



# EPIDEMIOLOGIC AND SOCIOCULTURAL FACTORS IN THE TRANSMISSION OF HIV INFECTION IN BLACK GAY AND BISEXUAL MEN

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AIDS (Acquired Immunodeficiency Syndrome), first reported in 1981 (Gottlieb, Schanker, Fan, Saxon, Weisman, & Posalki, 1981), is profoundly altering the lives and communities of millions in this country. By the year 1991, the U.S. Public Health Service projects that approximately 270,000 Americans will have contracted the disease, a dramatic increase from the current 58,000 cases (Macdonald, 1986). Of these, 179,000 people will have died from AIDS. This means the disease will have struck one of every 933 Americans. In the year 1991 alone, an estimated 74,000 new cases will be diagnosed and 54,000 individuals will die.

As drastic as these statistics may seem, when they are examined by ethnic groups, the picture is particularly disconcerting for blacks (Bakeman, McCray, Lumb, Jackson, & Whitley, 1987; Centers for Disease Control, 1987; Cochran, Mays, & Roberts, 1988; Friedman, Sotheran, Abdul-Quader, Primm, Des Jarlais, Kleinman, Mauge, Goldsmith, El-Sadr, & Maslansky, 1987; Mays & Cochran, 1987). As of April 4, 1988, 58,270 cases of AIDS had been reported in the United States (CDC Weekly Surveillance Report, 4/4/88). Of these, 14,992, or approximately 26 percent, were black, although blacks represent only 12 percent of the population. It was estimated in 1987 (Mays & Cochran, 1987) that 1 to 1.4 percent of the black population was possibly infected with the virus (figures based on 1980 Census, Bureau of the Census, 1983). This was three times the estimated rate among whites. Clearly, AIDS has the potential to have a much more destructive impact on the black community than among whites.

Using the U.S. Public Health Service model for projecting AIDS incidence rates in the general population, by 1991 there will be approximately 67,000 cases in blacks, with 31,500 cumulative deaths (Mays & Cochran, 1987). Yet this may underestimate by at least 20 percent the serious morbidity and mortality attributable to AIDS (Morgan & Curran, 1986). Underreporting or underidentification of cases is a continuing problem (Cochran, 1987). In addition, racial differences in health care utilization and risk behaviors may differentially affect the accuracy of the prediction of AIDS cases in blacks, resulting in a much higher estimate than we have presented.

The epidemiologic pattern of AIDS in blacks differs dramatically from that observed in whites. As shown in Figure 1, AIDS among whites is very clearly a disease affecting homosexual and bisexual males as its principal targets. For blacks, AIDS cases are more widely distributed throughout the population. Even among individuals in a single risk category, blacks are at relatively higher risk for AIDS than whites except for infections acquired through the receipt of blood products (Centers for Disease Control, 1987).

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## ADULT AIDS CASES BY RISK FACTORS AS OF APRIL 4, 1988

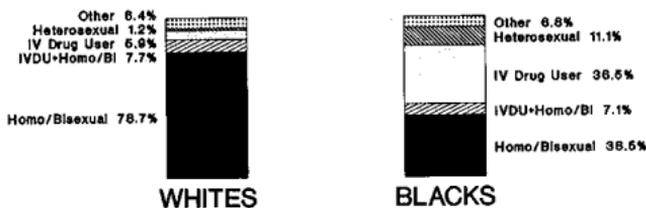


FIGURE 1

(Cochran & Mays, 1988)

### EPIDEMIOLOGICAL AIDS IN HOMOSEXUAL AND BISEXUAL MALES

Of the adolescent and adult cases reported nationally (Acquired Immunodeficiency Syndrome Weekly Surveillance Report, 4/4/88), approximately 64 percent ( $N = 36,603$ ) were homosexual and bisexual men, while an additional 7 percent ( $N = 4,266$ ) were intravenous (IV) drug abusing homosexual or bisexual males. Of these, 5,576 were black homosexual or bisexual males and 1,030 black IV drug-abusing homosexual or bisexual males. Thirty percent of black homosexual men with AIDS (including IV drug users) live in the urban Northeast (primarily New York City and its environs); for bisexual men, the percentage is 25 percent. In contrast, for white homosexual men with AIDS, 1/3 live in the urban West, principally the urbanized regions of San Francisco and Los Angeles. White bisexual men with AIDS are most likely not to live in an urban area of more than 1 million residents (34 percent).

