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Christian Grov
CUNY School of Public Health

Lena D. Saleh
Center for HIV/AIDS Educational Studies and Training (CHEST)

Jonathan M. Lassiter
Center for HIV/AIDS Educational Studies and Training (CHEST)

Jeffrey T. Parsons
CUNY Hunter College

RUNNING HEAD: Challenging race-based stereotypes

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Challenging race-based stereotypes about gay and bisexual men's sexual behavior and perceived penis size and size satisfaction

Christian Grov, PhD, MPH[1-3] Lena D. Saleh, PhD[3]

Jonathan M. Lassiter, PhD[3] Jeffrey T. Parsons, PhD [2-6]

[1] Department of Health and Nutrition Sciences, Brooklyn College of the City University of New York (CUNY).
[2] Doctoral Program in Public Health, The Graduate Center of CUNY
[3] Center for HIV/AIDS Educational Studies and Training (CHEST)
[4] Basic and Applied Social Psychology Doctoral Program, The Graduate Center of CUNY. New York, NY. USA
[5] Health Psychology Doctoral Program, The Graduate Center of CUNY. New York, NY. USA
[6] To whom correspondence should be addressed. 695 Park Avenue, New York, NY 10065. Department of Psychology, Hunter College of CUNY. jeffrey.parsons@hunter.cuny.edu 212-206-7919, 212-206-7994 (Fax)

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ABSTRACT

Racial prejudice and stereotyping in gay and bisexual communities may be important contextual factors that contribute to racial disparities in HIV. In an effort to challenge race-based stereotypes regarding gay and bisexual men's sexuality, we sought to determine the extent to which race and ethnicity were associated with (1) racial homophily (i.e., same-race partnerships), (2) sexual behavior (e.g., number of partners, condomless anal sex (CAS), sexual position (top/versatile/bottom)), and (3) perceived penis size and size satisfaction. Data were taken from a survey of 1,009 gay and bisexual men recruited using a street-intercept method at gay, lesbian, and bisexual community events in NYC in 2006—15% Black, 61% White, 18% Latino, and 6% Asian/Pacific Islander (mean age: 35.7). There was strong evidence of racial homophily among men who were in relationships, particularly for White and Black men. Race and ethnicity was largely unassociated with multiple dimensions of sexual behavior (e.g., number of partners, CAS, sexual positioning). Although we observed some racial and ethnic differences in perceived penis size that were consistent with stereotypes, the magnitudes of the differences were insufficient to justify the stereotype. As well, there were no significant differences with regard to satisfaction with penis size or lying to others about penis size. The disproportionate HIV prevalence among Black and Latino men does not appear to be as a result of differences in sexual behavior (e.g., CAS, number of partners) and race-based sexual stereotypes were largely unsupported by empirical data.

KEYWORDS: race and ethnicity; perceived penis size; penis satisfaction; condom use; sexually transmitted infections; men who have sex with men (MSM); gay and bisexual men

INTRODUCTION

Gay, bisexual, and other men who have sex with men (MSM) are challenged by various health disparities—e.g., poorer mental health outcomes (Cochran, Sullivan, & Mays, 2003; Meyer, 2003), elevated substance use (McCabe, Hughes, Bostwick, West, & Boyd, 2009)—in addition to HIV (CDC, 2013, 2014; Johnson et al., 2014). However, even within gay and bisexual communities, men of color are disproportionately affected by HIV (CDC, 2013, 2014). Researchers have tested a variety of behavioral hypotheses to determine why these disparities persist. Increasingly, these hypotheses incorporate an analysis of contextual factors in the lives of gay and bisexual men (O'Leary, Fisher, Purcell, Spikes, & Gomez, 2007; Peterson & Jones, 2009). Race-related prejudice and racial stereotyping in gay and bisexual communities are among these contextual factors (Ibanes, Van OssMarin, Flores, Millett, & Diaz, 2009; Paul, Ayala, & Choi, 2010; Relf, Huang, Campbell, & Catania, 2004) . Some researchers have begun to evaluate racial stereotypes regarding Black and Latino men's HIV risk behaviors. For example, several previously held, but now debunked, stereotypes were that racial and ethnic disparities in HIV among gay and bisexual men were due to differences in the frequency of condomless anal sex (CAS), frequency of sexual partners, greater substance use, or lower AIDS-related knowledge (Millett, Flores, Peterson, & Bakeman, 2007; Oster et al., 2011).

