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An Exploratory Internet Study of Black Men on the Down Low: Potential Factors Related to Non-Disclosure to Female Partners and Inconsistent Condom Use for Black Men who Have Sex with Men and Women (MSMW)

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This exploratory Internet study of Black men who have sex with men and women (MSMW) explored potential factors related to non-disclosure to female partners of their sexual activities with men, as well as factors related to inconsistent condom use. The majority of this sample (N=172) self-identified as heterosexual (62.8%) and employed full time (87.2%); 54% had no religious affiliation, while among those who did, 78% reported low acceptance of their sexuality at their place of worship. A full 81.4% who had anal sex with men always used condoms with men, as did 86.6% with female partners. A majority (84.9%, n = 146) had never told their female partners that they also had sex with men. The sample had very high response efficacy and condom use self-efficacy. The majority were high in self-concealment, reporting, for example (91.8%) that they have secrets they would lie about should anyone ask about them. The majority of the men had high autonomy (86.6%) and self acceptance (89%). Potentially increasing the risk of HIV transmission, BMSMW with high scores on a new religious affiliation scale (RAS) had low condom use self efficacy ($r = -25$, $p < .001$), low condom self-efficacy ($r = -.26$, $p < .001$), low self concept clarity ($r = -37$, $p < .001$), low autonomy ($r = -.30$, $p < 001$), low self-acceptance ($r = -.43$, $p < .001$), and a higher perceived susceptibility to HIV/AIDS ($r = .32$, $p < .001$). Future research needs to investigate the behavior of sub-groups of Black bisexually active men defined by level of religious affiliation, while those high in religious affiliation may need to be considered as being more vulnerable and at greater risk for HIV transmission; they may need tailored HIV prevention/intervention that accounts for this.

Keywords: Black MSMW, Bisexuality, HIV/AIDS, Condom Use, Non-disclosure, Religious Affiliation Scale

Among those men who have sex with men and women (MSMW), the activities of Black MSMW (BMSMW) have been a particular focus (Sandfort & Dodge, 2008; Dodge, Jeffries & Sandfort, 2008). Much interest has been generated in the risk of HIV transmission for BMSMW, correlates of risk factors (Wilton, 2008), and patterns of sexual risk and disclosure (Dodge et al, 2008). Controversy has been generated around BMSMW who do not disclose that they have sex with men to the women with whom they engage in heterosexual activity. Given this act of concealment, such bisexually active men have been described as being on the down low (King, 2004; Mays, Cochran & Zamudio, 2004; Millett, Malebranche, Mason & Spikes, 2005; Dodge et al, 2008).

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As a response to the stigmatization associated with homosexuality, and in the absence of acceptance of their sexual diversity, this group may remain hidden, conform to masculine social roles, and rely on private sex clubs and the Internet to find sexual male partners (Miller, Serner, & Wagner, 2005).

Many researchers (i.e. Boykin, 2005; Wheeler, 2006; Malebranche, 2004; Millett et al, 2005) have explored whether non-disclosure of sexual activity with men to female partners actually translates into risky sexual behavior. They have also suggested that the discourse on the down low may have resulted in an unwarranted focus on the lives of BMSMW, as while resulting in their stigmatization.

Ongoing research in this area is important, within the current era of the HIV/AIDS epidemic in the United States. HIV/AIDS statistics point to the fact that Blacks are disproportionately affected by HIV infection and transmission as compared to other racial groups. For example, statistics from the Centers for Disease Control and Prevention (CDC, 2007) indicated that Blacks accounted for more than 50% of new HIV diagnoses in the United States. It is important for research to further clarify the extent to which heterosexual women who unknowingly have sex with bisexually active men may be placed at high risk for HIV transmission.

Research was conducted by Montgomery, Mokotoff, Gentry, and Blair (2003) with a sample of 5,156 men and 3,139 women who were all HIV-positive, 34% of African American men who have sex with men (MSM), 26% of Hispanic MSM, and 13% of white MSM reported having had sex with women. Yet, most female partners of the men did not know that their partners also had sex with men; only 14% of White women, 6% of African American women, and 6% of Hispanic women in the study acknowledged having a bisexual partner.

While many studies have documented high risk sexual behavior on the part of BMSMW, others have reported that Black bisexually active men are aware of their personal sexual responsibilities and take measures to protect themselves and their partners. For example, some report that, in spite of not telling their female partners of their sexual affairs with other men, MSM self-reported less risky behaviors than men who were open about their sexuality (Millett et al., 2005).

Given the disagreement and controversy, it may be difficult to predict the extent to which BMSMW are placing their female partners at risk. In efforts to conduct more research to resolve the controversy, it is important to consider the views of those who object to any primary focus on individual-level factors in seeking to understand the lives of BMSMW, their behavior, and the factors responsible for high HIV prevalence rates in the Black community. It is held that racial and ethnic disparities in HIV infection and transmission rates cannot be understood without attention to the social determinants of risk.

Reflective of this view, there are those who argue for research that focuses on structural factors and potential structural interventions, rather than that which primarily focuses on individuals and individual-level factors (Beatty, Wheeler & Gaiter, 2004). Others argue for research that focuses more on social and interpersonal determinants of HIV risk, as well as links between interpersonal and structural determinants of risk (Mays, Cochran & Zamudio, 2004). Others argue the need for research exploring multiple levels and attending to multiple factors (Lane, Rubinstein, Keefe, Webster, Cibula, Rosenthal & Dowdell, 2004).

More specifically, Lane, et al (2004) suggest exploration of multiple factors, such as the following: structural violence (i.e. where unequal distribution of power and resources contributes to institutional racism, stigmatizing social norms, barriers to health care, etc…); and, ecological-level risk factors where a search for actors to blame is replaced by attention to macro-level entities (i.e. social environments, state and federal bureaucracies, etc..). Limited access to health insurance, limited sexually transmitted

disease (STD) clinic hours, and increased STDs may also account for increased transmission of HIV. Other pertinent factors include, as follows: the African American community's disproportionate rates of incarceration and disproportionate rates of death; the low male sex ratio relative to women; concurrent sexual partnerships (with male and female partners); residential segregation; commercial advertising and sales of douching products to African American women with possible resultant changes in vaginal ecology that may be associated with increased transmission of HIV; and, homophobic social norms (Lane, et al, 2004).

According to Ward (2005), homophobic social norms in the Black community are readily transmitted via the social context of the Black church. The result is a theologically-driven homophobia that has a damaging impact upon everything from physical health to interpersonal relationships to self-esteem; yet, even all this is seen as closely tied to a larger societal racism and historical patterns of demonizing black sexuality, suggesting the role of a larger social context. "Although church-projected homophobia" may drive some BMSMW away from church, others may elect to remain affiliated with the church and "endure the oppression" (Ward, 2005, p. 499).