While the number of black homosexual and bisexual cases may seem small, it is important to gauge these numbers in proportion to the representation of blacks in the population. Thus, as seen in Figure 2, 15.2 percent of cases in homosexual/bisexual males are black, although only 10.6 percent of males over age 12 years are black. Twenty four percent of cases with the cofactors of IV drug use and homosexual/bisexual male are among blacks. In contrast, whites represent 84.6 percent of males over age 12 years and 73.9 percent of AIDS cases associated with a single risk factor of homosexual sexual transmission (62.3 percent of IV drug use and homosexual transmission cofactors cases).

## AIDS CASES BY ETHNIC GROUP AS OF APRIL 4, 1988

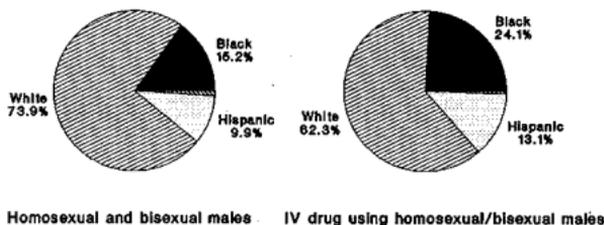


FIGURE 2

(Cochran & Mays, 1988)

If we presume an equivalent prevalence rate of male homosexual behavior across ethnic groups, even among gay and bisexual men, blacks are at higher risk for HIV infection than whites. In a recent study (Samuel & Winkelstein, 1987) of HIV seroprevalence among San Francisco gay men, 48.7 percent of whites evidenced antibodies to HIV versus 65.3 percent of blacks, despite a lack of statistically significant differences between the two groups in high risk behaviors such as needle sharing, receptive anal intercourse or number of sexual partners. The reasons for this higher prevalence rate among gay and bisexual men are still unknown. However, it may be only through achieving a greater understanding of the black gay male experience that these unexpected differences can be explicated.

### SOCIOCULTURAL FACETS OF THE BLACK GAY MALE EXPERIENCE

Prior to the appearance of AIDS in this country, studies on the sexual preferences and behaviors of gay men generally ignored the specific experiences of black men (Bell, Weinberg & Hammersmith, 1981). With the press of the AIDS epidemic to develop baseline information on men's intimate behaviors, this tendency rarely to study black gay men, or to do so in the same manner as white gay men, persists. While many researchers may recognize the importance of possible cultural differences, their approach has been to assume that black gay men would be more like white gay men than black heterosexual men. Questionnaires, sampling procedures and topics of focus have been more consistent with white gay men's experiences (see Becker & Joseph, 1988 for a comprehensive review of behavior change studies). This proclivity has resulted in an emergence of comparisons between black and white men using white gay standards of behavior that may be obscuring our understanding of important psychosocial determinants of sexual behaviors in black gay men. Given the differences that have been observed in family structure and sexual patterns between black and white heterosexuals, there is no empirical basis upon which to assume that black gay men's experience of homosexuality would perfectly mimic that of whites (Bell *et al.*, 1981). Indeed, very little is known empirically about the lives of black gay men (Mays & Cochran, 1987), though there are some indications, discussed below, that they are more likely to engage in activities that place them at greater risk for HIV infection.

In the absence of any data we need to proceed cautiously with assumptions that imply anything other than same sex activities of black gay men resemble those of white gay men. This caution is particularly true for AIDS studies that pur-

port to study psychosocial behavior. Studies of this type report not only on behavior but also attempt to describe motivations and circumstances that led to the behavior. In the absence of a set of questions or a framework incorporating important cultural, ethnic and economic realities of black gay men, interpretations emanating from a white gay male standard may be misleading.

#### DEVELOPMENT OF A BLACK GAY IDENTITY

In recent years, researchers (Spanier & Glick, 1980; Staples, 1981; Guttentag & Secord, 1983) have noted differences between whites and blacks in their intimate heterosexual relationships. Differential sociocultural factors presumably influence the development and specific structure of sexual behavior within black heterosexual relationships. These factors include the unavailability of same ethnic group partners, fewer social and financial resources, residential immobility and lack of employment opportunities. Many of these same conditions may surround the formation, maintenance and functioning of black gay male relationships.