Instead, racially homophilous sexual partnering (i.e., same-race partnerships) has been suggested as contributing to the high rates of HIV in minority communities (Clerkin, Newcomb, & Mustanski, 2011; Mustanski, Birkett, Kuhns, Latkin, & Muth, 2014; Newcomb & Mustanski, 2013). Specifically, racial homophily may further drive racial disparities in HIV among gay and bisexual men because of the higher community burden of both HIV and STIs—which are known to facilitate easier HIV acquisition—already present among Black and Latino MSM communities

(Hogben & Leichliter, 2008; Mustanski et al., 2014; Raymond & McFarland, 2009; Sullivan et al., 2014). Racial homophily may be a byproduct of racism and racial stereotypes within sexual minority communities as some racial groups may be considered more sexually desirable than others (Wilson et al., 2009).

Beyond racial stereotypes about HIV risk behaviors, there are broader racial stereotypes about these men's sexuality that are present within gay and bisexual communities. Such stereotypes are gaining attention in the research literature (Williams, Wyatt, Resell, Peterson, & Asuan-O'Brien, 2004; Yoshikawa, Wilson, Chae, & Cheng, 2004). To date, most of these studies have been qualitative in nature and mainly focused on what these stereotypes are, but have not fully examined their empirical basis.

Commonly Held Racial Stereotypes in Gay and Bisexual Male Communities

Racial stereotypes related to sexuality abound in society as a whole (HoSang & LaBennett, 2012; Seidman, 2011). These stereotypes are also diffused in sexual minority communities and usually focus on sexual prowess (i.e., their number of male partners), sexual positioning (i.e., top as "active" and bottom as "passive"), and penis size. Such stereotypes include that Black men have larger penises than others and beliefs of Black men's sexuality as "irresponsible" (i.e., greater CAS), aggressive and animalistic in nature (Bussel, 2006; Fields et al., 2012; HelloBeautifulStaff, 2011; Wilson et al., 2009). Latino men are stereotyped as sexually "passionate" and "ravenous" lovers, with little sexual-self-control and therefore—to use a pejorative term—promiscuous (i.e., greater number of partners) (Carballo-Dieguez & Dolezal, 1996; Dominguez, 2014; Tremlett 2011). In contrast, Asian gay and bisexual men are stereotyped as sexually submissive and therefore bottoms, with below average penises, and with limited power in sexual negotiation (Han, 2008; Lang, 2014; Wilson & Yoshikawa, 2004). Of

note, White gay and bisexual men are typically not racially stereotyped in ways that have negative implications on their sexuality. White gay and bisexual men are frequently seen as the norm outside or above the racial hierarchy within larger gay and bisexual communities (Wilson et al., 2009). Thus, they enjoy privilege and are stereotypically thought to be the most desirable race of sexual partners among gay and bisexual men (Han, 2007; Plummer, 2007). Although stereotypes regarding racial differences in penis size are fairly consistent, much less is known about size satisfaction. That is, if men do not meet racialized expectations with regard to penis size, are they subsequently less likely to report size satisfaction? All told, these racial stereotypes do not stand alone but are influenced by larger cultural ideas about race and sexuality and, in turn, affect sexual scripts among gay and bisexual men.

Sexual Scripts and Racial Stereotypes

Sexual scripts are cognitive blueprints that guide actions and help people make sense of their sexual behavior (Beres, 2014). These scripts operate at the cultural, interpersonal, and intrapsychic levels (Simon & Gagnon, 1986, 2003). Cultural scripts are collectively developed guidelines that dictate how sexuality is to be performed. Interpersonal scripts are scripts that are developed through one's socialization process and challenge generic scripts to fit within one's personal history with others. Intrapsychic scripts develop as the person develops and are used to assign meaning to his personal experiences. These scripts define the sexual behaviors, attitudes, and roles that are appropriate and accepted within any given context (Reed & Weinberg, 1984). Given the nature of sexual scripts, it is not hard to see how racial stereotypes can influence them at each level. Broad racial stereotypes about the hypermasculinity of Black and Latino men and passivity of Asian men are likely to influence cultural sexual scripts in gay and bisexual communities that cast these men as aggressive or submissive lovers, respectively (Bussel, 2006;

Carballo-Dieguez & Dolezal, 1996; Dominguez, 2014; Fields et al., 2012; Han, 2008; HelloBeautifulStaff, 2011; Tremlett 2011; Wilson et al., 2009; Wilson & Yoshikawa, 2004). Racial stereotypes (at the cultural level) might influence one to see himself (at the intrapsychic level) as an aggressive lover and thus only engage in sexual relationships (at the interpersonal level) with partners who are deemed submissive or less aggressive. There is decidedly less known about how scripts regarding racialized differences in penis size are associated with mens' size satisfaction. Although these connections between racial stereotypes and sexual scripts are informative about how racial stereotypes influence sexual behaviors and beliefs, there is still little quantitative empirical evidence about gay and bisexual men's actual sexual practices that either conform to or challenge such stereotypes.

