Internalized Homonegativity and Its Health-Related Consequences for MSM in San Salvador

STUDY OBJECTIVES

In this research brief, we examine internalized homonegativity (IH) and its relationship to health among men who have sex with men (MSM) in San Salvador, El Salvador. The first objective is to assess the influence of IH on health for MSM. The health-related outcomes examined include suicide, overall mental well-being, health seeking behavior, and sexual risk behavior. The second objective is to identify factors that influence IH and ways to prevent it among MSM.

MEASURING IH

MSM in San Salvador answered 23 questions about IH using Mayfield's IH index (Mayfield, 2001). The measure of IH used in this study has three components. The first component measured the participant's beliefs about the morality of same-sex attraction and reflects his acceptance or rejection of negative social attitudes about same-sex attraction for men. The second component measured the participant's personal homonegativity, defined as his emotions and attitudes toward his own sexual orientation and same-sex attraction. This includes feelings like shame, embarrassment, and resentment towards one's sexual orientation, or desire to control same-sex attraction. Finally, the third component captured positive feelings about same-sex attraction for men, or "gay affirmation." Response categories for the questions ranged from "strongly disagree" to "strongly agree." Participants were categorized as having either a "low," "medium" or "high" level of IH, relative to other respondents in the study, so that there were an approximately equal number of people in each group.

Introduction

Internalized homonegativity (IH) refers to negative attitudes that gay men may have towards homosexuality in general, and towards their own sexual orientation (Mayfield, 2001). It is influenced by a man's level of agreement or disagreement with negative social beliefs about male homosexuality, and the degree to which those beliefs affect his development of a positive sexual identity (Fassinger & Miller, 1996). Social attitudes about sexual orientation are defined by the culture in which a person lives. These attitudes may also influence one's own feelings about their attraction to the same sex through the "internalization" of the society's beliefs about homosexuality (Shidlo, 1994; Mayfield, 2001). Analysis of IH is one way to better understand how the distress a gay man feels in places where homosexuality is stigmatized might influence his health.

Key Findings

MSM Who Participated in This Study

Men who have sex with men (MSM) in the study sample were young, with 69% of participants in the 18–24 year old age group. Most study participants had completed secondary school or had post-secondary education (62%). A substantial number of participants in the study were poor, with 27% reporting no monthly income, and 43% earning less than $250 per month. Approximately half of the MSM in the study self-identified their sexual orientation as gay or homosexual (49%), or as bisexual or heterosexual (52%). The same percentage of MSM reported that they were either single (43%) or in a sexual relationship with another man or transgender woman (43%), while only 13% reported being in a partnership with a woman at the time of the study.

IH and Health among MSM in San Salvador

High levels of IH have been shown to negatively influence health for MSM, including suicide and depression (Newcomb & Mustanski, 2010), and in some cases sexual risk taking (Newcomb & Mustanski, 2011), in international settings. IH may also influence the health of MSM by serving as a barrier to seeking health services. Each of these factors was examined in the current study for MSM in San Salvador.

Suicide and Mental Health

Twenty-seven percent of MSM in the study reported that they always or sometimes think about committing suicide. The percentage of MSM who contemplated suicide increased as the level of IH increased.

STUDY METHODS

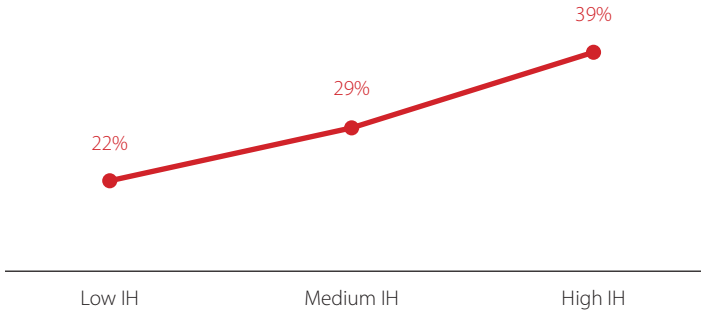
A cross-sectional survey was conducted among 506 MSM in San Salvador who were recruited through respondent driven sampling (RDS) from November 2011 to February 2012. Recruitment chains were initiated by five seeds, purposely selected based on their social standing and wide social networks. Each participant was administered up to three recruitment coupons to distribute to social acquaintances who met study eligibility criteria. This included being 18 years of age or older, having had anal sex with a man or transgender woman in the past 12 months, and having lived, worked or studied in San Salvador for a minimum of three months prior to the interview. This study was approved by the Tulane University Biomedical Institutional Review Board and the National Committee for Ethics and Clinical Investigation in El Salvador. For details about the methods used in this study, including the scales referenced in this brief and item summaries, please see the full report at: http://www.measureevaluation.org/publications/tr-13-92