Hence, there is also a rationale for exploring the potential impact of such structural/social contextual factors (e.g. impact of religious/church affiliation) and their relationship to individual-level variables (e.g. condom use patterns, condom use self-efficacy, disclosure patterns, concealment, etc…)—even if via individual-level self-report data. This is a viable starting point for such integrative exploratory research, incorporating attention to both individual- and social-contextual-level factors. There is also legitimacy in conducting this investigation via the Internet, given how it is used as a tool for searching for partners (Miller et al, 2005). In sum, this exploratory study seeks answers to a central question: For an Internet sample of BMSMW, what factors are associated with being on the down-low (i.e. non-disclosure to female partners) and an increased risk of HIV transmission (i.e. inconsistent condom use)?

Methods

Description of the Study Subjects

Participants in the study met the inclusion criteria of being 18 years of age or older, while self-identifying as a man who is Black, African American, or of African descent. They also reported having had sex with at least one man and one woman in the past 1 year.

Study Procedures

Participants were recruited from predominantly Black Men who have Sex with Men (BMSM) websites, as follows: www.brutha4brutha.com; www.craigslist.org www.adam4adam.com; www.men4now.com).

Flyers were also distributed via Community Based Organizations, including: Gay Men of African Descent (GMAD—www.gmad.org), Men of All Color Together /NY (MACTNY—www.mactny.org), Harlem United—www.harlemunited.org, and the African American Office of Gay Concerns (AAOGC—www.aaogc.org).

Flyers were also distributed at conferences.

All study participants were volunteers who accessed the Internet survey, provided informed consent online, and completed the study survey online.

Research Instruments

The research instrument was composed of several questionnaires or subscales. The final survey combining several scales took 30 to 45 minutes to complete online.

Demographic Information Questionnaire. First, a background and demographic in-formation questionnaire with 18 questions was created for the survey. Participants were asked questions about marital status, race/ethnicity, sexual orientation, education,

employment, religion and church involvement. Also, they were asked about having had sex with another man, or woman in the past 1 year, and if condoms were used consistently, some of the time, or never at all. A question asked if their sexual partner was told about their having had sex with another partner (i.e. men were told about another female partner and/or women were told about another male partner).

Religious Affiliation Scale (RAS). A new Religious Affiliation Scale (RAS) was created, taking 4 items from the demographics section of the survey. The questions for this scale asked participants to rate statements. They had to choose from among options provided for the following statements: (Level of Religious Affiliation) "My involvement with my religious group," rating this from a level that was high to none (on a 4-point Likert scale); (Church as Resource) "The church is a resource for spiritual guidance to me," rating this from strongly agree to strongly disagree (on a 5-point Likert scale); (Church for Sex) "The church provides me with a social opportunity for consensual sex with other men," rating this from strongly agree to strongly disagree; (Church Acceptance) "At my place of worship I perceive acceptance of my lifestyle/sexual activity to be," anywhere from high to none, as their rating. Regarding scoring, the Religious Affiliation Scale score was calculated as the mean of the 4 items with a higher score indicating a more positive experience with regard to religious affiliation. Internal consistency was investigated via this study (N = 172), having good internal consistency ($\alpha = .87$)

Condom Use Self-Efficacy Scale (CUSES) –12 Selected Items. The Condom Use Self-Efficacy Scale (CUSES) was used to assess an individual's perception of their ability to use condoms. The original scale contains 28 items (Brafford and Beck, 1991) with good internal consistency of (Cronbach's Alpha = .91. Test-retest reliability (2-week interval) was reported as also good (Pearson r = .81). Only 12 items were selected for this study (#s 2, 3, 4, 5, 6, 13, 22, 23, 24, 25, 26, and 28), given the use of a BMSMW sample and issues of appropriateness. Participants respond to items on a 5-point Likert scale, with responses ranging from strongly agree to strongly disagree. The modified scale in this study (N=172) showed good internal consistency ($\alpha = .89$).

Risk Behavior Diagnoses (RBD). The Risk Behavior Diagnoses survey (RBD) has been used at the HIV Counseling and Testing Program at the campus health center of Michigan State University since 1995 (Witte, Meyer & Martell, 2001). It is a 12-item scale that assesses client's perceptions of response efficacy, self-efficacy, severity, and susceptibility on a 5-point Likert scale, ranging from strongly disagree (1) to strongly agree (5). Items 13 to 15 measure Response Efficacy; items 16 to 18 measure Self Efficacy; items 19 to 21 measure Severity; and items 22 to 24 measure Susceptibility to HIV/AIDS. In this study, the four sub-scales showed adequate to good internal consistency (1) Response Efficacy, $\alpha = .91$; 2) Condom Self-Efficacy, $\alpha = .77$; 3) Severity, $\alpha = .90$; 4) Susceptibility, $\alpha = .92$).

Self-Concealment Scale (SCS). The Self-Concealment Scale (SCS) is a 10-item self-report measure designed to assess one's concealment of distressing information (Larson & Chastain, 1990). Scale items refer to (a) a self-reported tendency to keep things to one's self (e.g., "There are lots of things about me that I keep to myself"); (b) possession of a personally distressing secret or negative thoughts about one's self that have been shared with a few or no other persons (e.g., "I have negative thoughts about myself that I never share with anyone"); apprehension about the disclosure of concealed personal information (e.g., "If I shared all my secrets with my friends, they'd like me less") and keeping of specific secrets (e.g., "I have an important secret that I haven't shared with anyone").

Participants rate each item on a 5-five point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). Scores range from 10 to 50, with higher scores reflecting greater self-concealment. In one study (N = 306), internal consistency with Cronbach's Alpha was reported as .83,

while test-retest reliability (4 week interval) was .81 (Larson & Chastain, 1990).

Distress Disclosure Index (DDI). The Distress Disclosure Index (DDI) is a 12-item self-report measure designed to assess one's tendency to conceal versus disclose distress over time (Kahn & Hessling, 2001). The content domain of distress disclosure items includes, for example, both items covering whether the disclosure was proactive (i.e., I usually seek out someone to talk to when I am in a bad mood), as well as the audience to whom the distress was disclosed (i.e., when I am upset, I usually confide in my friends). Participants rate each item on a 5-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). Scores range from 12 to 60 with higher scores reflecting greater distress disclosure. Items 36, 38, 39, 41, and 42 are reverse scored. Internal consistency for the DDI using Cronbach's Alpha was reported to be .93 and .94 with two samples, respectively; and, test-retest reliability (Pearson r at 2-month interval) has been reported to be .80, suggesting a strong stability in self-reports of distress disclosure across a 2-month period (Kahn & Hessling, 2001).