Popular writings in past years by black gay men describe the difficulty in finding other black gay men for potential partners, the lack of a visible black gay community, an absence of role models, and the dearth of black gay male social or professional organizations (Soares, 1979; Beame, 1983). While gay bars, gay baths and public places existed where white gay men gathered, some of these were off limits to black gay men either due to actual or perceived racism within the white gay community or the danger of passing through white neighborhoods to participate in gay community activities. Thus, expectations that the experiences of black gay men are identical to those of white gay men seem unwarranted.

In examining differences between blacks and whites in the emergence of a homosexual orientation, Bell, Weinberg and Hammerstein (1981) found that, for the white males, pre-adult sexual feelings appeared to be very important. In contrast, among black males, childhood and adolescent sexual activities, rather than feelings, were stronger predictors of the development of adult homosexual orientation. Thus, blacks started to act at an earlier age on their sexual inclinations than whites did (Bell *et al.*, 1981). This would be consistent with black-white differences in the onset of heterosexual activity if socioeconomic status is not statistically controlled for (Wyatt, personal communication).

The typical conceptualization of sexual orientation is that individuals are located in terms of their sexual feelings and behaviors on a bipolar dimension where one extreme is heterosexuality, the other is homosexuality and lying somewhere in between is bisexuality (Bell & Weinberg, 1978). This definition does not include ethnicity or culture as an interactive factor influencing the expression of sexual behavior or sexual orientation. For example, Smith (1986) makes a distinction between black gays and gay blacks, complicating the demarcation between homosexuality and bisexuality. "Gay blacks are people who identify first as being gay and who usually live outside the closet in predominantly white gay communities. I would estimate that they amount to roughly 10 percent of all black homosexuals. Black gay men, on the other hand, view our racial heritage as primary and frequently live 'bisexual front lives' within black neighborhoods." These two groups are probably quite different in both social activities and sexual behaviors. The black gay man, strongly identified with Afro-American culture, will often look and behave much like the black heterosexual man except in his sexual behavior. The extent to which his same sex partners are integrated into his family and social environment may be a function of his class status (Soares, 1979). It has long been noted by blacks that there are differences, both in values and behaviors, between middle-class and working-class blacks. There is no reason to assume that, within the black gay community, such diversity would not persist. While Smith (1986) has described the black gay community in only two dimensions, we would be remiss if we stopped here. There is a growing population of black gays who have forged an identity acknowledging both statuses. As Sylvester writes in In the Life: A Black Gay Anthology, "At times I cried just remembering how it is to be both black and gay during these truly difficult times. But here we are, still proud and living, with a culture all our own."

We know less about the behavior of black men who identify as bisexual and least about those black men who engage in same-sex sexual behavior but identify as exclusively heterosexual. When the factor of social class is added the distinction between homosexuality and heterosexuality may become even more blurred. Among lower socioeconomic black men, those engaged in same sex sexual activities, regardless of their sexual object choices, may appear on the surface no different from black heterosexuals. If the support systems of black gay men are like those of black lesbians (Cochran & Mays, 1986), fewer economic resources result in a greater reliance on a black social network (both gay and heterosexual) for tangible and emotional support, a strong tendency to live in predominantly ethnic neighborhoods and the maintenance of emotionally and economically close family ties.

This extensive integration into the black heterosexual world may be a function of both fewer economic resources and ethnic identification. The culture of gay life, generally perceived to be white, may not be synonymous with the norms of black culture. Choices of how to dress, what language to use, where to live and who to have as friends are all affected by culture. The white gay community, while diverse, has developed norms concerning language, social behavior and other demarcations (Warren, 1974) that may not mesh well with certain subgroups of black gays. For example, in the past there has been a heavy emphasis in the gay white community (except among the middle-aged, middle class closeted gay men) on socializing in public places —bars, beaches and resorts (Warren, 1974). In contrast, the black gay community places greater emphasis on home entertainment that is private and not public, perhaps as a holdover from the days when discrimination in many public places was common. This pattern of socializing would facilitate the development of a distinct black gay culture (Soares, 1979). It is perhaps this difference in socializing that has frustrated health educators attempting to do AIDS education through the social network in gay bars. Generally, they have found that they do not reach a significant number of black men using this technique. An understanding of the black gay community makes salient that risk reduction strategies should focus on "risk behaviors" and not "risk groups." Emphasizing risk reduction strategies that rely on group membership require a social and personal identification by black men that, for many, may not be relevant.