ANALYSIS

The data from the survey was entered into the statistical analysis program, Respondent Driven Sampling Analysis Tool 6.01 (RDSAT) (www.respondentdrivensampling.org). This program facilitated the use of weights to account for the non-random selection of participants in the calculation of frequencies. The data was then transferred to the statistical software package STATA SE version 12.0. Bivariate and multivariate analyses were conducted by weighting the outcome variable. A cutoff of $p<.05$ was used for statistical significance. The predicted probabilities based on ordered logistic and logistic regression models are presented in the figures. Captions for each figure note control variables used in each model.

Figure 1 shows that 22% of MSM with low IH contemplated suicide, compared to 29% of MSM with medium IH, and 39% with high IH. A similar relationship was observed between IH and overall mental well-being. Scores on the SF-12 measure of overall mental well-being indicated worse health for MSM with high versus low levels of IH. The relationships between suicide, overall mental well-being and IH were statistically significant.

Figure 1: Percentage of MSM who have contepmplated suicide by level of internalized homonegativity (IH), San Salvador 2011–2012*

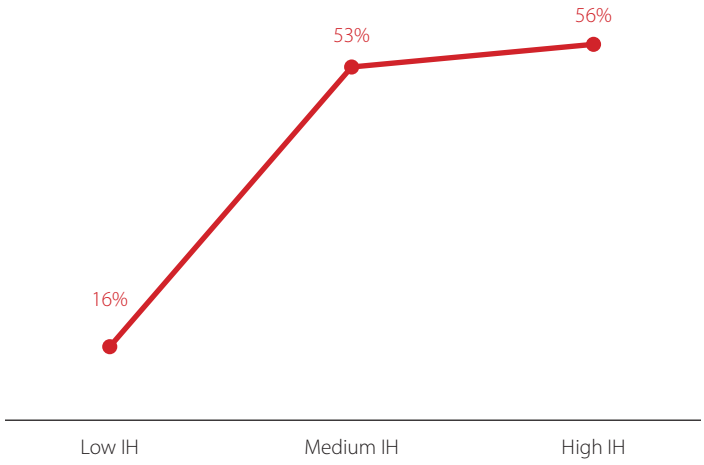


**Percentages presented are converted from the predicted probabilities calculated using logistic regression models that controlled for age, education, income, relationship status, sexual orientation, overall mental well-being, sexual assault in the last year, and binge drinking in the last month.*

Health Seeking Behavior

IH was also shown to serve as a barrier to seeking health services among MSM in the study. A total of 165 MSM in the study reported that they needed healthcare in the last year. Forty percent of those who needed healthcare in the last year postponed seeking it. As shown in Figure 2, this percentage was higher among MSM with higher levels of IH. Only 16% of MSM with low IH postponed seeking healthcare when they needed it, compared to 56% of MSM with high IH who postponed care. The relationship between postponement of healthcare and IH was statistically significant.

Figure 2: Postponement of healthcare in the last year by level of internalized homonegativity (IH), among MSM in San Salvador 2011–2012*



**Percentages presented are converted from the predicted probabilities calculated using logistic regression models that controlled for age, education, income, relationship status, and sexual orientation.*

