higher levels of use among NGI/bisexual MSM compared to homosexual MSM (Dawkins & Williams, 1997; U.S. DHHS, SAMHSA, 1998; Wilton et al., 2005). However, neither drug use patterns nor their interactions with sexual identity and behavior are well understood among NGI and bisexual African American MSM. Given the complex array of psychosocial stressors many African American MSM face (Mays & Cochran, 1988; Mays et al., 2004; Stokes & Peterson, 1998) and cultural differences compared to White MSM, drug use may interact with identity and behavior in unique ways and have implications for those seeking recovery for alcoholism or addiction to other drugs. We analyzed qualitative data from seven focus group discussions with NGI and bisexual African American MSM in order to explore the role that drugs and alcohol play in sexual behaviors with other men, sexual identity, and the meanings attached to same-sex sexuality. Analyses explored the men's socio-cultural context in order to understand the significance and meanings of these relationships within African American communities.

Method

Participants

Between July 2005 and February 2006, African American men were recruited to participate in seven focus group discussions, approved by the UCLA Institutional Review Board (IRB) as part of formative research for developing a new HIV prevention intervention for non-gay-identifying and bisexual African American MSM. Recruitment involved active and passive distribution of fliers at nightclubs, coffee houses, HIV/AIDS clinics, social service agencies, and street/park locations commonly frequented by the population. Most of these venues were not "gay-identified." Those calling the study headquarters to express an interest in participation were screened by telephone and informed that the purpose of the study was to better understand health utilization, cultural and gender factors, drug use, and attitudes and behaviors that influence HIV/AIDS-related risks among African American men.

The eligibility criteria included being 18 years of age or older, African American/Black, sexually active with at least one male partner in the prior 12 months, English-speaking, and non-gay-identifying. Non-gay identifying (NGI) meant that the potential participant did not use a sexual self-identity label or identified with a term other than "gay," such as "straight," "heterosexual," "bisexual," "Down Low/DL," or "same gender loving." This definition was used in an effort to recruit men who truly did not identify with the "gay" terminology and perceived lifestyle or community, but who were actively having sex with men and possibly women. Participants were asked three screening questions: (1) What sexual orientation label best described them (i.e., straight/heterosexual, gay, bisexual, Down Low/DL, same gender loving, no label); (2) whether they had had sex with a male partner in the previous 12 months; and (3) whether they had had sex with a female partner in the previous 12 months. In order to be eligible for the study, potential participants had to identify with a label other than gay and had to have been sexually active with a male partner. Although, sexual activity with female partners was also discussed during the screening process, being sexually active with a female partner was not an eligibility criterion, but the screening information was used to explore further the incongruence between sexual labels and behaviors. While drug use among NGI African American MSM/MSMW was discussed, active drug use was not an entry criterion or directly assessed.

A total of 73 potential participants contacted the study's main telephone number. Twenty-four callers were determined to be ineligible, 18 identified as "gay", and six identified as "heterosexual/straight" and lacked male partners. Nineteen callers were not screened because they were unreachable after calling the project and leaving their contact information, leaving 30 eligible participants. The primary reason for not being reachable was that the contact information provided by the potential participant was no longer usable. An additional 16 participants were recruited and enrolled directly at the focus group discussion locations; however, information was not available on others who learned about the study in the field but did not contact the study by telephone. A total of 46 eligible men participated in seven focus group discussions conducted at locations operated by three collaborating community-based organizations (CBOs) in Los Angeles and a mission that provides shelter, housing, food, recovery, and other services to those in need. One CBO provides a range of health, outreach, testing, and prevention services for indigent adults. The second operates residential drug treatment programs, while

the third operates a cultural center focusing on mental and physical health issues affecting African Americans.

Although HIV status was not initially a criterion for group entry, the first three focus groups included 29 men who indicated they were HIV-infected and one man who indicated he was HIV-antibody negative. These groups are described in greater detail elsewhere (Harawa, Williams, Ramamurthi, & Bingham, 2006). Recruitment for the remaining four groups focused on uninfected men, with the last four groups including 16 men who had recently tested HIV-antibody negative or otherwise perceived themselves to be uninfected. One focus group involved men receiving services from the mission, at least two of whom were in drug treatment; another involved 11 men who were clients of one of the collaborating CBO's residential drug treatment programs.

The mean age of participants was 41.5 years (range, 22–61 years). Table 1 contains socio-demographic information on the sample stratified by whether the group included predominately HIV-infected or uninfected men. The HIV-infected groups' participants had lower socioeconomic status (SES) and were less likely to identify as bisexual or have sex with women or with transgender women than participants in the uninfected groups. Overall, SES was low with 63% unemployed and 70% reporting annual household incomes of less than $20,000.