#### SEXUAL BEHAVIOR

Bell and Weinberg, in a 1978 study comparing sexual activities of white and black gay men, found that blacks were more likely to report having engaged in anal sex, both passively and actively, than white gay men. In terms of our current knowledge of AIDS, this appears to be one of the highest risk factors for contracting the HIV virus (Friedland & Klein, 1987). A second aspect of black gay men's sexuality is that they may be more bisexual in their behaviors than white gay men. Evidence for this comes again from Bell and Weinberg (1978), who reported that black gay men were significantly more likely to have engaged in heterosexual coitus (22 percent) in the previous 12 months than white gay men (14 percent). This seems to be borne out nationally by the AIDS statistics. Among male homosexual/bisexual AIDS patients, black men are more likely than white men to be classified as bisexual (30 percent vs. 13 percent) rather than homosexual (70 percent vs. 87 percent). Due to the intense homophobia in the black community and the factors we discussed above, men may be more likely to remain secretive regarding their homosexual activities (Mays & Cochran, 1987). This may provide a mode of transmission of the AIDS virus outside of an already identified high risk group.

There are several other differences between black and white gay men noted in the Kinsey Institute data that have implications for contracting the HIV virus. Looking at sexual behavior both pre- and post-Stonewall, black gay men, in comparison to white gay men, were more likely to be sexually active across ethnic boundaries and less likely to report that their sexual partners were strangers (Gebhard & Johnson, 1979; Bell & Weinberg, 1978). Sexual practices post-Stonewall underwent profound change in the gay community. Black gay men were a part of that change (Gebhard &

Johnson, Bell & Weinberg, 1978). However, these differences in meeting partners or choice of partners remain. They are apparently less maleable to change than specific risk-related sexual behaviors.

While the 1978 Bell and Weinberg study was conducted on a small sample in the San Francisco area, it is suggestive of the need for further research to assess the prevalence of risk behaviors and strategies most effective for decreasing risk. Indeed, a recent report of ethnically-based differences in syphilis incidence rates (Landrum, Beck-Sague, & Kraus, 1988) suggests black gay men are less likely than white gay men to be practicing "safer sex." Sexual behavior has multiple determinants and it is important that variables such as culture, ethnic identification and class be incorporated into health education programs designed to promote sexual behavior change by black men.

#### INTRAVENOUS DRUG USE

IV drug use is more common in the black community (Gary & Berry, 1985) which may explain the higher than expected prevalence of blacks in the co-categories of IV drug user and homosexual/bisexual male shown in Figure 2. HIV infection is endemic among urbanized Northeast IV drug users who most likely to be black (Ginzburg, MacDonald, & Glass, 1987). Ethnic differences exist between the percentage of homosexual/bisexual men with AIDS who are also IV drug users; for white gay and bisexual men with AIDS, 9 percent have histories of IV drug use, while for blacks, the figure is 16 percent. Black gay and bisexual men who do not use IV drugs may also be at increased risk because they are more likely than whites to be sexual partners of black men who are IV drug users. In the Bell and Weinberg study (1978), 22 percent of white men had never had sex with a black man, whereas for black respondents, only 2 percent had never had sex with a white man.

#### ALCOHOL AS A COFACTOR

Recently, alcohol use has been implicated as a cofactor that facilitates the occurrence of high risk sexual behavior among gay men (Stall, McKusick, Wiley, Coates, & Ostrow, 1986). In predicting alcohol use among black gay and bisexual men, one might expect that normative use patterns will be influenced by what is common behavior in both the black and gay communities.