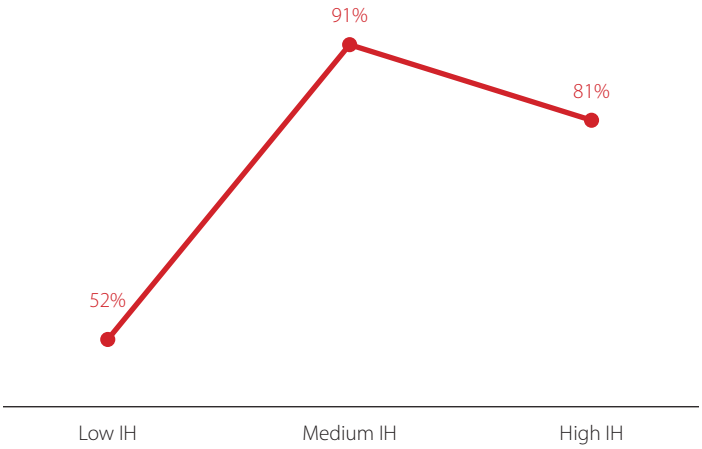
Fear of provider discrimination may be an important reason why MSM postponed care. In this study, the level of IH was higher among MSM who had a regular healthcare provider. Additionally, MSM who reported experiencing discrimination from healthcare providers also had higher levels of IH.

Sexual Risk-Taking Behavior

The relationship between risky sexual behavior and IH is not clear based on available research literature from international settings. While some studies have shown IH to be associated with increased sexual risk behavior, other studies have failed to do so (Newcomb & Mustanski, 2011; Smolenski, Stigler, Ross & Rosser, 2011). In this study, several measures of sexual risk behavior were explored in relation to IH, with different results based on the type of risk behavior. An association was not found between condom use and level of IH for MSM in this study. The different measures of condom use examined include condom use at last sex, consistent condom use with the last sexual partner, consistent condom use with all recent sexual partners, and consistent condom use with all recent non-regular partners. Paying for sex and IH was also explored. MSM were more likely to have bought sex in the last year if they had high versus low IH, but this relationship did not remain statistically significant when the analysis controlled for other variables.

However, a statistically significant relationship was demonstrated between IH and having a risky sexual partner, as well as having sexually concurrent partnerships, in the last six months. Participants were asked to describe the HIV/STI risk characteristics of their three most recent sexual partners in the last six months. A risky sexual partner was defined as a partner who was likely to have an STI, was HIV positive, had ever been incarcerated, was a sex worker, used injection drugs, used crack or cocaine, or had other sexual partners. Seventy-seven percent of MSM reported having at least one risky sexual partner in the last six months. As shown in Figure 3, the likelihood of having a risky sexual partner increased as the level of IH increased, after controlling for other important variables. Only 56% of MSM with low levels of IH reported a risky sexual partner, compared to 91% with medium and 81% with high levels of IH.

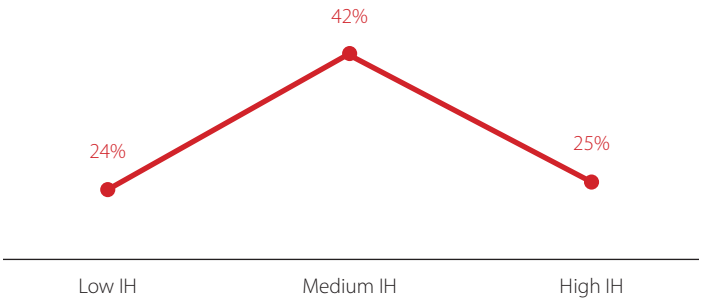
Figure 3: Percentage of MSM with a risky sexual partner in the last 6 months by level of internalized homonegativity (IH), San Salvador 2011–2012*



**Percentages presented are converted from the predicted probabilities calculated using logistic regression models that controlled for age, education, income, relationship status, sexual orientation, HIV knowledge, sexual assault in the last 12 months, sex exchange in the last 12 months, and binge drinking in the last month.*

Sexual concurrency, defined as having multiple sexual partnerships that overlapped in time in the previous six months, was also examined in relation to IH (Figure 4). To measure sexual concurrency, participants were asked to provide the date of the first and last time they had sexual intercourse with their three most recent sexual partners in the last six months. The number of MSM in the study who reported sexual concurrency was significantly higher for MSM with medium levels of IH compared to low levels of IH. However, no difference was found for MSM with high levels of IH compared to low levels of IH. The same association observed for sexual concurrency was also found for multiple sexual partnerships in the last six months and IH.