Self-Concept Clarity (SCC). The Self-Concept Clarity (SCC) scale (Campbell et al., 1996) is a 12-item self-report measure designed to measure the extent to which self-beliefs are clearly and confidently defined, internally consistent, and stable. Participants responded to all items on five point Likert scales anchored by strongly disagree (1) and strongly agree (5). Scores range from 12 to 60, with higher scores reflecting greater self-concept clarity. Those with relatively higher levels of uncertainty, instability, and inconsistency have low self-concept clarity. Scale items tap personal internal consistency and temporal stability of self-beliefs (i.e., "I seldom experience conflict between the different aspects of my personality"); Items 48, 51, 54, and 55 assess the temporal stability of self-beliefs along with more generic self-certainty items (i.e., "In general, I have a clear sense of who I am and what I am"). Internal consistency for the SCC scale was .86 (Cronbach's Alpha). For test-retest reliability at 4-month and 5-month intervals, correlations of .79 and .70 were reported, respectively, suggesting high levels of temporal stability (Campbell et al., 1996). The Self-Concept Clarity (SCC) scale findings with this sample (N=172) indicated good internal consistency (Cronbach's Alpha = .84). Two items were negatively correlated so they were excluded from the scale, leaving a total of 10 items.

Psychological Well-Being Measure (PWB)—Autonomy (AUT) and Self-Acceptance (SA) Sub-Scales. Ryff's (1989) Psychological Well-Being Measure elicits responses 5-point Likert scales (1=strongly disagree to 5= strongly agree), while two sub-scales were deemed of greatest utility in the present study: autonomy and self-acceptance. The autonomy (AUT) sub-scale measures qualities such as self-determination, independence, and regulation of behavior; with regard to internal consistency, a Cronbach's Alpha of .51 was reported. The self-acceptance (SA) subscales measures the extent to which one holds a positive attitude toward one's self; for internal consistency, a Cronbach's Alpha of .75 was reported. In this study (N=172), adequate internal consistency was found for each subscale (Autonomy, $\alpha = .70$; Self-Acceptance, $\alpha = .70$).

Data Analyses

Descriptive statistics, including mean and standard deviation, were used to describe the sample and results on the various measures. Relationships among variables were explored through inferential, utilizing t-tests and Pearson's Product Moment (r) correlation. Given the multiple comparisons, significance was set at $p < .001$ (Bonferroni adjustment). Consistent with this being an exploratory research study, there was no hypothesis testing with this sample of convenience. Moreover, the small sample size and lack of sufficient numbers in sub-categories (as we shall see in results) prohibited effective modeling of the dependence of the study's binary response variables on potential explanatory variables,

compromising the performance of logistic regression analyses. Thus, the results for the t-test comparisons and correlations follow.

Results

Demographics

The sample of convenience included Black males (N=172) who responded to the Internet survey, having met criteria as BMSMW. The majority identified as African American (66.3%). Sixty-two percent of participants (n = 108) self identified as heterosexual, 20.3% (n =35) as bisexual, and 16.3% (n = 28) as homosexual/gay. A majority of respondents (n=94, 55.2%) had no religious affiliation, were single (n = 93, 54.1%), and employed full time (n=150, 87.2%). Regarding income, 48.3% (n =83) had income between $30,000 and $49,999. For education, while 35.5% had 4-year bachelors degrees, 22.7% (n = 39) had a high school education or less. See Table 1 for a description of the study sample's other demographics of note.

Results for the Study Scales

Using the study sample of BMSMW (n=172), findings indicated that the scales/sub-scales utilized in the investigation showed adequate to good internal consistency, using Cronbach's Alpha. Table 2 displays these values, along with the mean scores (and SD) attained for on each scale/sub-scale.

Patterns of Condom Use and Disclosure

Given the study focus, of particular interest were the men's patterns of condom use and disclosure of their sexual activities.

Condom Use. The majority of men in the sample (81.4%, n = 140) who had anal sex with men always used condoms with men. Similarly, a majority of the men (86.6%, n = 149) always used condoms with women during vaginal sex. See Table 3.

Disclosure. Less than half (48.8%, n= 84) reported that they always disclosed to their male partners that they also had sexual relations with women, while 28.5% (n = 49) and 22.7% (n = 39) responded that they sometimes or never told their male partners about their also having sex with women, respectively. In contrast to the pattern of disclosure with men, when it came to disclosure to women, a majority (84.9%, n = 146) had never told their female partners that they also had sex with men. See Table 4.

Findings for when Men are Having Sex with Men: Consistent Versus Inconsistent Condom Use

Inconsistent users of condoms with men (sometimes/never used condoms) were not different from consistent users of condoms with men (always used condoms) on variables such as education or income. See Table 5.

Findings with the Religious Affiliation Scale (RAS). Inconsistent users of condoms with men (sometimes/never used condoms) when compared to men who consistently (always) used condoms scored significantly higher on three of the four RAS items, as follows: Level of Religious Affiliation (inconsistent M = 2.50, SD = 1.07 versus consistent M=1.73, SD = 1.02, $t = 3.61$, $df = 166$, $p < .000$); Church as Resource (inconsistent M = 3.75, SD = 1.62 versus consistent M = 2.60, SD = 1.60, $t = 3.48$, $df = 166$, $p < .001$); and, Church Acceptance (inconsistent M = 2.11, SD = .88 versus consistent M = 1.44, SD = .63, $t = 4.77$, $df = 166$, $p < .001$). See Table 5.

Findings for When Men are Having Sex with Women: Consistent versus Inconsistent Condom Use

Inconsistent users of condoms with women (sometimes/never used) were not different from consistent users of condoms with women (always used condoms) on variables such as education or income.

Table 1: Characteristics of Black Males who Have Sex with Men and Women (BMSMW) (N=172)

Characteristic	n=	(%)
Ethnicity		
African American	114	66.3%
Other African country	18	10.5%
Ghanaian	16	9.3%
Caribbean	21	12.2%
Other	5	3.0%
Education		
High School or less	39	22.7%
Associates (or Some College)	29	16.9%
Bachelors (4-yr degree)	61	35.5%
Masters (or some graduate school)	35	20.3%
PhD (Doctoral degree)	8	4.7%
Income		
$10,000 – $29,999	14	8.1%
$30,000 - $49,999	83	48.3%
$50,000 - $99,999	48	27.9%
$100,000 or more	2	1.2%
Missing	25	14.5%
Sexual Self-identification		
Heterosexual	108	62.8%
Bisexual	35	20.3%
Homosexual/gay	28	16.3%
Other	1	0.6%
Employment Status		
Full Time	150	87.2%
Unemployed	12	7%
Part Time	10	5.8%
Religious Affiliation		
None	95	55.2%
Protestant	35	20.3%
Catholic	12	7%
African Methodist	10	5.8%
Baptist	7	4.1%
Other	10	5.8
Involvement in Religion		
None	93	54.1%
Moderate	39	22.7%
Low	22	12.8%
High	18	10.5%
Marital Status		
Single	93	54.1%
Divorced	28	16.3%
Married	14	8.1%
Living with significant other	16	9.3%
Separated	13	7.6%
Widowed	8	4.7%