Current Study

To address gaps in the literature, using a community-based sample of gay and bisexual men from New York City, we sought to determine the extent to which race and ethnicity were associated with (1) racial homophily (among partnered men), (2) sexual behavior and sexual health—including the number of recent male sex partners, CAS, sexual position identity (e.g., top, bottom), sex under the influence of club drugs and STI diagnosis, and (3) perceived penis size and size satisfaction. In so doing, our goal was to add to prior research suggesting that Black, White, Latino, and Asian/Pacific Islander gay and bisexual men's sexual behaviors are, in fact, more similar than they are different. As well, we sought to contribute to empirical data that investigated race-based stereotypes regarding penis size. And, by also investigating size satisfaction, we expand on available literature with regard to an area in which there is little published

METHODS

Participants and Procedure

A cross-sectional, street-intercept method (Miller, Wilder, Stillman, & Becker, 1997) was adapted to survey 1,065 gay and bisexual men at a series of gay, lesbian, and bisexual (GLB) community events in New York City in the fall of 2006 through the *Sex and Love Study*, *version 5.0*. This approach to collecting data has been used in numerous studies (Carey, Braaten, Jaworski, Durant, & Forsyth, 1999; Chen, Kodagoda, Lawrence, & Kerndt, 2002; Kalichman & Simbaya, 2004; Rotheram-Borus et al., 2001), including those focused on GLB persons (Benotsch, Kalichman, & Cage, 2002; Kalichman et al., 2001), and has been shown to provide data that are comparable to those obtained from other more methodologically rigorous approaches, such as time-space sampling (Halkitis & Parsons, 2002).

At both two-day long community events, the research team hosted a booth, and a member of the research team actively approached each person who passed the booth. Potential participants were provided with information about the project and offered the opportunity to participate. The response rate was high, with 83.0% of those approached consenting. The survey required 15-20 minutes to complete, and–to promote confidentiality–participants were handed the survey on a clipboard so that they could step away from others to complete the questionnaire privately. Upon completion, participants deposited their own survey into a secure box at the booth. As an incentive, those who completed the survey were given a voucher for free admission to a movie. Survey data were entered into an SPSS database and checked/verified by project staff for accuracy.

Measures

Demographics

Participants indicated their age (in years), sexual identity (gay, 89.6%; bisexual, 9.1%; or some other MSM identity, 1.3%), education (in ordinal categories), HIV status (HIV-positive, 13.0%; HIV-negative, 76.6%; never tested, 10.3%), income (collapsed into 0 = < $60,000 and 1 = ≥ $60,000), relationship status, whether they had children (0 = no, 1 = yes), and race and ethnicity (by checking all that applied). Response categories to race and ethnicity included "African American/Black," "Asian/Pacific Islander," "European/White," "Latino," and "Other, specify." For the present study, data from Black (n = 152), Asian/Pacific Islander (API; n = 62), Latino (n = 177) and White (n = 618) men were used. Those of multiracial or "other" identities were excluded from analyses (n = 56, 5.3% of the sample). Those in a relationship (n = 401) were asked a follow up question about the race or ethnicity of their partner.

Sexual behavior/health, substance use, and sexuality

Participants were asked about their lifetime diagnoses with or treatment for seven STIs (anal/genital warts HPV; anal/genital herpes HSV-2; crabs/scabies/pubic lice; gonorrhea, Chlamydia or other urinary tract infection; hepatitis B; hepatitis C; and syphilis). Participants indicated if they had recently (< 90 days) engaged in condomless anal sex (CAS) with non-main male partners as a top (0 = no, 1 = yes) and bottom (0 = no, 1 = yes). Men indicated the number of non-main male partners they had sex with (< 90 days), if they had used club drugs (ketamine, MDMA/ecstasy, GHB, cocaine, methamphetamine) in the last 90 days (0 = no, 1 = yes), and if they had sex under the influence of club drugs in the last 90 days (0 = no, 1 = yes). Men indicated their preferred sexual positioning/role (Top 100%; Mostly top; Versatile 50/50; Mostly bottom; Bottom 100%). This was trichotomized (Top and Mostly top were coded "top," Versatile remained "versatile," and Bottom and Mostly bottom were coded "bottom").

Men were asked, "Do you consider your penis size to be?" with response categories "below average," "average," "above average," and "way above average." For this analysis, men indicating "above average" (n = 321, 31.8%) and "way above average" (n = 33, 3.3%) were collapsed into a single category as to preserve statistical power and limit the use of degrees of freedom during chi-square analyses. Men also indicated if they lied to others about their penis size (coded 0 = no, 1 = yes), and if they wished their penis was bigger (coded 0 = no, 1 = yes).