Figure 4: Percentage of MSM with sexually concurrent partnerhips in the last 6 months by level of internalized homonegativity (IH), San Salvador 2011–2012*



**Percentages presented are converted from the predicted probabilities calculated using logistic regression models that controlled for age, education, income, relationship status, sexual orientation, HIV knowledge, sexual assault in the last 12 months, sex exchange in the last 12 months, and binge drinking in the last month.*

The results related to sexual concurrency and IH highlight the importance of understanding and addressing different levels of IH, both medium and high. Each level of shame and self-stigma may affect behavior in a different way. For example, MSM with a medium level of IH may have a lower feeling of self-worth than MSM with low IH. However, their feelings about their sexuality are not so severe that they would prevent engagement with the gay community or having active sexual relationships. In contrast, MSM with a high level of IH may have such extreme negative feelings about their sexual orientation that they remain socially isolated from the gay community, and may not have sexual relationships in the same way. While this may seem protective for this one form of sexual risk behavior, the previous results presented for suicide, mental health, health seeking behavior, and having a risky sexual partner, demonstrate that high IH is detrimental overall. Therefore, the level of severity of IH must be taken into account to understand how it affects behavior, and both medium and high levels are important.

What Can We Do to Decrease IH among MSM in San Salvador?

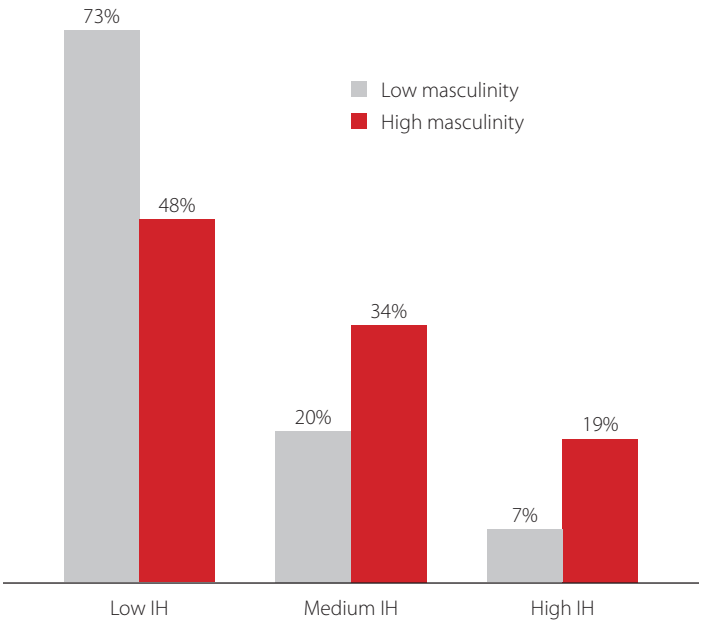
The data from this study demonstrate that MSM with medium or high levels of IH are more likely to have contemplated suicide, to report poorer overall mental well-being, to have postponed medical care, to have had a risky sexual partner, and to have had sexually concurrent relationships in the last six months. These health-related outcomes provide justification for the need to prevent high levels of IH among MSM in San Salvador. The data from this study indicate several factors that may reduce IH among MSM.

Gender Norms and IH among MSM in San Salvador

In every society there are shared ideas and expectations about what is considered acceptable behavior for different groups of people. These shared beliefs are referred to as social norms (Bicchieri, 2006). Social norms are influenced by political, religious, economic, and other historical factors, and may change over time. For IH, gender norms are an important type of social norm to consider. Gender norms refer to beliefs and expectations about appropriate characteristics, roles, responsibilities, and behaviors for men and women. When referring to men specifically, these ideas and attitudes are described as "masculine ideologies," and physical and behavioral characteristics acceptable for men define what is considered to be "masculine" (Pleck, Sonenstein & Ku, 1993).

In this study, the relationship between masculine ideologies and IH was explored among MSM using the Traditional Male Role Attitudes Scale (Pleck et al., 1993). This measure includes eight questions that measure the participant's level of agreement with statements depicting beliefs and expectations about what men should be like and should do. The questions include items measuring the perceived importance of having "status" or "respect" from others as a man, being "tough," and not possessing feminine traits. One question referred specifically to sexual behavior, stating that "men are always ready for sex." Three new items were added to this scale to capture behavior related to seeking health services (for example, "seeking help for a health problem is a sign of weakness," and "real men don't let others tell them how to take care of themselves"). Participants were categorized as having either a "low" or "high" adherence to traditional male role attitudes, relative to other respondents in the study, using a median split. Figure 5 shows that after taking into account important sociodemographic characteristics, MSM with lower levels of adherence to traditional male norms had lower levels of IH. Seventy-three percent of MSM with low levels of adherence to traditional male norms had a low level of IH, while only 48% of MSM with high levels of adherence to traditional male role norms had low IH.