Table 2. Internet Survey Scale Means, Standard Deviations, and Cronbach's Alpha (N =172)

Study Scales/Sub Scales ````	M	SD	Cronbach's Alpha
I. Religious Affiliation Scale (RAS)	8.30	4.00	.87
II. Condom Use Self-Efficacy Scale (CUSES)	55.45	5.19	.89
III. Risk Behavior Diagnostic (RBD) Scales			
1) Response Efficacy (RE)	14.72	1.27	.91
2) Condom Self-Efficacy (CSE)	14.34	1.65	.77
3) Severity (SEV)	14.79	1.17	.90
4) Susceptibility (SUS)	14.26	2.88	.92
IV. Self-Concealment Scale (SCS)	37.71	6.36	.74
V. Distress Disclosure Index (DDI)	38.46	10.99	.94
VI. Self Concept Clarity* (SCC)	46.05	6.69	.92
VII. Psychological Well-Being (PWB)			
1) Autonomy (AUT)	16.81	2.07	.70
2) Self Acceptance (SA)	16.76	1.93	.70

*Two items (# 52 and 56 were excluded from the scale because they were negatively correlated).

Table 3. Patterns of Condom Use with Male and Female Partners (N= 172)

	Condom Use with Men		Condom Use with Woman	
Response	n	%	n	%
Never	1	0.6%	2	1.2%
Sometimes	27	15.7%	17	9.9%
Always	140	81.4%	149	86.6%
Missing	4	2.3%	4	2.3%

Table 4. Patterns of Disclosure to Male and Female Partners (N = 172)

	Disclosure to Male Partners About Sex with Women		Disclosure to Female Partners About Sex with Men	
Response	n	%	n	%
Never	39	22.7%	146	84.9%
Sometimes	49	28.5%	23	13.4%
Always	84	48.8%	3	1.7%

Table 5. Differences on Select Demographic Variables for Men Having Sex with Men: Consistent Versus Inconsistent Condom Use (N=172)

	Consistent: Always Use Condoms		Inconsistent: Sometimes/Never Use Condoms				
Selected Demographics	M	SD	M	SD	t	df	p. (2-tail)
Education	2.74	1.16	2.32	1.12	-1.73	166	.085
Income	4.31	.59	4.05	.85	-1.65	141	.102
Religious Affiliation Scale (RAS)							
Level of Affiliation	1.73	1.02	2.50	1.07	3.61	166	.000*
Church as Resource	2.60	1.60	3.75	1.62	3.48	166	.001*
Church for Sex	1.85	.91	2.64	1.31	3.05	166	.004
Church Acceptance	1.44	.63	2.11	.88	4.77	166	.000*

*p< .001

Finding:Religious Affiliation Scale (RAS). Inconsistent users of condoms with women scored when compared to men who consistently used condoms with women scored significantly higher on two of the four individual items of the RAS, as follows: Level of Religious Affiliation (inconsistent M = 2.79, SD = .98 versus consistent M=1.75, SD = 1.04, t = 4.13, df = 166, p < .001); and, for Church as Resource (inconsistent M = 3.95, SD = 1.55 versus consistent M = 2.64, SD = 1.61, t = 3.34, df = 166, p < .001). See Table 6.

Findings for Condom Use Self-Efficacy Scale (CUSES)

With the modified version of the Condom Use Self-Efficacy Scale (CUSES), using just 12 items from the original scale, participants reported very high condom use self efficacy.

For example, 100% (n = 172) of participants reported that they agree/strongly agree that they could purchase condoms without feeling embarrassed, 97% (n = 168) were confident they could remember to carry a condom with them should they need one, 100% (n =172) of participants were confident they could discuss condom use with any partner, and 93.4% (n = 161) were confident they could use a condom during intercourse without reducing sexual sensations.

Group Differences for Condom Use Self-Efficacy. Men who consistently used condoms with men (M = 4.71, SD = .33) were significantly higher (t -6.78 = df = 166, p< .001) on condom use self-efficacy than men (M = 4.20, SD = 49) who did not always use condoms with men; see Table **7**.

Similarly, men (M = 4.68, SD = .38) who consistently used condoms with women were significantly higher (t = -5.57, df 166 = p< .001) on condom use self efficacy than men (M = 4.14, SD .54) who did not consistently use condoms with women; see Table 8.

Findings with the Risk Behavior Diagnoses (RBD): *Sub-Scale Findings*

*RBD-Response Efficacy***.** Response efficacy was very high. For all three questions, assessing perceptions of condom's effectiveness in preventing HIV/AIDS, condom's efficacy to prevent AIDS and the likelihood of not getting AIDS if one used condoms, responses for strongly agree or agree approached about 98% (98.2%, 98.3%, and 97.7%, respectively).

RBD- Severity. Perceptions of the severity of AIDS were high. Of the 168 participants, 97% (n = 167) reported that they perceived AIDS to be severe, 98.8% (n = 170) believed that AIDS is a significant disease, and 98.9% (170) reported that AIDS is a serious disease.

RBD-Susceptibility. Participants had a very low perception of susceptibility to contracting HIV/AIDS; 88.4% of participants had low perception of contracting HIV/AIDS, 89% believed they were not at risk for HIV/AIDS, and 91.9% had low perception of contracting AIDS.

Group Differences for RBD-Susceptibility: Condom Use. There was a significant difference (t=3.53, df = 166, p < .001) where men who inconsistently used condoms with men (M=2.18, SD =1.37) were higher on perceived susceptibility to HIV/AIDS when compared to men who consistently used condoms with men (M=1.24, SD= .72); see Table 7. Similarly, as compared to men (M = 1.22, SD = .71) who consistently used condoms with women, men (M = 2.84, SD 1.28) who inconsistently used condoms with women reported significantly more susceptibility to HIV/AIDS (t = 5.39, df = 166, p< .001); see Table 8.