Although all participants indicated during the eligibility screening that they were non-gay identifying, five (11%) men described themselves as gay in the demographic survey administered after the focus group discussions. Also, although the eligibility criteria included having had sex with a man in the past 12 months, five men (11%) indicated that they had not had sex with a male in that time period. Approximately half of the participants were bisexual, defined here as self-reporting sex with both male and female partners in the prior 12 months. Thirteen percent reported sex with male-to-female transgender partners.

Procedure

Two ethnically similar male facilitators, a marriage and family therapist and a psychiatrist (the co-PI), both with significant experience working with African American MSM/MSMW, conducted the focus groups. Each focus group session lasted 90–120 minutes, was audiotaped, and transcribed verbatim. To ensure confidentiality, no personal identifiers were included in the transcripts of the group discussions or on the post-group surveys. Verbal informed consent was obtained using IRB-approved procedures. Once informed consent was obtained, nametags were distributed, whereby participants were free to print a pseudonym or their real first names. After completing the group, participants were asked to complete a short demographic survey.

Measures

The semi-structured focus group interview guide was developed through discussions with experts in the field of HIV/AIDS, CBO collaborators, and a community advisory board of African American MSM/MSMW. Eleven questions specifically targeting NGI African American MSM/MSMW were included. Questions explored: (1) the influences and motivators of sexual and general health-seeking behaviors, (2) condom use behaviors and attitudes, (3) nuances and techniques for describing same-sex behaviors and identities, (4) race and gender expectations of African American men, (5) drug and alcohol use, (6) experiences of being HIV-infected or uninfected, and (7) ideal strategies for engaging African American men in HIV risk-reduction programs. The question specific to the use of drugs and its relation to the men's sexual lives was framed as: *What is the role drugs and alcohol play in sexually active African American MSM's lives?* Probes were used when necessary to solicit additional or more detailed responses.

Data Analysis

Consensual qualitative research (CQR) (Hill, Thompson, & Williams, 1997) and a constant-comparison method of data analysis, based in grounded theory (Strauss & Corbin, 1998), were used in the data analysis. The analysis team consisted of six members, including the principal investigator, co-principal investigator, two investigators from the collaborating CBOs, the project director, and one co-facilitator. In the first phase of analysis, members read the sections of each focus group transcript that discussed alcohol or drug use, meeting weekly to discuss the phenomena they identified relevant to drug use and sexual identity and behaviors. Major themes identified in each transcript were summarized in matrix form and circulated to the group for feedback. In the second phase of analysis, the group met to discuss themes identified across transcripts, identify common domains, and refine them into categories that were then applied consistently to quotations across all transcripts using Atlas.ti^{TM} software to code and manage the data.

Results

In most groups, participants listed drug use and addiction as one of the major health problems facing African American men. Alcohol and crack cocaine were the most frequently discussed drugs, with alcohol referenced by participants in all but one focus group and crack cocaine mentioned in all groups. Methamphetamines, generally "crystal," were mentioned in four focus groups, with participants indicating

Table 1 Participant characteristics by self-reported HIV-antibody status of their focus groups ($N = 46$)

	HIV-positive ($n = 30$)[a]		HIV-negative/unknown ($n = 16$)		Combined totals ($n = 46$)	
	n	%	*n*	%	*n*	%
Employed						
Currently employed	7	23	10	62	17	37
Unemployed	23	77	6	38	29	63
Education						
Not completed college	28	93	11	69	39	85
Completed college	2	7	5	31	7	15
Annual income						
$20,000 and less	24	80	8	50	32	70
$20,000 and more	6	20	8	50	14	30
Sexual identity						
Heterosexual	4	13	6	38	10	22
Bisexual	12	40	5	31	17	37
Gay	5	17	0	0	5	11
Same gender loving or SGL	3	10	1	6	4	9
Down low or DL	1	3	2	13	3	7
Homosexual	3	10	0	0	3	7
Queer	1	3	0	0	1	2
Other/None of the above	1	3	1	6	2	4
Don't know	0	0	1	6	1	2
Sex in the past 12 months						
With men	27	90	14	88	41	89
With women	13	43	12	75	25	54
With transgender women	1	3	5	31	6	13
No sex	1	3	0	0	1	2
Sex with both men and women	11	37	12	75	23	50

[a] Includes one participant who stated that he was negative. Personal identifiers were not included in the demographic survey. Hence, we could not separate out this participant and include data from all participants in the first three groups with otherwise HIV-infected men

that its use is becoming more common among African Americans, particularly younger African American MSM. Powder cocaine, marijuana, drug injection, ecstasy, and "Pink Panthers" or LSD were also referenced. Additionally, from the focus group discussions, it was reported that "almost everyone used weed [marijuana] and alcohol." Although we do not know exactly how many men used drugs or experienced drug dependence, a minimum of 11 or 23% did as they were recruited from the residential drug treatment program.