Figure 5: Level of adherence to traditional male norms by level of internalized homonegativity (IH), among MSM in San Salvador 2011–2012*



**Percentages presented are converted from the predicted probabilities calculated using ordered logistic regression models that controlled for age, education, income, relationship status, and sexual orientation.*

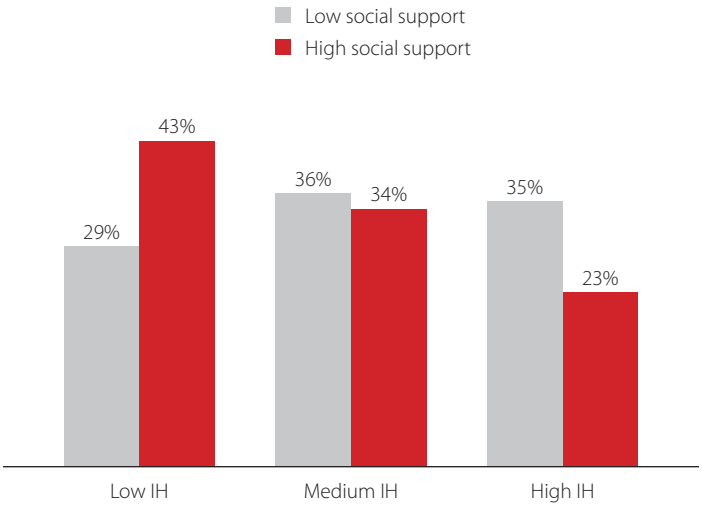
High versus low adherence to traditional male norms is associated with a 14% increase in the probability of being in the medium IH group, and a 12% increase in being in the high IH group. These associations were statistically significant, and suggest that addressing social norms related to masculinity is one way to reduce IH among MSM.

Social Support and IH

Increasing supportive relationship for MSM is one way that IH might be reduced. Social support has been shown to be positively associated with health and well-being in other populations, and is noted as an important factor related to coping in times of stress (Zimmet, Farley, Werkman & Berkoff, 1990). Social support refers to both the quantity of social relationships one has, as well as the quality of resources that social relationships can provide. Examples of these resources include emotional assistance and empathy, advice giving, information sharing, as well as tangible and financial resources. In the current study, MSM were asked about these forms of support from different types of people including family, friends, and their romantic partner using the, "Multidimensional Scale of Perceived Social Support," (Zimet et al., 1990). Participants were asked their level of agreement with 12 different statements about social support, and were categorized as having either a "low" or "high" level of social support relative to other respondents in the study using a median split. As shown in Figure 6, MSM with a high level of social support were more likely to report a low level of IH. Among MSM with high social support, 43% reported a low level of IH, while only 34% reported medium and 23% report high IH, after controlling for important socio-demographic characteristics. The opposite is true for MSM with a low level of social support. Among MSM with low social support only 29% report low IH, compared to 36% who reported medium and 35% who report high IH, after controlling for important socio-demographic characteristics. The relationship between social support and IH was statistically significant.

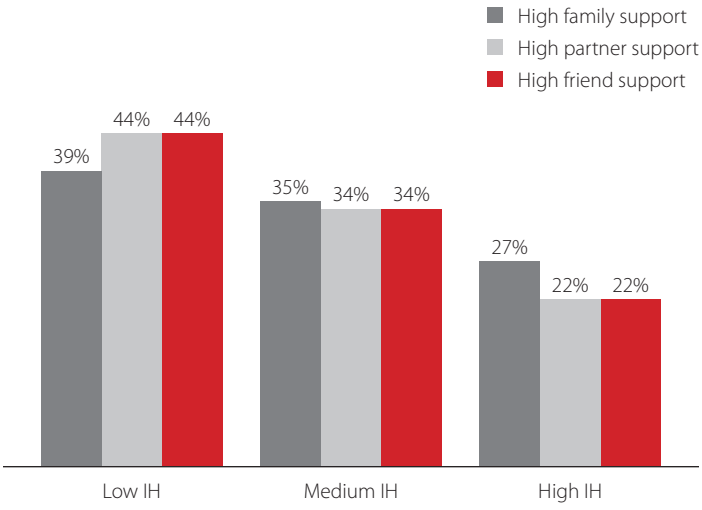
The relationship between IH and social support followed the same pattern when examined specifically by relationships with friends, family, or partners. Figure 7 shows the percentage of people with high family, friend, and partner support at each level of IH. For each different type of relationship the percentage of MSM reporting high social support decreases as level of IH increases. This association is statistically significant for support from friends and partners, but not from family, after controlling for important socio-demographic characteristics. The number of other MSM and transgender women the participant knows was also assessed in relation to level of IH, but showed no statistical association.