RPD-Condom Self-Efficacy. Participants reported high condom self efficacy. Almost 90% (n = 154) reported that they agreed or strongly agreed that using condoms to prevent AIDS is convenient; 95.3% (n = 164) believed that using condoms to prevent AIDS is easy, and 97.6% (n = 168) reported

Table 6. Differences on Select Demographic Variables for Men Having Sex with Women: Consistent Versus Inconsistent Condom Use (N=172)

	Consistent: Always Use Condoms		Inconsistent: Sometimes/Never Use Condoms				
Selected Demographics	M	SD	M	SD	t	df	p. (2-tail)
Education	2.69	1.13	2.63	1.38	-.16	166	.871
Income	4.29	.59	3.94	.87	-2.19	142	.030
Level of Religious Affiliation	1.75	1.04	2.79	.98	4.13	166	.000*
Church as Resource	2.64	1.61	3.95	1.55	3.34	166	.001*
Church for Sex	1.92	.95	2.53	1.54	1.68	166	.109
Church Acceptance	1.46	.59	2.37	1.06	3.63	166	.002

*p< .001

Table 7. Differences on Religious Affiliation and Other Individual-Level Variables for Men's Condom Use with Male Partners: Consistent versus Inconsistent Condom Use (N=172)

	Consistent: Always Use Condoms		Inconsistent: Sometimes/Never Use Condoms				
Religious Affiliation and Other Individual-Level Variables	M	SD	M	SD	t (166)	df	p. (2-tail)
Religious Affiliation Scale	1.90	.92	2.75	1.03	4.34	166	.000*
Condom Use Self Efficacy	4.71	.33	4.20	.49	-6.78	166	.000*
Risk Behavior Diagnoses Survey							
Response Efficacy	4.98	.19	4.80	.52	-1.76	166	.089
Condom Self-efficacy	4.86	.36	4.63	.70	-1.65	166	.109
Severity	4.98	.21	4.83	.37	-1.99	166	.056
Susceptibility	1.24	.72	2.18	1.37	3.53	166	.001*
Self-Concealment	3.78	.54	3.97	.71	1.32	166	.196
Distress Disclosure Index	3.21	.89	3.19	1.06	-.14	166	.885
Self-concept Clarity	4.71	.52	4.09	1.03	-3.05	166	.005
Psychological Well-Being							
Autonomy	5.71	.57	5.17	.94	-2.93	166	.006
Self-acceptance	5.70	.52	5.01	.88	-4.01	166	.000*

*p< .001

Table 8. Differences on Religious Affiliation and Other Individual-Level Variables for Men's Condom Use with Female Partners: Consistent versus Inconsistent Condom Use (N=172)

	Consistent: Always Use Condoms		Inconsistent: Sometimes/Never Use Condoms				
Religious Affiliation and Other Individual-Level Variables	M	SD	M	SD	t (166)	df	p. (2-tail)
Religious Affiliation Scale	1.94	.93	2.90	1.06	4.17	166	.000*
Condom Use Self Efficacy	4.68	.38	4.14	.54	-5.57	166	.000*
Risk Behavior Diagnoses Survey							
Response Efficacy	4.95	.37	4.61	.66	-2.17	166	.043
Condom Self-efficacy	4.85	.46	4.39	.86	-2.28	166	.034
Severity	4.96	.35	4.67	.62	-1.89	166	.074
Susceptibility	1.22	.71	2.84	1.28	5.39	166	.000*
Self-Concealment	3.78	.57	3.93	.84	.75	166	.462
Distress Disclosure Index	3.20	.89	3.06	1.15	-.64	166	.523
Self-Concept Clarity	4.73	.49	3.78	1.05	-3.91	166	.001*
Psychological Well-Being							
Autonomy	5.72	.58	4.74	.93	-4.50	166	.000*
Self-acceptance	5.70	.53	4.74	.72	-5.69	166	.000*

*p< .001

that they are able to use condoms to prevent AIDS. There were no significant findings for group comparisons for condom self-efficacy.

Findings for the Self-Concealment Scale (SCS)

Most (74.4%, n = 128) participants agreed/strongly agreed that they had important secrets about themselves that had not been shared with anyone. The majority (83%, n = 143) agreed/strongly agreed that if they shared all their secrets, they will be less liked by friends. About 90% (n = 154) of participants agreed or strongly agreed that it is their nature to keep lots of things to themselves. Slightly over 70% (n = 122) of participants have the tendency to keep to themselves bad things that happen to them. Moreover, 91.8% (n = 158) of participants reported that they have secrets they would lie about should anyone ask about them. Ninety-five (55.2%) participants agreed that they refuse to share their secrets because they are embarrassing. One hundred and sixty-two (94.2%) participants agreed or strongly agreed that a reason for not telling their secrets is that telling a secret backfires. A majority of participants (78.5%, n = 135) disagreed or strongly disagreed that their secrets had tormented them.

Findings with the Distress Disclosure Index (DDI)

The pattern of disclosure was mixed for the sample, given they responded as follows on sample items: "I prefer not to talk about my problems" (52.9%, n = 94 disagree/strongly disagree versus 32.6%, n = 56 agree/strongly agree); "I rarely look for people to talk with when I am having a problem" (51.1%, n = 88 agree/strongly agree versus 36.1%, n = 41 disagree/strongly disagree); "I typically don't discuss things that upset me" (47.7%, n = 84 agree/strongly agree versus 22.5%, n = 56 disagree/strongly disagree); "When I am distressed I don't tell anyone" (51.8%, n = 99 disagree/strongly disagree versus 16.9%, n = 29 agree/strongly agree); "If I have a bad day, the last thing I want to do is to talk about it" (51.7%, 89 disagree/strongly disagree versus 24%, n = 41 agree/strongly agree); "When I feel upset I usually confide in my friends" (54.7%, n = 94 agree/strongly agree versus 15.1%, n = 26 disagree/strongly disagree.

There was no significant differences between those who consistently used condoms and those who did not on distress disclosure.

Findings for Self-Concept Clarity (SCC)

Fifty-eight percent (n = 100) reported disagree/strongly disagree to the question "My beliefs about myself often conflict with one another" as against 15.2% (n = 26) who reported agree/strongly disagree. Other responses include the following: "On one day I might have one opinion of myself and on another day I might have a different opinion" (91.2%, n = 157 disagree/strongly disagree versus 4%, n = 7 agree/strongly agree); "I spend a lot of time wondering about what kind of person I really I am" (92.4%, n = 159 disagree/strongly disagree versus 5.8%, n = 10 agree/strongly agree); "Sometimes I feel that I am not really the person that I appear to be" (90.7%, 156 disagree/strongly disagree versus 6.4%, n = 11 agree/strongly agree); "When I think of the kind of person I have been in the past, I am not sure what I was really like" (92%, n = 159 disagree/strongly disagree versus 5.2%, n = 9 agree/strongly agree); Sometimes I know other people better than I know myself" (91.8%, n = 158 disagree/strongly disagree versus 6.4%, 11 agree/strongly agree); "My beliefs about myself seem to change very frequently" (91.8%, n = 158 disagree/strongly disagree versus 4.1%, n = 7 agree/strongly agree); "If I were asked to describe my personality, my description might end up being different from one day to another day" (91.9%, n = 158 disagree / strongly disagree versus 5.3%, n = 9 agree/strongly agree); "In general, I have a clear sense of who I am and what I am" (93.1%, n = 160 agree/strongly agree versus 3.5%, n = 6 disagree/strongly disagree); "It is often hard for me to make up my mind about

things because I don't really know what I want" (89.5%, 154 disagree/strongly disagree versus 4.7%, n = 8 agree/strongly agree).

Group Differences for SCC: Men who consistently used condoms with women (M = 4.73, SD = .49) were significantly higher (t = -3.91, df = 166, p< .001) on self concept clarity as compared to men (M = 3.78, SD =1.05) who used condoms inconsistently; see Table 8.