Norms for alcohol use in the black community reflect a polarization of attitudes, shaped, on the one hand, by traditional religious fundamentalism and rural southern heritage and, on the other, by a focus on socializing in environments where is drinking is common, such as bars, nightclubs and home parties (Herd, 1986). This latter norm is more prevalent in urban black communities. Blacks and whites vary in small ways in their drinking patterns, although blacks are more likely to suffer negative consequences, including alcohol-related mortality and morbidity, from their drinking than are whites. Current rates of mortality due to liver cirrhosis indicate that rates are 10 times higher in black men aged 25-34 as compared to white males. While drinking is found across all socioeconomic groups of blacks, health and social problems associated with drinking have been found more often in low income urban blacks (Lex, 1987). Similarly, for this group it was found that black males 30-59 were most likely to use alcohol to face the stress of everyday life situations. This is the group most affected by HIV infection.

Within the gay male community, alcohol abuse is a serious problem (Icard & Traunstein, 1987). This may result from both the sociocultural stress of discrimination and the tendency for gay-oriented establishments to be drinking establishments as well. Thus, gay men frequently socialize in environments where alcohol consumption is normative.

Black gay and bisexual men, depending upon their relative identification with the black or gay community, would be expected to demonstrate behavior consistent with these norms. For some, this might mean a high level of abstinence apart from social drinking consistent with other black Americans; for others, alcohol consumption might more closely resemble that of white gay men with concomitantly higher rates of alcohol dependency.

Early AIDS epidemiologic tracking programs conceptualized the disease as a result of the gay lifestyle (Mays, 1988). Indeed, now discarded names for different manifestations of the illness included Gay-related Immunodeficiency Disease and Gay cancer. This focus on discrete risk factors continues to the present, although the additional populations of IV drug abusers, hemophiliacs, persons born in Haiti and Central Africa and recipients of blood transfusions after 1978 have been added to the list. For whites, this approach is highly successful, describing the presumed HIV transmission vector in 94 percent of cases; for native-born blacks, the percentage of cases accurately labeled by a single risk factor (including the combination of IV drug use and male homosexual contact) drops to 88 percent (Cochran, 1987). This underscores the reality that sociocultural factors varying across ethnic groups strongly influence individuals' behavior, and by this, their risk of contracting HIV. For black gay and bisexual men, the reliance on highly specified risk groups (or factors) ignores the fundamental nature of their behavioral location in society. The multiplicity of their identities may indirectly increase their risk for HIV infection by exposing them to more diverse populations (Grob, 1983).

First, as blacks, they are behaviorally closer to two epicenters of the AIDS epidemic: IV drug use and foreign-born blacks (primarily those from Haiti and Central Africa where HIV infection is more common). Social and behavioral segregation by ethnic status is still a reality of the American experience and black gay and bisexual men suffer, like other blacks, from pervasive racism. As we noted above, if their social support systems are similar to what we know of black lesbians (Cochran & Mays, 1986), extensive integration into the black heterosexual community is common. Behaviorally, this may include both IV drug use and heterosexual activity with HIV-infected individuals. Thus, black gay and bisexual men are at increased risk for HIV infection simply by virtue of being black.

Second, as men who have sex with other men, black gay and bisexual men are often members of the broader gay community in which ethnicity probably reflects the general U.S. population (84 percent white). Black gay and bisexual men may have relatively open sexual access to white men, although racism in the community may preclude other forms of socializing (Icard, 1985). Data from the Bell and Weinberg study (1978) suggests several interesting differences, as well as similarities, between white and black gay men. Blacks reported equivalent numbers of sexual partners, both lifetime (median = 100-249 partners) and in the previous 12 months (median = 20-50), as whites. Although they were significantly less likely than white gay men to engage in anonymous sexual contacts (51 percent vs. 79 percent of partners), more than two-thirds reported that more than half their sexual partners were white men. In contrast, none of the white respondents reported that more than half their partners were black. It should be kept in mind, however, that a greater percentage of the white sample (14 percent) was recruited at bath houses than the black sample (2 percent). Nevertheless, at least sexually, Black gay men appear to be well integrated into the gay community. Therefore, black gay and bisexual men are also at higher risk for HIV infection because they are behaviorally close to another epicenter of the AIDS epidemic: the gay male community.

Third, as a social grouping unto itself, the black gay and bisexual male community may be more diverse than the white gay community (Icard, 1985). Some men identify more closely with the black community than the gay community (black gay men); others find their primary emotional affinity with the gay community and not the black community (gay black men). To the extent that this diversity of identity is reflected in behavioral diversity as well, HIV transmission may be greatly facilitated (Denning, 1987).