Figure 6: Percentage of MSM with low or high social support by level of internalized homonegativity (IH), San Salvador 2011–2012*



*Percentages presented are converted from the predicted probabilities calculated using ordered logistic regression models that controlled for age, education, income, relationship status, and sexual orientation.

Figure 7: Percentage of MSM with high family, partner, or friend social support by level of internalized homonegativity (IH), San Salvador 2011–2012*



*Percentages presented are converted from the predicted probabilities calculated using ordered logistic regression models that controlled for age, education, income, relationship status, and sexual orientation.

Disclosure of Sexual Orientation and IH

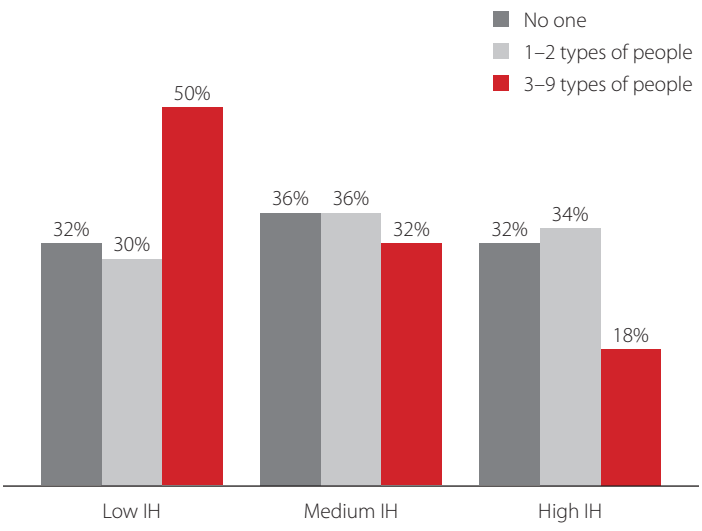
It is possible that MSM with a higher level of shame associated with their sexual orientation would limit their social relationships for fear of discrimination or unintentionally revealing their same-sex sexual attraction to others. In some cases, this could serve as a barrier to the social support that these relationships might provide. However, disclosure of sexual orientation may also be damaging if the person to whom one discloses is not accepting of their sexual orientation. It is difficult to tell the influence of disclosure on IH in this study because the data is cross sectional. This limits our ability to tell if people with low IH are more likely to disclose their sexual orientation to others, or if disclosure helps to reduce IH by providing social support.

Participants were asked if they had disclosed their sexual orientation to their mother, father, male or female siblings, other family members, male or female friends, coworkers, and healthcare provider. Figure 8 shows that the level of IH decreases as the number of different types of people to whom one has disclosed increases. Among MSM who had disclosed to three or more types of people, 50% had low IH, 36% had medium IH, and only 18% had high IH.

When IH was examined by disclosure to each of the different types of people, the results were mixed. There was no statistically significant association between disclosure to one's mother, father, brother, or male friend and level of IH. However MSM who had disclosed their sexual orientation to a sister, other family members, female friends, or coworkers had a lower level of IH. In contrast, MSM who had disclosed their sexual orientation to their healthcare provider had a higher level of IH. These differing results may be due to a low level of IH leading to disclosure (for example, in the case of coworkers), or because certain people are more accepting of their sexual orientation, thus contributing to lower IH (for example, in the case of disclosure to a sister, female friend, or other family member).

Finally, it is also possible that disclosure results in increased IH if the person to whom one discloses is not accepting. This may be the case with the higher level of IH among MSM disclosing to a healthcare provider, given that a substantial proportion of MSM in this study also reported experiencing discrimination from a healthcare provider.