Analytic Plan

We first describe racial and ethnic differences in demographic characteristics (e.g., age, sexual identity, income, education, HIV-status, relationship status). Where appropriate, chi-square and ANOVA F tests were used. As a post hoc for ANOVA, Bonferroni tests were used for group comparisons, and as a post hoc for chi-square, partial chi-square was used. Next, we describe the extent in which, among men in relationships, participant's race was dependent or independent of his partner's (i.e., racial homophily) using crosstables, column percentages, and a chi-square test for independence.

Third, we compared racial and ethnic differences across various indicators of sexual behavior and sexual health. These included number of recent casual male sex partners, lifetime STI diagnoses, anal sexual role (top, bottom, versatile), CAS and recent club drug use as well as sex under the influence of club drugs. We also examined bivariate racial and ethnic differences in perceived penis size, size satisfaction, and lying to others about penis size. Where appropriate, chi-square and ANOVA F tests were used. As a post hoc for ANOVA, Bonferroni tests were used for group comparisons, and as a post hoc for chi-square, partial chi-square was used.

Finally, we ran a series of multinomial logistic regressions with race or ethnicity as the dependent variable. Multinomial logistic regression compares multiple groups through a

combination of binary logistic regressions. As such, we compared Black men with API, White, and Latino men; API with White, and Latino men; and White with Latino men. Independent variables included age (under 40 = 0, 40+ = 1), self-identification as gay (1 = yes), income over $60,000 (1 = yes), having a college education (1 = yes), HIV-positive (1 = yes), prior diagnosis for genital warts (1 = yes), crabs (1 = yes), or hepatitis B (1 = yes), and perceiving one's penis size as average (1 = yes, 0 = no). These items were selected because they were significant at the bivariate level.

RESULTS

Table 1 reports characteristics of the sample across racial and ethnic group. Ages ranged from 18 to 90. White men were significantly older than others and a larger portion of White men reported earning an income over $60,000 compared to Black, Latino, and API men. Compared to others, a significantly smaller portion of Black men self-identified as gay. API and White men reported more education than Black and Latino men. Consistent with published data discussed in the introduction, significantly larger proportions of Black and Latino men indicated they were diagnosed HIV-positive compared to others, and API men were the least likely to report being HIV-positive.

Race and ethnicity were unassociated with relationship status. However, for men in relationships, there was strong evidence of racial homophily, particularly for Black and White men. That is, 61% of Black men said their partners were also Black and 71% of White men said their partner was also White. Latino men appeared to be the most diverse with regard to partners' race, but they still partnered with other Latino men at higher rates than other groups (e.g., 44% of Latino men said their partner was also Latino compared with only 16.9% of Black men who said their partner was Latino).

--Table 1--

Table 2 reports on racial and ethnic differences in STI history, sexual behavior, substance use, and perceived penis size and satisfaction. There were no racial or ethnic differences with regard to the number of recent casual male sex partners, CAS with casual male partners (either insertive or receptive), recent club drug use, or sex under the influence of club drugs. In addition, race and ethnicity were unassociated with sexual position identity (i.e., top, bottom, versatile) and lifetime history of genital herpes, hepatitis C, syphilis, or Chlamydia, gonorrhea, or other urinary tract infections. Race and ethnicity were associated with genital warts, crabs, and hepatitis C. A significantly smaller proportion of API men reported genital warts than White, Black, and Latino men. And, compared to others, a significantly larger proportion of White men reported crabs/scabies/pubic lice. Compared to API and Latino men, a significantly larger proportion of White men reported hepatitis B diagnosis.

There were some racial and ethnic differences in perceived penis size such that, compared to others, a larger proportion of API men perceived their penis size to be average. And, compared to White men, a significantly larger proportion of Black men perceived their penis to be above average. However, there were no racial or ethnic differences in satisfaction with penis size or lying to others about one's penis size.

--Table 2--

Lastly, we performed a series of multinomial logistic regressions with race and ethnicity as the dependent variable (see Table 3). Independent variables included age, self-identification as gay, income, education, HIV-positive serostatus, penis size, and lifetime exposure to genital warts, crabs, and hepatitis B. Several significant associations that were observed at the bivariate level remained significant after controlling for other variables. These included the observed

associations between race/ethnicity and sexual identity, education, and prior experience with crabs/scabies/pubic lice. Meanwhile, the significant bivariate associations between race/ethnicity and genital warts and hepatitis B were no longer significant in multivariable models.