In response to focus group questions preceding the specific discussion of drug use, participants described specific expectations of African American men that reflected traditional masculine role norms (including heterosexism), racist sexual stereotypes, the importance of family, and a recognition of a shared history of racism and struggle. This sociocultural context is partially reflected in the following quotations:

P1[2]: I think it also boils down to the African American (AA) community is a conservative community and it's a liberal community. It can be conservative, it can be liberal on civil rights issues and all those issues, but when it comes to the issue of homosexuality, sexuality, same-sex marriage, it can be very conservative. So, you guys have to realize that we come from a very religious-based community also. Families that grew up in church, families that are very religious, and they instill that in you as you grow up. So, as a result of that, it's a hell of a lot of pressure growing up in an AA community and being a homosexual. (HIV-positive group)

P2: I think for me it's this whole idea or this concept of do I still see myself as a man or how one would define me as a man or a role of a man in terms of masculinity. Also, for

[2] In all of the quotes involving more than one participant, P1, P2 ... P-N, indicates a statement from a different person.

me, it's acceptance from my family because I tend to prioritize my family very, very high and it's being able to know to myself that, OK this is my choice, my preference but how do people see me, because for me that's important in my world. I know that [for] some of us or for myself, it's identity. [Identity] is truly critical because we live in a society that places a lot of interest on perception, identity, and if you're working in a certain line of work mainly corporate America and if you're gay or out of the box or however you label yourself, it becomes a big issue. So, it puts you in a whole different perspective of how you want to, I guess, be who you are. (HIV-negative group)

These examples illustrate the pressure that African American MSM/MSMW may feel when it comes to their sexual identity. Being gay or bisexual is not accepted and is even condemned in many contexts that are central to African American communities. So, many men may struggle with who they are and finding places where they can be more comfortable with their sexuality.

We identified 18 subthemes directly related to drug use and sex in the population and grouped them under four overarching domains. These describe the interaction of drugs and alcohol with same-sex sexuality among NGI and behaviorally bisexual African American MSM. They include drug and alcohol use and transactions as *motivators*, *allowers*, *rationalizers*, and *facilitators* for having sex with other men. Further, we discuss how these four roles help to decrease cognitive dissonance regarding issues of masculinity and participation in same-sex sexuality but also how they complicate a fifth domain, *recovery from drug addiction*, for some African American MSM.

Drugs as Motivators

Drugs as *motivators* of same-sex activity refer to instances in which men report having sex with other men solely or primarily because of their own drug use or dependence. Three subthemes were identified, which described how drugs motivated or influenced same-sex activity including: (1) exchange of sex for drugs or money to buy drugs, (2) formative early childhood sexual experiences with men that involved drugs, and (3) drug use contributing to feelings of hypersexuality or sexual compulsion that were most easily satisfied by male partners.

A small number of participants seemed to indicate that, for them, sex with men was limited to periods of active drug-use and generally occurred within the context of exchange sex. Exchange sex (or sex for drugs, money, or shelter) was referenced by multiple participants and in all but one of the focus group discussions. In some instances, exchange sex was described as a means to meet multiple needs, including obtaining drugs or money and fulfilling desires for sex with men. In others, the drugs or the means to buy them were discussed as a sole motivator for sex with men. For example:

P1: I only messed around [with men] because I am such a stone-cold crack head that I had to have it ... whatever it took to get it. You know what I'm saying? When it came to crack cocaine, you know and then I discovered crystal meth. (shelter, HIV-negative group).[3]

P2: I think, uh, that drug use and alcohol abuse is the major reason why HIV is out of control today. Because even straight men know that they can go and make money with having a guy suck their dick so they can get that next hit, you know. And like I said, when people are on drugs and intoxicated, they tend to be less careless about, they're not thinking about no condom.... And, you know, it's just the way it is. ... I don't care who it is, if you want that hit bad enough and you know I can go down the street and get this punk to suck my dick for $20, I don't care how many wives and how many kids you got, you want that next hit... you going. You know, you going. (HIV-positive group).

Some participants questioned, however, whether any man would engage in sex with another man without having some same-sex attractions.

The reports of "straight men" willing to receive oral sex from another man in return for money reflect complex power dynamics. In these encounters, the person giving oral sex may be seen as playing the submissive role; however, during the sex act, he may ultimately control the pleasure and orgasm experienced by the *straight* man whose desire for drugs has become so intense that he has willingly participated in sex with a "punk." This challenges the idea that the *real* man or the *straight* man is in complete control of the exchange, as drug dependence has led him to transgress masculine gender norms and the touch of another man has led him to orgasm.

For one participant, exchange sex was part of his early, formative sexual experiences with other men and led to years of prostitution as a means to access drugs.

P: Like I said, I was just a straight prostitute out there because I had to get the next hit... but I've had sex with men without drugs... so it ain't a matter of me just smoking and having sex with men. Uh, I think I turned my first little trick for a six-pack of beer when I was like 16. I didn't know what I was doing at the time, but it quickly came to mind what was going down and he basically gave

[3] Group designation, the drug treatment program and homeless shelter focus groups are specified as the participants were all clients of the program or recruited from the area surrounding the shelter. The other five groups were diverse and are designated just by the participants' self-reported HIV status.

me some head, [a] hit, and it was on and popping after that (shelter, HIV-negative group).