Findings for Psychological Well-Being (PWB): Autonomy (AUT) and Self-Acceptance (SA) Sub-Scales

Autonomy Sub-Scale. Responses indicated that most participants (86.6%, n = 149) reported that they are not influenced by other people with strong opinions. Ninety-three percent (n = 160) of participants indicated that they have confidence in their own opinions, even if they are contrary to general consensus. Similarly, 92.5% (n = 159) of participants said that they judge themselves by what is important, not by the values of what others think is important.

Group Differences for Autonomy. Men who consistently used condoms with women (M = 5.72, SD = .58) were significantly higher (t = -4.50,df = 166, p< .001) on autonomy than men who did not consistently or never used condoms with women (M = 4.74, SD = .93); see Table 8.

Self-Acceptance Sub-Scale. Findings indicates that the vast majority of men enjoyed high self-acceptance. Eighty-nine percent (n = 153) of participants reported that when they look at the story of their lives, they are pleased with how things have turned out. Ninety-two percent (n = 158) said that they like most aspects of their personality, and 92.4% (n = 149) of participants reported that they feel satisfied with their achievements in life.

Group Differences for Self-Acceptance. Men who consistently used condoms with other men (M = 5.70, SD =.52) were significantly higher (t -4.01, df = 166, p< .001) on self acceptance when compared to men who were inconsistent or never used condoms with men (M = 5.01, SD = .88); see Table 7. Similarly, men who consistently used condoms with women (M = 5.70, SD =.53) were significantly higher (t = -5.69, df = 166, p< .001) on self acceptance when compared to men who did not consistently used condoms with women (M = 4.73 SD = .71); see Table 8.

Correlations

Pearson product-moment correlations identified relationships among study variables. The correlation matrix appears in Table 9.

Correlations with the Religious Affiliation Scale (RAS). The higher men's scores on the RAS then the lower their condom use self efficacy (r = -25, p< .001), the lower their condom self efficacy (r = -26, p<.001), the lower their self concept clarity (r = -37, p< .001), the lower their autonomy (r = -.30, p< 001), the lower their self-acceptance (r = -.43, p< .001), and the higher their perceived susceptibility to AIDS (r = .32, p< .001).

Correlations with the Condom Use Self-Efficacy Scale (CUSES) –12 Selected Items. The higher men's scores on the version of the CUSES used in this study, then the higher their scores, not surprisingly, on the Risk Behavior Diagnoses Scale's (RBD) Condom Self-Efficacy (CSE) sub-scale (r = .40, p< .001); and, the higher their scores for self acceptance (r = .48, p < .001), the higher their scores for autonomy (r = .44, p< .001), the higher their scores for self concept clarity (r = .34, p< .001), and the higher their scores for perceived severity of HIV/AIDS (r = .16, p< 001). On the other hand, those with a higher score on the CUSES scored lower for perceived susceptibility to HIV/AIDS (r = -.28, p< .001).

Correlations with the Risk Behavior Diagnoses Scale (RBD) Sub-Scales. Men with higher scores on the response efficacy (RE—perceived effectiveness of condoms) sub-scale had higher scores for condom self-efficacy (r = .59, p< .001), higher scores for

Table 9. Correlation Matrix for Relationships Among Religious Affiliation and Other Individual-Level Variables (n=172)

Measures**	RAS	CUSE	RE	CSE	SEV	SUS	SCS	DDI	SCC	AUT	SA
1. RAS	--										
2. CUSE	-.25*	--									
3. RE	-.19	.10	--								
4. CSE	-.26*	.40*	.59*	--							
5. SEV	-.14	.16	.82*	.65*	--						
6. SUS	.32*	-.28*	-.40*	-.38*	-.40*	--					
7. SCS	.06	.05	.37*	.24	.19	.05	--				
8. DDI	.06	.13	.08	.07	.08	-.08	-.09	--			
9. SCC	-.37*	.34*	.37*	.40*	.36*	-.50*	-.22	.14	--		
10.AUT	-.30*	.44*	.37*	.36*	.32*	-.24	.04	.08	.61*	--	
11.SA	-.43*	.48*	.26*	.32*	.24	-.37*	-.10	.07	.65*	.80*	--

*p < .001 2-tailed significance

**Measures:

1. RAS = Religious Affiliation Scale
2. CUSE = Condom Use Self Efficacy Scale
3. RE = Response Efficacy of Condoms (of the Risk Behavior Diagnosis, RBD)
4. CSE = Condom Self Efficacy of the RBD
5. SEV = Severity of the RBD
6. SUS = Susceptibility of the RBD
7. SCS = Self Concealment
8. DDI = Distress Disclosure Index
9. SCC = Self Concept Clarity
10. AUT = Autonomy (of the Psychological Well- Being Scale, PWB)
11. SA = Self Acceptance of the PWB)

perceived severity of HIV/AIDS($r = .82$, $p < .001$), higher scores for self concealment ($r = .37$, $p < .001$), higher scores for self-concept clarity ($r = .37$, $p < .001$), and higher scores for self acceptance ($r = .26$, $p < .001$). Yet, those with higher scores for response efficacy had lower scores for perceived susceptibility to HIV/AIDS ($r = -.40$, $p < .001$).

Participants with higher scores on the condom self efficacy (CSE) sub-scale reported higher scores for perception of the severity of AIDS ($r = .65$, $p < .001$), higher self concept clarity ($r = .40$, $p < .001$), higher autonomy ($r = .36$, $p < .001$), higher self acceptance ($r = .32$, $p < 001$). Also, those with higher scores for CSE had lower scores for the perception of susceptibility to HIV/ AIDS ($r = -.38$, $p < .001$).

Men with higher scores on the severity (SEV-perception of the severity of HIV/AIDS) sub-scale had lower scores for the perception of susceptibility to HIV/AIDS ($r = .40$, $p < .001$). On the other hand, higher scores for SEV were associated with higher scores for self concept clarity ($r = .36$, $p < .001$), higher scores for autonomy ($r = .32$, $p < .001$).

Finally, those with higher scores on the susceptibility (SUS, perceived susceptibility to HIV/AIDS) sub-scale had lower scores for self concept clarity ($r = .50$, $p < .001$), and lower scores for self-acceptance ($r = .37$, $p < .001$).

Correlations – Self-Concept Clarity. Men with higher scores for self concept clarity had higher scores for autonomy ($r = .61$, $p < .001$), and higher scores for self acceptance ($r = .65$, $p < .001$).

Correlations with the Psychological Well-Being Autonomy - Sub-Scale. Those with higher scores for autonomy (AUT) had higher scores for self acceptance ($r = .80$, $p < .001$). See the correlation matrix in Table 9.