Figure 8: Percentage of MSM having disclosed to no one, 1–2, or 3–9 types of people by level of internalized homonegativity (IH), San Salvador 2011–2012*



**Percentages presented are converted from the predicted probabilities calculated using ordered logistic regression models that controlled for age, education, income, relationship status, and sexual orientation.*

Recommendations

The data from this study indicate that reducing IH among MSM should be a public health priority in San Salvador. This is important for the overall health and mental well-being of MSM, and for prevention of HIV and other sexually transmitted infections (STI). Reducing IH among MSM is a feasible goal that can be achieved through interventions that address the problem at multiple levels in the short and long term. These levels include individual MSM, the social network of MSM, the health delivery system, and the larger community through changes in social norms.

Individual Level: Provide Therapy to Individuals to Reduce the Influence of IH on Health

One way to reduce the influence of IH on health is through one-on-one or group counseling with MSM using different therapeutic techniques. Several theoretical (Cass 1979), and empirical (Fassinger & Miller, 1996; Troiden, 1988) models and frameworks exist for understanding the process of identity formation and IH among MSM. These models can be adapted to guide programs that provide education, therapy, and counseling needed to support the development of a positive self-identity that would reduce IH among MSM in San Salvador. In addition to supporting positive identity formation, several forms of individual therapy

to reduce the distress caused by IH should be considered in programs for MSM. For example, the techniques of cognitive behavioral therapy (Ross et al., 2007), and acceptance and commitment therapy (Yadavaia & Hayes, 2012) have shown to be promising approaches to reduce the influence of IH in other contexts, and might also be considered for MSM in San Salvador.

Interventions to reduce IH should be targeted at the specific level of IH experienced by the individual. One of the main findings of this research brief is that persons at medium and high levels of IH experience different health risks. While MSM with extreme levels of IH may be more likely to contemplate suicide and postpone seeking health services, MSM with a medium level of IH are more likely to have sexually concurrent partnerships and multiple sexual partners. Therefore, interventions should focus on the specific level of IH for each individual, and depending on the health outcome they aim to address. For sexual health outcomes like HIV/STI it is imperative that MSM at the medium level, as well as extremely high levels of IH, are included in interventions.

Like other literature on this topic, the results of this study show that IH influences mental health outcomes. However, it is important to note that same-sex attraction itself is not a mental health problem. Rather, living in contexts that stigmatize same-sex attraction, and the distress this causes MSM, is the problem that should be addressed through individual and group therapy.

In many parts of the world, including the Central America region, interventions to support MSM have been promoted through programs focused on HIV/AIDS. Through a long-standing commitment to this vulnerable population, these organizations are well positioned to support other programs to increase the overall health and well-being of MSM. However, it is important that these organizations include personnel equipped to provide individual counseling and therapy, and are supported through additional training and supervision in this area.

Social Network Level: Promote Social Support and the Development of Allies for MSM

In this and other studies (Szymanski & Kashubeck-West, 2008; Lehavot & Simioni, 2011), social support has been shown to be an important resource that can reduce the negative influence of IH on well-being for sexual minorities. The results of this study indicate that social support from family, friends, and partners specifically, should be promoted as a way to prevent IH among MSM in San Salvador. Fostering this type of support requires that key people in the social network of MSM are targeted through education, counseling, and social messaging to become allies for this population.

In the field of HIV/AIDS, it has been recognized that stigma experienced by people living with HIV (PLHIV) can also affect their caregivers, families, and supporters. In the same way that stigma of HIV can spread to others in the social networks of PLHIV, stigma related to homosexuality can affect people in the social network of MSM. It is important to recognize this potential fear of homosexual stigma among possible allies in the social network of MSM and work to reduce it through programs. It is not always possible to change the opinions or values of people, even when there is a demonstrated social benefit to this change. However, it is possible to create an enabling environment for those who are motivated to change. Programs and future research should explore appropriate channels and mechanisms to equip potential MSM allies with the skills to support their child, sibling, friend, or coworker who may be going through a difficult transition in accepting their sexual orientation. Curriculum and programs that target potential allies of MSM in other settings should be appropriately adapted for the cultural context in San Salvador (Garofalo, Mustanski & Donenberg, 2008; Clark, 2010; PFLAG, 2013), in consultation with MSM advocates and MSM themselves.