In this statement, the participant enjoys sex with men, but engages in it for the primary purpose of getting his "next hit." Another participant who mentioned an early sexual experience involving coercion by an older male partner also reported having exchanged sex in order to obtain drugs.

In other instances, participants indicated that sex with men was a response to the sexual compulsion and desire that was brought on by stimulant use. For example, this participant seems to indicate that one is more susceptible to same-sex attractions when high and that an easily aroused man who is also high makes the ideal potential sexual partner in these circumstances:

P1: When you're high, I believe when you're high and you're under the influence of a lot of things...
P2: It don't matter.
P1: ...and you want to have sex, especially if it's with the type of gentleman that can take a hit and get hard real quick (drug treatment program, HIV-positive group).

The participant below indicates that crack cocaine use causes him to want to play the receptive rather than the insertive role in sexual intercourse when asked to identify the factors that affect his sexual behavior.

P: Cocaine...Rock cocaine, Rock cocaine...I mean, it flips the script on me just like that. Instead of me poking, I want to get poked, I mean, just like that. (HIV-negative group)

Drugs as Allowers

Drugs as *allowers* of same-sex behavior refer to instances where drug intoxication allows a man to act out his desire for sex with another man despite a personal intention to avoid the behavior. This domain encompassed *four* subthemes: (1) disinhibition regarding sexual contact with men, (2) a belief that sex between men is disordered, wrong, sick, or perverted, (3) a method of coping with both internalized and felt homo/biphobia, and (4) "quasi-suicidal behaviors" where participants describe repeated risky sexual activity in terms of taking huge risks with one's life.

For the participant below, using cocaine made him feel more comfortable with his same-sex attractions and gave him "permission" to fulfill these sexual desires; however, he found it necessary to reinforce to the listener that he was not effeminate and did not, in other ways, transgress masculine gender role norms.

F: Earlier, you had said that sometimes when men aren't able to deal with their feelings about having sex with another man, they might use, can you tell me a little bit about that?
P: Yeah, you know, I've had that experience myself. You know, at the time when I used to do cocaine... cocaine gave me a feeling like I could sort of let my guard down, and not be effeminate... like, I never had the desire to be like a drag queen or dress drag or anything like that. But, if I wanted to be like [with] a guy, I felt more sexually aroused and I felt more comfortable in approaching a guy if that's what I wanted to do. You know?
F: While you were using?
P: Yeah ...So, in other words, the drug actually gave me permission to let out what I was feeling when I wasn't using the drug. Or, what I was thinking. (HIV-negative group)

Below, this participant refers to being involved with sex with men while drunk and later regretting the action when sober.

P: I think it almost kind of reinforces the... When you're down, after you've had a night that you've been drinking, you've had sex, you were drunk, whatever the case may be, when you're not drunk it's like why the fuck did I do that? You kind of try to separate yourself even further from that lifestyle. That's just something I do when I'm that way versus... um, that's something that's a part of me and that's a desire that I have or whatever the case may be. I think that it becomes-you can almost demonize it a little bit, you know. Men-it's real disgusting. Like, I think I hate to be drunk. You know, what I'm saying? So, if I do something while I'm drunk, then I can really dismiss it, you know. (HIV-negative group).

In this case, the intoxication reinforced the participant's negative views about participating in sex with other men, allowed him to separate himself from his actions, and contributed to his negative feelings about gay or bisexual "lifestyles."

Drugs as Rationalizers

Closely related to the role of drugs as *allowers* was when they were used as *rationalizers* of same-sex behavior. In these instances, drugs or alcohol were purposefully used or being intoxicated or high was referenced retrospectively in order to justify or explain having sex with another man or being seen with an "obviously" gay man. The effect of the drug use or the drug transaction is to not threaten the individual's personal or public perception as a heterosexual man. Subthemes included concern about (1) fulfilling masculine gender role expectations and (2) homophobia among peers. The difference between drugs as *allowers* for same-sex behavior and *rationalizers* of the same was that the former refers to overcoming an internal resistance to sex with other men, whereas that latter refers to a strategy for

working around society's disapproval of sex between men. Often, both roles came into play. For example, in the quote below, the participant described men for whom drugs "allowed" sex with other men because it provided them with an "excuse" for their actions while enhancing their sexual desires. This excuse was one they could give to others *and* to themselves in order to avoid admitting to or thinking about the implications of their sexual desires and actions.