Controlling for other variables, White men had higher odds of being older than Latino men. Similarly, White men had significantly higher odds of earning over $60,000 than API and Latino men, but not Black men. Controlling for other variables, compared to Black and White men, API men had significantly greater odds of perceiving their penis size as average.

--Table 3--

DISCUSSION

Using a large community-based sample of gay and bisexual men, this study compared Black, White, Latino, and API men across a variety of characteristics. We found race and ethnicity were associated with some demographic characteristics (e.g., education, income) and HIV-positive diagnosis that were consistent with published research (CDC, 2012). Additionally, findings provided empirical evidence both supporting and challenging the influence of racial stereotypes on gay and bisexual men's sexual scripts. Our findings suggest that racial stereotypes about men of color being sexually "promiscuous" or submissive do not significantly impact these men's scripts in ways that contributed to them engaging in stereotypical sexual behavior. The Black and Latino gay and bisexual men in our sample did not behave in "sexually aggressive" (operationalized through the number of recent partners and sexual positioning) or "irresponsible" (operationalized through CAS and sex under the influence of club drugs) manners any more than White gay and bisexual men. Analyses indicate that disproportionate HIV prevalence among Black and Latino men is *not* a factor of these men having more sex partners or more CAS, anal sexual positioning, or having sex under the influence of club drugs. This too adds further support

to research suggesting that, compared to White gay and bisexual men, men of color engage in equivalent or lower levels of behaviors that would put them at risk for HIV infection (Millett et al., 2007; Millett, Peterson, Wolitski, & Stall, 2006). The influence of racial stereotypes that cast Asian gay and bisexual men as passive, and therefore more likely to engage in interpersonal sexual scripts where they are receptive partners (i.e. bottoms), and Black men as sexually dominant, and therefore insertive partners (i.e. tops), were not supported in our data. These findings suggest that gay and bisexual men of color express versatility in their sexual relationships. This versatility has implications for HIV prevention as it could facilitate strategic positioning (i.e. HIV-negative men taking the insertive role in CAS with his HIV-positive partners) which has been shown to be an effective harm reduction strategy for HIV risk (Jin et al., 2009; Parsons et al., 2005).

Race and ethnicity were associated with perceptions of penis size that were consistent with racial stereotypes. Therefore, it does seem that racial stereotypes about penis size (i.e. Black men have larger penises and Asian men have smaller penises) influence intrapsychic sexual scripts about how men perceive themselves. However, we highlight that the results indicated that overall—and across *all* groups—the majority of participants perceived their penis size to be average. Thus, although some differences were observed that were consistent with racial stereotypes, the magnitude of these differences was insufficient to justify the stereotypes. In addition, although there were some racial and ethnic differences in perceived penis size, there were no significant differences with regard to size satisfaction or lying to others about penis size.

Consistent with prior research (Clerkin et al., 2011; Newcomb & Mustanski, 2013), there was strong evidence of racial homophily among men who were in relationships, particularly for White and Black men. In fact, there was such strong evidence of dependence (i.e., overlap

between the participant's race and that of his partner's) that expected counts fell below five in 40% of cells in the contingency table (e.g., no Black men reported Asian partners and no Asian men reported Black partners), and thus the chi-square value should not be interpreted. As a result, our interpretation of racial homphily was based on column percentages, as with previous research (Newcomb & Mustanski, 2013).

Racial homophily among gay and bisexual men may be related to racial stereotypes that influence sexual scripts at the cultural, interpersonal, and intrapsychic levels. For example, racial stereotypes at the cultural sexual script level purport that Latino men are "ravenous" lovers, with low sexual-self-control and therefore "promiscuous." At the interpersonal level, these stereotypes might contribute to gay and bisexual men of other races developing sexual scripts that cast Latino men as unfaithful and sexually irresponsible partners. At the intrapsychic level, such stereotypes may cause men of other races to think, "If I want a faithful partner, I should not date Latino men" and thus refuse to engage in relationships with Latino men. Given that we found that men of color do not have more partners and do not engage in more CAS, but still bear higher HIV prevalence, it is possible that stereotype- and racism-driven racial homophily may be what continues to perpetuate racial disparities in HIV among gay and bisexual men. In essence, "It is not what you do with your partners; it is what sexual networks are *available* to you" (c.f., Millett et al., 2007; Mustanski et al., 2014; Wilson et al., 2009).