Health Systems Level: Reduce Discrimination Encountered by MSM When Seeking Health Services

It is important that MSM do not avoid seeking health services because of fear of discrimination. Instead, the healthcare setting should become a safe place for MSM to disclose their sexual orientation, and receive appropriate care and advice from their healthcare provider. Research from other settings demonstrates the importance of disclosure to a healthcare provider for receiving appropriate information about HIV and other health problems that disproportionately affect MSM (Bernstein et al., 2008).

Recent efforts supported by donor organizations and the El Salvador Ministry of Health to provide healthcare personnel with training in sensitivity for trans population should also be considered for MSM (Maroquin et al., 2013). These workshops used

curriculum developed to increase health provider's knowledge about sexuality, gender, and issues pertinent to the health of sexual minorities. They also provided a space for providers to reflect on their own values and belief systems, and how this may influence the level of care they provide clients (Corona & Arango, 2013). In translating this type of training to address the needs of MSM, it is important for providers to understand how to serve clients who may be at different stages of identity development, and when and how it might be appropriate to encourage disclosure of sexual orientation.

It is important that training efforts with health providers include ongoing mentoring and supportive supervision for the participants. It is also important to continue trainings so that new health professionals entering the field are also reached. It should be communicated to health providers in all medical fields, not only those who provide HIV/STI services, that provision of health services to MSM is considered a basic job requirement, with appropriate sanctions in place in the case of stigmatizing behavior towards a patient.

Even more challenging than dealing with the overt discrimination that MSM may encounter in the healthcare setting, is the fear of inadvertent sexual orientation disclosure that may prohibit MSM from seeking care altogether. MSM with a high level of IH may avoid health services, not only from fear of discrimination from others, but because consultations in healthcare settings may trigger discussions about their sexuality which they would prefer to avoid (Herek, 2007). For this reason it is important that healthcare providers are equipped with the skills necessary to provide consultation to persons still in a stage of denial or confusion about their sexuality, and the resources to link these MSM with appropriate counseling services.

Invest in Longer-Term Interventions to Change Social Norms

Cultural attitudes by their very nature are amenable to change. In this study, adherence to traditionally masculine norms was shown to be associated with higher IH among MSM. In other research, adherence to masculine norms has been shown to negatively influence health-behavior for men, most prominently in the area of sexual risk behavior. Promoting more egalitarian gender norms and devaluing those that emphasize violence and sexual prowess would potentially benefit MSM, as well as heterosexual men and women.

A deliberate and systematic approach to norm change should be adopted to reduce the impact of adherence to traditional male norms on IH for MSM. This requires programmatic work to identify and define the specific types of norms to be changed (for example, personal, injunctive, or descriptive norms) (Bicchieri, 2006), and a mechanism to change each type of norm, and perception of norms on the part of MSM. Social norm change interventions from the field of substance use (Berkowitz, 2005), and violence prevention (WHO, 2009), may serve as examples in this area.

Norm change may also be accomplished through changes in laws and policies that would support acceptance of MSM. A recent analysis of IH in 38 countries demonstrated the association between structural factors (for example, laws recognizing same-sex marriage or same-sex adoption) and the level of IH among MSM (Berg et al. 2013). Lobbying for a human rights approach that would confer legal protections for MSM may help to create this type of norm change, and has been recognized as an important way to achieve improvement in health for MSM in neighboring regions (Avrett, 2012).

Conclusions

The results of this study indicate that IH is an important issue to address in order to reduce risk for HIV/STI and improve mental health and well-being among MSM in San Salvador. IH among MSM in this context adversely influences suicide, mental well-being, health seeking behavior, and sexual risk behavior. The way that IH influences behavior and health depends on the level of IH, and both medium and high levels have detrimental effects. Different programmatic activities should be targeted towards MSM with medium versus high levels of IH. The level of IH among MSM in San Salvador is related to their adherence to traditional masculine gender norms. It is also influenced by the level of social support MSM receive from family, friends, and partners. Disclosure of sexual orientation may be one mechanism for decreasing IH among MSM, but only if the people to whom MSM disclose are accepting of their sexual orientation.

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