> P: I think that drugs, alcohol, and sex and the MSM have been a major factor because what it has done for men that were on the down low that really had the feelings or had it inside of them. The drugs allowed them to have the excuse to experience what we've always wanted to experience anyway. You know? Once we got loaded, once we hit the pipe, once we were using speed, or once we had the alcohol, then, when I fucked around with you, I can say I was fucked up last night (laughter). So, what it does, or what it has done, or what it did; it opened up the door to bring the down low, to expose it more. Because now we found something that lets us do what we want to do, be who we want to be. And, we have an excuse to do it. It enhanced our feelings, it gives an excuse for our feelings, and enabled us to do what we enjoy doing anyway. And in most cases, even if we became sober, we still do it. (HIV-positive group)

The next participant explained why some African American MSM/MSMW feel a need to use drugs in such a fashion-denial of one's same-sex sexual desires and fear of projecting an effeminate image or experiencing homophobic verbal or physical assaults from peers. He argues that masculinity and sexual identity issues are closely related to many MSMW's overall self-concept and esteem.

> P: Well, a lot of them have inferiority complexes about their manhood being compromised, and this, that, and the other. And, they like on...the shy tilt, you know, in denial. Um, they want to be, they don't want others to know that they mess around, so to speak (laughter). And uh, it's one of those things wherein, many of them, uh, I don't mess with a person of the same-sex, I don't want my girl to see me with someone like that, or whatever the case may be. And then if someone says something off the record, they be ready to fight and this, that, and the other because somebody might, you know, say something derogatory, call them a punk, or whatever the case may be, and then they feel as if they have to defend their manhood, you know what I mean? So, a lot of them are like, peeping around the corner and trying to get you in places where nobody is really looking, you know, this, that, and the other, where they don't want to be bothered. And, you know, they have issues. They use drugs as an excuse. Ok, cause you know how the crack epidemic is... And, I think that guys mess with gay people for two reasons. There's something tangible. They don't like you. They like what you can do for them, for the most part. So, if any number of reasons that a person comes up with, worried about what their homeboys got to say...they have an excuse. Because most people want to project an image, you know, that, I'm a man. And, you don't have to go through all those head trips and stuff if you're not insecure about yourself. (HIV-positive group)

The term "mess around" is common slang for being sexually involved with men but may also reflect a tendency of some MSM/MSMW to see relationships with other men as transitory, unimportant, and unemotional. For example:

> P: ...I can't see myself in a loving, caring relationship with a man, I cannot see, I can't, you know, as holding hands, being a married man. I cannot see myself being that, but I can see myself having sex with a man all the time. (shelter, HIV-negative group)

Drugs as Facilitators

Drugs as *facilitators* ease access to potential sexual partners and existence as an NGI or bisexual African American MSM. Subthemes included (1) the secret, illicit nature of both drug use and sex with other men, (2) power dynamics of the sex/drug exchange, and (3) the often sexually charged social settings in which drugs and alcohol were frequently used. For example, a few men discussed public and social settings that served both as pick-up spots for MSM and as venues where drugs or alcohol were sold and used, thus contributing to a tendency for MSM to have sex under the influence. These settings included bars, clubs, and private parties. Much illicit drug use, however, as with sex between men, occurs in secret with people who either accept drug use or use drugs themselves. Therefore, the two activities can very easily coexist. For example, the participant above described men who, under the guise of using drugs, would go off secretly with known drug-using MSM in order to have sex with them. Men further indicated that drugs facilitated sex with men even when sober or not a drug user because drugs gave them power that could be leveraged in the sex-drug exchange to find sexual partners and negotiate what they wanted from partners who were in search of a next "hit."

Other subthemes that emerged related to drugs as *facilitators* of same-sex activity and included (4) increased comfort with approaching potential partners, (5) a method of coping with secretly engaging in sex with men, and (6) gender differences in sexual arousal between males and females. This participant felt less inhibited in approaching someone he was attracted to when under the influence.

P: If I'm using drugs or alcohol, I might be less inhibited, and, you know, if I see somebody I wanted to be with, I might be more likely to go up to them and, you know, try and get that going, as opposed to not. You know? That influence or something, it gives me more courage to say what I want to say. (HIV-negative group)

Another described how drugs may be used to deal with the feelings and stress associated with secretly engaging in sex with men.

P: I think that it, you know, if I have to be with my girlfriend Monday through Sunday through Friday, then on Saturday I have to lie to her and sneak out because I want to be with a guy, that's a lot of pressure. ... If I use drugs or alcohol, you know, maybe I don't know how to cope with those feelings, so I want to smoke or I want to drink or do whatever, just to learn, you know, not to learn but just to deal with the feeling because I don't know how to do with my thoughts or my feelings. (HIV-negative group)

Some participants indicated that when they were high and very sexually aroused, they preferred male to female sexual partners. Participants indicated that male partners were easily aroused and required less emotional commitment and initiated fewer conflicts than did women. One participant, however, described how his female drug-using partners were more aroused and ready to have sex when under the influence of stimulants. Hence, these drugs seem to have the benefit of also making some females primarily interested in sex. Below, this participant indicated that his drug-using female partners also tended to accept his bisexual behavior, a statement that was supported by other group participants.