Although we do not have biological data on STIs, there were no significant bivariate racial or ethnic differences in four of the seven STI groups men self-reported on. In addition, lifetime exposure for two of the remaining three STIs (genital warts, hepatitis B) was not significantly associated with race or ethnicity in multivariate models. It may be that observed associations seen at the bivariate level were better explained by age differences across groups—

White participants were older in our study, and older individuals are more likely to report a greater number of lifetime partners and to have been exposed to an STI (Coburn & Blower, 2010; Hurt et al., 2010; Joseph et al., 2011; Oster et al., 2011). It is noteworthy that our measure was of lifetime exposure. Other measurements of STIs including biological assessments, or recent exposure (e.g., last 12 months) would be equally important to assess, especially in light of CDC data suggesting that racial/ethnic disparities persist in rates of STIs (Hogben & Leichliter, 2008; Sullivan et al., 2014).

Our findings provide support for the hypothesis that racial stereotypes fueled by racism may contribute to the high burden of HIV in racial and ethnic minority gay and bisexual men's sexual networks via racial homophily. Individual and network factors, and multilevel policy initiatives that address racism via its correlates (e.g. poverty, systemic educational barriers, and incarceration) may be effective to ameliorate the negative effects of racism in gay and bisexual men's lives. Structural level race-based economic and cultural discrimination has implications for men at the community and individual level such as fostering medical mistrust related to HIV testing and treatment and confidentiality related to these processes (Bogart & Thorburn, 2006; Thorburn-Bird & Bogart, 2005), low access to HIV drugs because of economic difficulties (Millett et al., 2012), and almost no HIV prevention initiatives that are culturally-specific and developed for and by gay and bisexual racial and ethnic minority men (Nelson, Walker, DuBois, & Giwa, 2014). Policies are needed that increase access to quality and culturally affirming education, economic opportunities, fair criminal justice treatment, and access to culturally-sensitive medical care. Such policies can help decrease the effects of racism that contribute to higher HIV prevalence in racial and ethnic minority communities and thus make racial homophily a risk factor.

Our findings should be understood in light of this study's limitations. First, these data do not generalize to all gay and bisexual men, as this sample was limited to those who attended large-scale GLB events in New York City. Furthermore, as these analyses drew from cross-sectional data, causality between variables should not be inferred, nor do these analyses rule out the potential for confounding effects from other variables not assessed. This sample does, however, give a comprehensive picture about the types of individuals that attend large scale GLB events, and comprise a considerable (and accessible) portion of the gay, bisexual, and MSM communities in New York City. Although efforts were taken to ensure confidentiality, there was potential for biased responses due to social desirability in the reporting of sensitive information. In addition, analyses are based on data collected in 2006. Behavior patterns and attitudes about race, racism, and race relations in and among gay and bisexual communities may have shifted since these data were collected. As with all social research, these factors must be considered when evaluating the findings.

The survey instrument used for this analysis assessed a broad range of variables related to demographic characteristics and sexual health. Such an instrument helps provide a general perspective about a variety of characteristics; however, it has its limitations. Consistent with the brief street-intercept survey method (Miller et al., 1997), many of the questions on this survey were quantitative and closed-ended. There are many arenas where additional contextualization may help to better explain findings. For example, it would be important to investigate the race and age of partners to determine if sexual behavior varies based on these characteristics (Hurt et al., 2010; Joseph et al., 2011; Newcomb & Mustanski, 2013). Likewise, it would be important to investigate the extent to which sexual position identity coincides with actual sexual behavior (Wei & Raymond, 2011). Questions regarding CAS were limited to non-main partners. Since

these data were collected, researchers have highlighted that a significant number of new HIV infections are via main partners and thus sexual behavior with main partners remains an important area for future investigations (Sullivan, Salazar, Buchbinder, & Sanchez, 2009). In addition, this study did not ask about men's beliefs regarding racial stereotypes among gay and bisexual men or if they themselves held such stereotypes. It would also be beneficial to specifically measure the level to which gay and bisexual men hold racial stereotypes and how these levels relate to their sexual behaviors and beliefs. It should be noted that due to concerns about interpretability and statistical power, some variables (e.g. HIV status, sexual orientation) were dichotomized. This should be considered when making inferences related to specific categories of men who do not identify as gay (e.g. bisexual, queer) and to people who did not know their HIV status.

Finally, in an effort to increase response rates for questions on penis size, men were not asked to report a numeric measurement (i.e., in inches or cm), but rather select from a nuanced range of values (i.e., average, above average) about their perceived penis size. Our use of a non-metric scale to capture perceptions of penis size reduces some precision; however, a numeric measure (i.e., inches) is still subject to self-report biases, as not all men have actually measured their penis, and those who have may not use identical levels of precision (Grov, Wells, & Parsons, 2013). We do not know men's basis for comparison (e.g., was it against men of the same race or all races?). Therefore findings should be specifically understood as relating to perceptions of penis size and do not provide any information about actual penis size.