Discussion

Condom Use and Disclosure

This exploratory study succeeded in recruiting a convenience sample (N=172) of men who have sex with men and women (BMSMW) who voluntary completed an online survey. Data analysis showed that the majority of BMSMW in the study (81.4%; n = 140) always used condoms with men, as well as with women (86.6%, n = 149). The suggestive data paint a picture of BMSMW as being mostly responsible and diligent in reducing the risk of HIV transmission through consistent condom use. On the other hand, the majority of men in this study (84.9%, n = 146) had never told their female partners that they also had sex with other men.

This study's results are reminiscent of the Chicago-based study where researchers found that Black men who had sex with men but identified as heterosexual, and did not disclose their sexual activities with men, reported fewer sexual risks than BMSM who disclosed (Crawford et al., 2002). This study's findings are also reminiscent of those in a study of 5,589 young MSM, where BMSM were less likely than white MSM to disclose their sexual behavior to others; those BMSM who did not disclose were more likely to have un-protected vaginal or anal intercourse with women, but less likely to have unprotected anal intercourse with male partners or to be HIV positive (Millett, 2005). This study's findings on high rates of consistent condom use with men and women serves to support the position that non-disclosure of one's status as a BMSMW with female partners does not necessarily translate into risky sexual behavior (Boykin, 2005; Wheeler, 2006; Malebranche, 2004; Millett et al, 2005).

Yet, concerns about HIV trans-mission remain legitimate, given study findings of inconsistent/no condom use being reported by men with male (n=27, 15.7%) and female (n=17, 9.9%) sexual partners. Also, inconsistent condom users (when compared to consistent condom users) reported higher perceived susceptibility to HIV/AIDS—whether for sex with men or women, adding cause for concern.

Aside from causes for concerns, there was much that was reassuring that emerged from the study. In addition to high rates of condom use, the majority of the men in the sample also had high levels of condom use self-efficacy (CUSES). The vast majority of men in the sample also perceived condoms as effective in preventing HIV/AIDS transmission, and perceived AIDS as a severe, significant disease. Perhaps because of the high rates of condom use, a majority of men had a lower perception of susceptibility for contracting HIV/AIDS, while not believing they were at risk for HIV/AIDS. Also, there was no evidence of barriers to condom use operating for most of the sample. The overwhelming majority of men saw using condoms to prevent HIV/AIDS as convenient, using condoms to prevent HIV/AIDS as easy, and reported that they were able to use condoms. The sample had such positive views on condom use—whether they used condoms consistently or not, and whether they disclosed sex with men to women or not.

Religious Affiliation: Toward Links with Structural/Social Factors

The study contributes to the field a new Religious Affiliation Scale (RAS) with good internal consistency. Although based on individual-level self-reports by men, the RAS provides a window into potential social-contextual factors impacting the lives of BMSMW. When comparing consistent users of condoms (with men and women) to inconsistent condom users, those who were *inconsistent* scored significantly higher on the RAS and most sub-scales.

Of note, the higher men's scores on the RAS, then the lower their condom use self efficacy, condom self efficacy, self concept clarity, autonomy, self-acceptance, Also, the higher their scores on the RAS, the higher their perceived susceptibility to HIV/AIDS. Collectively, this picture calls

for a closer examination of the manner in which high levels of religious affiliation may be having a detrimental impact. This supports the suggestion by Ward (2005) that those BMSMW maintaining a church affiliation may be enduring oppression and suffering a damaging impact upon their health, relationship, and self-esteem. These findings also resonate with a report by Woodyard et al. (2000), regarding how MSM attending traditional churches reported few spiritual gains and negative feelings of self-worth.

Given a theologically-driven homophobia that may be present in the church and may drive away some BMSMW (Ward, 2005), it was not surprising to find in this study that more than half of the sample (54%, n = 93) reported that they had no religious affiliations. Also, not surprising, of those who were involved with religion or churches (n = 77), 78% (n = 62) reported church acceptance of their lifestyles and sexuality to be low.

Cause for Caution. These study's findings are important, given how, increasingly, the church is being seen as a convenient setting for the delivery of prevention interventions with African Americans, whether for diabetes (Boltri, Davis-Smith, Seale, Shellenberger, Okosun, & Cornelius, 2008) or HIV/AIDS prevention interventions (Cornelius, Moneyham & LeGrand, 2008; Hatcher, Burley, Lee-Ouga, 2008; Collins, Whiters, & Braithwaite, 2007).

Because BMSMW are on the down low, they may be present in churches even when prevention interventions are being delivered to the church membership as a whole—and not specifically targeting BMSMW. Before further expanding the use of the church as a site for HIV/AIDS prevention interventions, and targeting BMSMW, in particular, this study's findings need to be considered. The result may be systematic changes in the social context of the church so that homophobic messages and experiences of oppression of the kind Ward (2005) discusses do not occur for BMSMW.

This is important, given the potential correlates of high religious affiliation identified in this study (i.e. lower condom use self-efficacy, lower condom self efficacy—which may exacerbate HIV transmission risk in the Black community). The potential correlates of high religious affiliation identified in this study argue for researchers and interventionists further considering potential structural factors operating in the church as a social context; these factors may negatively impact individual level behavior (i.e. condom use, disclosure, etc…). This is consistent with how numerous authors urge attention in research, as well as in the design of prevention and intervention strategies, to the structural and environmental factors that may be operating in social contexts (Beatty, Wheeler & Gaiter, 2004; Lane, Rubinstein, Keefe, et al, 2004; Mays, Cochran & Zamudio, 2004). This study's findings for religious affiliation support such a structural analysis of the social context of the church setting, given how religious affiliation showed a relationship with important individual-level variables.

It is understandable why the church is being increasingly identified as a convenient and accessible location for the delivery of prevention messages, since is it so often seen as a source of valuable resources for African American community members. Even the men in the sample seemed to attest to this reality. Of those who reported a high level of religious affiliation (n = 77), the vast majority (94.5%, n = 72) reported that the church served as a resource for them. However, other findings suggest it is appropriate to question whether, as a social context, the church is currently a suitable locale for delivering HIV/AID prevention to BMSMW, given how structural level factors (i.e. social norms against homosexuality and bisexuality) may be operating.

Of note, study findings (i.e. higher religious affiliation being associated with lower condom use self efficacy and higher perceived susceptibility to HIV/AIDS) were similar to those found by others. For example, using a sample of 220 college

students to examine the relationship between religiosity, sexual behaviors, and sexual attitudes, one study found that individuals who saw religion as playing a more important role in their lives tended to fear HIV more, perceiving high susceptibility; and, individuals who viewed their religion as having more sanctions against sexual behaviors had less self efficacy for using and buying condoms (Lefkowitz, Gillen, Shearer & Boone, 2004).

Self-Concealment

In this study, the total mean score for the sample on the self-concealment scale (37.72, SD = 6.36) was much higher than what was found with African American college students at a predominantly White Northeastern University—where scores ranged from approximately 23 to 26 (Wallace & Constantine, 2005).