P1: Okay, and then on the flip side, with the women... See in addiction community, women are more accepting of men who mess with men, then just straight women. That's just my experience.
P2: Yeah.
P3: Cuz they're curious about it too.
P2: That's right.
P1: Because if I'm laying it good to a girl and if she knows I'm fucking with a guy too... it fucks her up.
P1: And it's interesting to them. You know what I'm saying?
P2: Yeah.
P1: And I never, ever, I never hid it in the addiction community. (shelter, HIV-negative group)

Same-Sex Sexuality and Recovery from Drug Dependence

Because of the multiple roles that drugs play in the lives of African American MSM/MSMW and a frequent lack of acceptance of their homosexuality/bisexuality, many men discussed having to go through a process of accepting their same-sex behaviors and desires along with society's negative views of them in order to experience true *recovery* from drug addiction and maintain sobriety. *Recovery* subthemes included (1) honesty with self and others regarding same-sex sexuality, (2) self-acceptance of sexuality, and (3) ignoring other people's opinions about them. One participant explained that he was currently in drug treatment for the ninth time and that his only chance for success is if he does not hide his same-sex activity and deals with his sexuality.

P: You know what I'm saying then with others? As opposed to how I've been before where, you know... See, I don't want no one to think of me, but now I'm getting to the point where another person's thought and opinion of me is not as important as what I think about me, what myself thinks about me...The other thing I'm fortunate to have, my sponsor is gay, so it's easier for me, you know what I'm saying... damn good sponsor too, it's easier for me to deal with some of the issues I had with him. So, I don't have to hide the fact that I messed around and slept with anyone, I started really getting into this recovery thing. So, I'm fortunate to have somebody where I'm not going to have [to say] I'm fine... I'm not going to have to hide... where I am going to have to be honest... Because I'm telling you, it's my ninth program and the reason that I've been here is because I've always held back something. (shelter, HIV-negative group)

Another participant later concurred and indicated that the focus group dialogue helped him to feel more comfortable with the idea of discussing his sexuality with his sponsor.

P: You know what? I'm kind of grateful for this research right here because of the fact that this has given an opportunity to feel more comfortable to talking about it so maybe now I can talk about it with my sponsor. Cuz, in the... in the beginning, when I got this particular sponsor, I already knew that this subject was not going to be part of my [inventory]... Because, because but, for the ah, ah, the seriousness of my disease, my life is at stake here, I have to get this off of me, I have to be able to divulge this to another human being. (shelter, HIV-negative group)

Other substance use, sex-related subthemes, not discussed here, were raised by participants. These included decreased motivation for using protection or thinking about HIV risk, increased HIV susceptibility, increased sexual performance and enhanced sexual experiences, risk of sexual dysfunction and relationship difficulties with prolonged use, and the ability to separate from negative feelings related to being HIV infected.

Discussion

We highlighted five interacting roles of drugs and same-sex sexuality among NGI and bisexual African American MSM. Along with enhancing sexual encounters, men described alcohol use and illicit drug transactions, use, and abuse as *motivating* sex with other men, *allowing* and *rationalizing* same-sex activity, and *facilitating* access to male sex partners. Those in *recovery* for substance abuse indicated that an unwillingness to admit their same-sex activity or to come to terms with their homosexuality or bisexuality contributed to drug relapses. Gay-identifying MSM have also reported using stimulants in order to enhance sexual experience and performance and to ease access to sexual partners by lowering inhibitions and increasing confidence and sociability (Diaz, Heckert, & Sanchez, 2005; Halkitis, Fischgrund, & Parsons, 2005). Among NGI African American MSM/MSMW, drugs further facilitate access to partners through drug-sex related transactions and social contexts that may be more accepting of their homosexuality or bisexuality.

The *allowing* and *rationalizing* domains may be strategies for dealing with feelings of isolation related to dealing with both racism and bi/homophobia in their daily lives, insecurity about fulfilling African American masculine gender role expectations, a sense that homosexuality is inherently sinful or disordered, and fear of homophobic reactions from others. Participants described men in these circumstances as disengaged from cognitive processes, including thoughts about the longer-term health and potential implications of their actions. Hence, the use of drugs as *allowers* or *rationalizers* of same-sex activity may also be associated with risky sexual intercourse among these men. The *allower* and *rationalizer* roles are consistent with the Escape Model proposed by McKirnan, Ostrow, and Hope (1996) to explain high rates of continued unsafe sex and inconsistent data on associations between drug use and unsafe sex in gay-identifying MSM.