Conclusion

This study investigated the extent to which race and ethnicity were associated with key facets of gay and bisexual men's lives, including their penis size and satisfaction and racial

homophily. Although race and ethnicity were associated with several demographic characteristics, it was largely unassociated with multiple dimensions of sexual risk behavior and sexual positioning. In many ways, our findings challenge racialized stereotypes with regard to sexuality and sexual behavior, thus our findings provide evidence for the dismantling of social policy and structural factors that contribute to racism.

With regard to factors that perpetuate racial and ethnic disparities in HIV among gay and bisexual men, sexual behavior does not appear to be a contributing factor; meanwhile partner characteristics (i.e., racial homophily) do. HIV prevalence is higher among Black and Latino gay and bisexual men (CDC, 2012), and by virtue of racially homophilous partnering, Black and Latino men are highly likely to come in contact with HIV-positive partners. In essence, it is not *what* happens during sex, but with *whom* it happens. Here too our data highlight the need to develop social policies that foster increased access to and education about a range of HIV prevention strategies that are disaggregated from any roots in race-based stereotypes about sexual behavior.

Future research should explore the drivers of racially homophilous sexual partnering, as well as any protective benefits offered by this type of partnering. This may inform strengths-based prevention efforts that take into account nuanced understandings of race in men's sexual behaviors. It would also be beneficial to quantitatively measure the level to which gay and bisexual men hold racial stereotypes and how these levels relate to their sexuality. In addition, more research is needed to better understand racial stereotypes about White gay and bisexual men held by both men of color and White men. Research has established that racial/ethnic minority men do not participate in more sexual risk behaviors than White gay and bisexual men (Millett et al., 2007; Millett et al., 2006) consequently, addressing the socio-structural drivers of

disproportionate HIV rates, such as racism within the LGBT community will be an important next step for both research and social policy.

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Table 1. Racial and ethnic differences in demographic characteristics

	Af. Amer./Black *n* = 152 Group A		Asian/ Pacific Islander *n* = 62 Group B		White *n* = 618 Group C		Latino *n* = 177 Group D				
	M	SD	*M*	SD	*M*	SD	*M*	SD	*F*	*p*	Post hoc[1]
Age in years, range 18 - 90	36.9	11.0	33.0	8.4	40.2	13.1	32.8	10.1	21.55	< .001	C > A, B, D; D < A
	n	%	*n*	%	*n*	%	*n*	%	χ^2	*p*	
Self-identified as gay											
Yes	114	75.0	59	95.2	566	91.6	165	93.2	41.90	< .001	A < B, C, D
Income											
< $60,000	102	71.3	44	75.9	313	54.1	124	77.0	40.91	< .001	A, B, D ≠ C
≥ $60,000	41	28.7	14	24.1	266	45.9	37	23.0			
Education											
Some college or less	59	41.0	13	22.0	115	19.7	66	40.2	53.37	< .001	A, D ≠ B, C
College degree	60	41.7	23	39.0	268	45.9	64	39.0			
More than a college degree	25	17.4	23	39.0	201	34.4	34	20.7			
HIV-positive											
Yes	30	21.0	1	1.7	64	10.6	33	19.2	25.53	< .001	A, D > B, C; B < C
Relationship status											
Single	84	58.7	33	55.9	332	57.7	91	54.5	3.05	0.80	
Non-monogamous	24	16.8	10	16.9	103	17.9	25	15.0			
Monogamous	35	24.5	16	27.1	140	24.3	51	30.5			
Partner's race or ethnicity (among those in a relationship), valid *n* = 401											
Af. Amer./ Black	36	61.0	0	0.0	20	8.3	8	10.7	--		
White	12	20.3	15	60.0	172	71.1	27	36.0			
Latino	10	16.9	2	8.0	23	9.5	33	44.0			
Asian/Pacific Islander	0	0.0	6	24.0	19	7.9	1	1.3			
Multi-racial/other	1	1.7	2	8.0	8	3.3	6	8.0			

-- Chi-Square cannot be interpreted, 40% of cells have an expected count below 5

[1] Bonferroni for ANOVA, Partial Chi-Square for Chi-Square

Table 2. Racial and ethnic differences in sexual behavior, STI diagnosis, and penis size