Thus, black gay and bisexual men are individuals often located behaviorally at the crossroads of HIV transmission. Their multiple social identities make it more likely that the practicing of high risk behavior, whether sexual or needle-sharing, will occur in the presence of HIV.

## PERCEPTIONS OF RISK

There may be a reluctance among black gay and bisexual men to engage in risk reduction behaviors because of the perception by some members of the black community community that AIDS is a "gay white disease," or a disease of intravenous drug users (Mays & Cochran, 1987). In addition, many risk reduction programs are located within outreach programs of primarily white gay organizations. These organizations often fail to attract extensive participation by black gay men.

Research findings suggest that the personal perception of being at risk is most often influenced by accurate knowledge of one's actual risk and personal experiences with the AIDS epidemic (McKusick, Hortsman & Coates, 1985). There may be a variety of reasons why black gay and bisexual men do not see themselves as at risk. These include the notion of relative risk and a lack of ethnically credible sources for encouraging risk perceptions (Mays & Cochran, 1988). Relative risk refers to the importance of AIDS in context with other social realities. For example, poverty, with its own attendant survival risks, may outweigh the fear of AIDS in a teenager's decision to engage in male prostitution. Economic privilege, more common in the white gay community, assists in permitting white gay men to focus their energies and concerns on the AIDS epidemic. For black gay men of lesser economic privilege other pressing realities of life may, to some extent, diffuse such concerns. Credible sources relates to the issues that we have presented here of ethnic identification. Black gay men who are emotionally and behavioral distant from the white community may tend to discount media messages from white sources.

## TRACKING CHANGES AMONG THESE MEN

We know very little about the response of black gay and bisexual men to the threat of AIDS. Recent research attempts to identify psychosocial and lifestyle factors predictive of risk reduction behaviors among gay men have utilized almost exclusively caucasian informants. Generally, few participants in the major federally funded studies of gay men have been black gay men (Becker & Joseph, 1988). The reasons for this low participation rate have not been empirically documented, but probably have multiple origins. Researchers, in designing their studies, may utilize questions that lack cultural relevance or rely on recruitment strategies emphasizing white gay community and friendship networks. Additionally, there may be resistance by the black community to allow access to participants. This may stem both from past experiences with white researchers who conducted their research with insensitivity to black individuals and the community itself, and from the general distrust many blacks have of whites as a whole. Apart from these issues, the generally greater religious conservatism in the black community encourages a level of homophobia that may lead black men who are sexually active with other men to be more difficult to locate in the first place.

It is within this context that we have designed a national study of AIDS risk reduction in black gay and bisexual men. Our goals are to gather data that are culturally accurate: 1) in documenting the HIV-related knowledge, attitudes, perception of risks and sexual activities of black men who engage in same sex activities; 2) in assessing to whom these men feel they can turn for support and information to cope with everyday stresses and hassles as well as HIV-related concerns; and 3) to determine what barriers prevent or hinder these black men from seeking out health and AIDS related information.

Our goal is to reach at least 1,000 black gay and black men who participate in same sex activities with other men throughout the United States. We are striving to reach a very diverse group. Black men living in rural or urban areas, men who identify as gay, bisexual or heterosexual (if they engage in same sex activities), men whose occupations range from never employed to professionals and the full spectrum of the age range from 18 years and up. The success of our reaching this diverse group depends on the participation of members of the community.

As the study is totally anonymous, we depend on others to help us reach black men. Questionnaires are distributed through social and professional organizations such as the National Coalition of Black Lesbians and Gays and by mem-

bers of the gay heterosexual community. If white gay men and lesbians wish to assist the project, they should request copies of the questionnaires to disseminate to friends or acquaintances that are black and sexually involved with other men. Individuals may also request copies of the questionnaire or the information flyers describing the study to place in bars, bookstores, gyms or distribute at houseparties that will be attended by large numbers of black men. Each individual who helps, no matter how small the effort, is important to the attempt to accurately reflect the diversity of the black men's community. If you are interested in either participating in the study or disseminating questionnaires, you can call or write Dr. Vickie M. Mays, c/o Black Community AIDS Research and Education (Black C.A.R.E.) Project, 1283 Franz Hall, Los Angeles, CA 90024-1563 (213) 825-9858.

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