It should be noted that self concealment in this study did not directly refer to concealing information about bisexual activity. Sexual activity could be part of the information that participants concealed.

The high self-concealment scores found in this study are consistent with the majority of men (84.9%, n = 146) reporting they had never told their female partners that they also had sex with men, practicing non-disclosure, or being on the down low. While not surprising, to understand these high self-concealment levels, the lives of BMSMW need to be examined in relation to structural and social-contextual factors (e.g. homophobia, processes of stigmatization) that may also be operating—as other have argued (Beatty, Wheeler & Gaiter, 2004; Lane, Rubinstein, Keefe, et al, 2004; Mays, Cochran & Zamudio, 2004).

Those higher in self-concealment had higher scores for response efficacy (perceived effectiveness of condoms) and higher perceived severity of HIV/AIDS. The concealment data analysis adds to the emergent picture of BMSMW as vigilant and responsible. Thus, future research requires complex models that consider interactions among a multiplicity of factors operating on many levels, as others have indicated (Lane et al, 2004). For, no simplistic picture of BMSMW can be painted, as this study's suggestive data indicates.

Toward a Positive Portrait via Psychological Constructs

To the extent that any prior research had contributed to any negative stereotyping or stigmatizing of BMSMW (Boykin, 2005), this study begins to suggest a positive portrait.

For distress disclosure, a portrait of psychological health emerged. This was seen in many men reporting the ability to disclose any distress they experience with others (e.g. friends). Also, there was a strong pattern for positive self-concept clarity, as exemplified by the following sample item findings: "In general, I have a clear sense of who I am and what I am" (93.1%, n = 160 agree/strongly agree); and, "It is often hard for me to make up my mind about things because I don't really know what I want" (89.5%, 154 disagree/strongly disagree). Moreover, the majority who were consistently using condoms with women were significantly higher on self concept clarity than the minority who inconsistently or never used condoms.

Furthermore, men with higher scores for self concept clarity also had higher scores for autonomy (self-determination, independence, and regulation of behavior). Those with higher scores for concept clarity also had higher scores for self acceptance (higher attitudes toward one's self). High self concept clarity was also positively correlated with high condom use self efficacy, high perception of severity, high condom self efficacy and high response efficacy. The sample men emerge as knowing who they are and what they are with clarity and confidence. They know what to do when it comes to condom use and the reality of living in an era of HIV/AIDS, believing condoms work. High self concept clarity was positively correlated with high condom use self efficacy, high perception of severity,

high condom self efficacy and high response efficacy. These positive results are reminiscent of those of others who found that African American gay and bisexual men with a more positive self-identification reported higher levels of self-esteem, HIV prevention self-efficacy; in addition, they reported stronger social support networks, greater life satisfaction, and less psychological distress (Crawford et al, 2002). In this manner, in this study, the variable of self concept clarity was important to include, allowing a positive portrait to emerge of BMSMW.

Limitations

Multiple limitations plague this exploratory Internet study and must be kept in mind when interpreting the findings. The sample was one of convenience, being limited to those who had the opportunity to hear of the study or had access to a computer, the Internet, and the study link—limiting the extent to which findings generalize beyond the sample. In addition, the small sample size and lack of variability for some responses limited the inferential statistics that could be performed. Another limitation involved a serious unintended error in transferring the survey items into the survey.monkey.com software. This involved the omission of the question to ascertain the participants' ages, restricting data analysis and interpretation.

As an Internet study, there is also the issue of veracity in reporting information online; a limitation of using the surveymonkey.com technology for hosting the survey is that it is possible that an extremely motivated subject might respond to the survey more than once. Also, those accessing computers and the Internet might be very different in education and income from those who lack such access. Associations between low socioeconomic status (SES) and risky behavior have been found among Black MSM (Mays et al., 2004), hence, it is important to consider the limitations in a study with a sample lacking variability, being skewed toward those with middle/higher SES, as was the present study. Recall how 87.2% (n=150) were employed full time, 48.3% (n =83) had income between $30,000 and $49,999, and 60.5% (n=104) had a 4 year bachelors degree or higher (MA, or Doctorate). The study men may not represent the broad range of diverse BMSMW. On the other hand, with so much attention being paid to the high numbers of Black men who have incarceration histories (e.g., Lane et al, 2004), this Internet study is providing an alternative picture of a well-educated, middle-income, highly employed sample of Black men. However, this adds further to the list of reasons why the study findings may not generalize beyond the sample.

Also, no measure of social desirability was used. Men highly sensitive to stigma and perhaps even hyper-vigilant to the public discourse on the down low and how public health models and the popular media are currently vilifying them might be prone to offer socially desirable responses—i.e., reporting high condom use all the time. Future research needs to use a social desirability measure for other reasons. Response bias may also appear by way of respondents who think they know or assume the intentions of the researcher through the flyers distributed, or through other publications, or the study surveys; and, given such perceptions, respondents might provide responses they deem "right" or consistent with the purpose of the study. Moreover, the study sample was very high in self-concealment. Such a sample may be capable of concealing or hiding any information they elect not to share, especially that which is stigmatizing.

As a convenience sample, the characteristics of volunteers must be kept in mind. There are many reasons that could prompt people to volunteer to take the survey. Some might be motivated to dispel negative public health and popular media stereotypes. Others engaging in high risk behavior might tend to avoid such a study. Hence, self-selection factors must be kept in mind as another serious limitation of the study, given the use of a convenience sample of volunteers.

Another limitation of the study was that it did not include information on substance use and abuse. Substance use might have played a role in inconsistent condom use (See Wilton, 2008).

Implications

Despite many limitations, the results of this exploratory study suggest that there is potential in the use of Internet surveys in future research in order to gain greater understanding of the lives of BMSMW, particularly if some of the limitations mentioned in this section are overcome. Meanwhile, the Internet provides a promising alternative to face-to-face survey administration, potentially facilitating disclosure of sexual behavior that may be stigmatizing. Building on this study's preliminary findings of potential factors related to condom use and non-disclosure to female partners for BMSMW, future Internet studies hold the promise of further building our knowledge base.

In future research, it is recommended that the RAS be used, or some other measure of degree of religious affiliation. Future research needs to investigate the behavior of sub-groups of Black bisexually active men defined by level of religious affiliation. This is important, as research findings on a variety of variables might vary depending upon degree of religious affiliation.

Interventions might also be tailored in light of scores on the RAS. Those high in religious affiliation might be seen as more vulnerable, at greater risk for HIV transmission, and as needing tailored HIV prevention and intervention messages that appreciate their potential exposure to homophobic and stigmatizing messages in the socio-cultural context of the church; tailored HIV prevention/interventions need to account for their potentially lower condom use self-efficacy and lower self-acceptance, for example. Thus, there is a role for the RAS in future research and intervention studies, particularly given findings of good internal consistency for this brief measure.

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