McKirnan et al. (1996) suggested that unsafe sex frequently occurs not because of a lack of knowledge or personal skills and standards to use condoms, but a disengagement from the mental processes leading to safer sex that is frequently aided by drug use. For example, their model suggests that MSM sometimes combine drugs and sex in order to escape awareness of HIV-related concerns and justify participation in risky sex. We propose that NGI African American men may also combine sex and drugs to escape temporarily full awareness of their same-sex desires, concern about others' disapproval, internalized homophobia, and day-to-day stressors associated with life as African American men. The escape model posits that men with high performance standards, negative affect, high cognitive restraint, and positive expectancies around the benefits of sex under the influence are more vulnerable to cognitive disengagement. Many NGI and bisexual African American MSM experience added stressors in the first three categories. Added performance standards include fulfilling the sexually charged role of the "strong Black male" (Kraft et al., 2000). Increased negative affect may result from feelings of social isolation and racial marginalization (Harawa et al., 2006; Kraft et al., 2000; Miller, Serner, & Wagner, 2005; Williams et al., 2004). Cognitive restraint may include intentions to avoid sex with other men completely or avoid any emotional involvement with male sex partners (Kraft et al., 2000; Miller et al., 2005).

Participation in survival sex has been raised by some as a reason for same-sex behavior and elevated HIV rates among Black men (Kalb & Murr, 2006; Lichtenstein, 2000; Mays et al., 1988). Survival sex may occur more frequently in the population because of high rates of incarceration (Sabol, Minton, & Harrison, 2007), unemployment (U.S. Department of Labor, 2006), and low socioeconomic status; however, many participants discussed sex in return for drugs rather than for basic survival needs. Although most of study participants who discussed selling sex to men reported having also had sex with men for other reasons, our findings support the idea that exchanging sex for drugs or the means to buy drugs leads some African American men to have sex with other men. Two prior research studies indicate varying rates of participation in exchange sex among Black MSM/MSMW (11–37%) but did not examine race-specific differences by gay identification (Peterson et al., 1992; Rietmeijer et al., 1998). Studies in other populations indicate histories of exchange sex by a significant minority of Black men. A study of 702 predominately Black opiate and cocaine users in Baltimore found that 25% of male participants had paid for sex and 4.7% had sold sex in the prior 90 days (Latkin, Hua, & Forman, 2003). Nine percent of street-recruited Black men from Harlem, ages 18–29, reporting selling sex, a practice which was associated with psychological distress, HIV infection, and crack cocaine dependence (El-Bassel et al., 2000). Interestingly, a three-city study involving 82 crack-smoking male sex workers (65% Black) found that three-quarters had initiated sex trading prior to first using crack (Jones et al., 1998), indicating that many men begin exchanging sex for other reasons or other types of drugs.

Drug treatment has many benefits, including the reduction of risky sexual behaviors (Shoptaw, Reback, Frosch, & Rawson, 1998). NGI African American MSM/MSMW may, however, struggle with recovery from substance abuse and dependence. Men who perceive drugs to be their sole *motivators* for MSM sex may experience psychological discomfort if they continue to be attracted to other men while sober or experience gender role conflict based on their past same-sex activities. Gender role conflict is defined as a psychological state in which socialized gender roles have negative consequences on the person or others. It occurs when rigid, sexist, or restrictive ideas about gender lead to personal restrictions and devaluation of oneself or others (Good et al., 1995). Men who strongly associate heterosexuality with the masculine gender

role may be especially likely to experience this conflict. Drugs may have also been the primary coping strategy by which they dealt with their same-sex attractions. Men who used drugs in a way that *allowed* or *rationalized* MSM sex may become socially isolated and experience frustration and depression if they do not develop other coping strategies for dealing with their sexual desires, gender role conflicts, and possible rejection from friends and family (Simonsen, Blazina, & Watkins, 2000). In addition, complete suppression of their same-sex desires may lead some men to have relationships with females that are artificial or deceitful and to experience psychological distress as their primary sexual desires are toward other men. Men who use drugs or drug transactions to *facilitate* access to male partners will need to identify other strategies and skills to fulfill their sexual desires and may feel isolated if they are not aware of or comfortable in non-drug using settings in which to meet other MSM.

Researchers specializing in the area suggest that mainstream drug treatment and self-help programs (e.g., 12-step meetings) may not adequately serve the needs of gay and bisexual men (Shoptaw et al., 1998). At least one drug treatment program tailored for gay-identifying men has shown greater success with these men than a standard untailored treatment approach (Shoptaw et al., 2005). Many NGI and bisexual African American MSM, however, may feel a lack of connection with gay/bisexual communities and reject gay labels and norms leading them to refuse, ignore, or not be aware of the few programs that exist for sexual minority men.

We caution the interpretations of these data. Although recent discussions of African American men on the *down low* have focused attention on the important concerns facing African American MSMW, they have also further stigmatized the group. For example, this attention has reinforced the idea that NGI MSM/MSMW are at highest risk for HIV and responsible for much of the HIV epidemic's spread (Boykin, 2005), whereas the available data point to higher HIV risk behaviors and HIV prevalence among gay-identified Black MSM (Millett et al., 2005). Closely related to these assumptions is the assumption, particularly common in the White population, that non-gay-identification is a maladaptive reaction to internalized homophobia and that "coming out" as a gay-identified man would be a healthier alternative. This may or may not be the case for many bisexual and NGI African American MSM. A better understanding of the socio-cultural and possibly developmental context of healthy sexual identity development among Black men is needed (Crawford, Allison, Zamboni, & Soto, 2002). Together with the affirming qualities found in many gay communities are aspects that, at their extremes, support hypersexual behaviors and illicit drug abuse (Mattison et al., 2001; Sandowick, 1998; Worth & Rawstorne, 2005). Ethnic minority MSM/MSMW may be more susceptible to unhealthy participation in these activities because of their lower socioeconomic status and because geographic gay enclaves tend to be predominately White. Minority MSM/MSMW often lack cultural capital and political power in these settings and may be subject to discrimination and racialized sexual objectification (Boykin, 2005; Kraft et al., 2000). For example, Latino MSM methamphetamine and cocaine users in San Francisco report using these stimulants to have more anal sex and to fit in with other gay men (Diaz et al., 2005). Black gay-identified community organizations, businesses, clubs, and social networks exist in many urban centers; however, they may be located outside of Black geographical areas, are small, and are focused around meeting sexual partners or engaging the effeminate aspects of gay culture (e.g., the ball community—balls are events in the Black lesbian, gay, bisexual, and transgender community to which people come as both spectators and participants to compete in a variety of dance and drag categories), thus making them less accessible to bisexual and NGI African American MSM. These men clearly have a difficult sociocultural terrain to negotiate. Continued research to examine and illuminate this terrain will ultimately help to improve provisions of HIV, mental health, and substance use services and increase access to care in these populations.

This study has limitations that are common to qualitative focus group research. These include a small sample size with the potential social desirability bias or "group think" that may be encouraged by the group interview. Another is the self-selected nature of the sample that over represented HIV-infected and lower socioeconomic status African American MSM/MSMW. Finally, because our original study objectives were not to fully explore substance use and same-sex sexuality in African American MSM/MSMW, the question regarding drug use was one small part of the semi-structured interview guide. Related issues raised by participants were not always fully explored. Nevertheless, in most groups, participants discussed drug use in answer to other questions and spent significant time candidly describing various sex and drug dynamics that occur within the NGI African American MSM/MSMW population.

We originally formulated the theoretical constructs in this article to describe types of drug-using bisexual and NGI African American MSM. We reframed them to discuss the ways in which these men use drugs in their sexual lives. Our data, based on focus group answers to a set of questions covering a range of different issues, do not permit us to determine if certain participants consistently use drugs to *rationalize*, *motivate*, *facilitate*, or *allow* sex with other men or if these roles are situation-specific and vary over time. They also do not allow a thorough understanding of the progression of same-sex desires, sexual activities with men and women, drug and alcohol use, and identity exploration in African American MSM/MSMW. Undoubtedly, these are interrelated and differ by individual; however, future qualitative research using one-on-one life-history interviews

will illuminate this progression and serve to enrich our understanding of the important dynamics raised here.

For individuals of all sexual orientations and backgrounds, drugs and alcohol often facilitate access to sexual partners and enhance or heighten the sexual act. For substance abusers of all sexual orientations and genders, sex can provide a means for obtaining drugs or the money to pay for them. For many NGI and bisexual African American MSM, however, drug use is also profoundly tied to conflicts regarding issues of sexual identity and negotiating the dissonance between sexual desires and societal expectations and norms. For some, drugs provide a means of negotiation that conveniently circumvents both disavowal of one's desires and internalization of this dissonance. Over time, they can extract an enormous cost in the form of addiction, disease, incarceration, social isolation, and loss of position and personal dignity.

Unfortunately, failure to resolve the sexual issues can create a barrier to accessing or benefiting from drug treatment services for recovery from alcohol and drug addiction. Our data call for awareness of these realities in agencies that serve African American men with substance disorders, greater sensitivity to issues of male homosexuality and bisexuality in Black communities, and integration of substance abuse and HIV prevention services. Such awareness calls for recognition, not only that some Black men have non-heterosexual desires and experiences, but that human sexuality is often not well-suited for static, one-dimensional categories such as "gay" and "straight." Given that many NGI African American MSM/MSMW will not attend settings geared for gay men and may present themselves as 'heterosexual,' it will often not be possible or appropriate to target them for specialized "gay" services. Treatment programs should, therefore, acknowledge and explicitly accept the diverse sexual experiences of their clients while providing non-judgmental forums that allow exploration of a range of sexual issues. Although none of these are specific to African Americans, they all have unique implications in African American communities because of the ways in which sexuality and sexual expression are linked to their history of race-based oppression. In the process, such forums may assist bisexual and NGI African American MSM with coming to terms with their personal sexual desires and histories and constructing for themselves an identity and set of behaviors that is consistent with a healthy and sober lifestyle and a fully realized and integrated self. The dialogues may also create greater acceptance within recovery communities and reduce social isolation of NGI MSM/MSMW.

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