	Af. Amer./Black n = 152 Group A		Asian/ Pacific Islander Group B		White n = 618 Group C		Latino n = 177 Group D				
	M	SD	*M*	SD	*M*	SD	*M*	SD	*F*	*p*	Post hoc[2]
Number of casual male partners, < 90 days, single and non-monogamous men only, valid n = 653	4.7	9.4	4.0	9.1	4.3	7.2	3.4	6.0	0.51	0.68	
	n	%	*n*	%	*n*	%	*n*	%	χ^2	*p*	
Lifetime STI diagnosis											
Genital warts	22	15.0	2	3.4	111	18.5	21	12.4	11.33	0.01	B < A, C, D; D < C
Genital herpes	10	6.8	0	0.0	43	7.2	11	6.5	4.49	0.21	
Crabs, scabies, pubic lice	34	23.0	10	17.2	285	47.1	37	21.8	65.39	< .001	C > A, B, D
Chlymadia, gonorrhea, or Urinary tract infection	31	20.9	8	13.8	141	23.4	28	16.6	5.79	0.12	
Hep. B	9	6.2	1	1.8	58	9.7	6	3.6	10.75	0.01	B, D < C
Hep. C	8	5.5	0	0.0	22	3.7	6	3.6	3.53	0.32	
Syphilis	19	12.8	1	1.7	51	8.5	19	11.2	7.37	0.06	
Anal sex role											
Top (insertive)	85	40.6	18	30.0	205	34.2	52	31.1	7.57	0.27	
Versatile	55	38.5	20	33.3	238	39.7	66	39.5			
Bottom (receptive)	30	21.0	22	36.7	156	26.0	49	29.3			
Anal sexual behavior with casual male partners, < 90 days											
Insertive, no condom	27	27.6	6	15.0	79	19.6	28	27.5	6.10	0.11	
Receptive, no condom	16	16.5	6	15.0	80	19.8	20	19.8	1.00	0.80	
Any condomless sex (receptive or insertive)	29	29.9	7	17.5	110	27.1	33	32.4	3.48	0.32	
Club drug[1] use, < 90 days											
Yes	27	19.1	8	13.6	94	15.9	21	12.7	2.66	0.45	
Sex under the influence of club drugs[1], < 90 days											
Yes	15	10.9	4	6.8	59	10.1	12	7.4	1.88	0.60	
Perceived penis size											
Below avg.	4	2.9	7	12.1	47	7.7	7	4.2	26.89	< .001	A ≠ C; B ≠ A, C, D
Avg.	72	51.4	44	75.9	334	55.0	104	61.9			
Above avg.	84	45.7	7	12.1	226	37.2	57	33.9			
Wishes penis was larger											
Yes	44	31.7	26	44.1	204	33.8	48	29.1	4.63	0.20	
Has lied to others about penis size											
Yes	46	33.3	25	43.9	216	35.6	57	34.3	2.12	0.55	

[1] Club drugs include ketamine, ecstasy/MDMA, GHB, cocaine, and methamphetamine

[2] Partial chi-square

Table 3. Multinomial logistic regression contrasting race or ethnicity

	White			Asian/Pacific Islander			Af. Amer./Black		
SECTION A. Referent outcome group: Latino men	AOR	95% CI	*p*	AOR	95% CI	*p*	AOR	95% CI	*p*
Age 40 or over	**1.87**	1.21 -- 2.91	0.01	1.23	0.57 -- 2.65	0.60	1.30	0.75 -- 2.25	0.35
Self-identified as gay	0.74	0.34 -- 1.58	0.43	0.99	0.26 -- 3.86	0.99	**0.28**	0.13 -- 0.61	0.002
Income is over $60K	**1.98**	1.27 -- 3.10	< .001	0.99	0.46 -- 2.11	0.97	1.38	0.78 -- 2.44	0.27
Has at least college education	**2.20**	1.44 -- 3.36	< .001	**2.78**	1.25 -- 6.17	0.01	1.04	0.62 -- 1.75	0.87
HIV-positive	**0.28**	0.16 -- 0.51	< .001	**0.10**	0.01 -- 0.75	0.03	0.94	0.48 -- 1.83	0.86
STI diagnosis									
Genital warts	1.49	0.82 -- 2.72	0.19	0.44	0.09 -- 2.04	0.29	1.13	0.53 -- 2.42	0.75
Crabs	**2.41**	1.52 -- 3.80	< .001	0.75	0.31 -- 1.82	0.53	0.95	0.52 -- 1.73	0.86
Hep. B	2.56	0.86 -- 7.63	0.09	1.00	0.10 -- 9.52	1.00	1.79	0.48 -- 6.76	0.39
Perceives penis size as average	0.75	0.50 -- 1.12	0.16	1.68	0.79 -- 3.53	0.18	0.61	0.37 -- 1.01	0.06

	White			Asian/Pacific Islander		
SECTION B. Referent outcome group: Af. Amer./Black men	AOR	95% CI	*p*	AOR	95% CI	*p*
Age 40 or over	1.45	0.92 -- 2.26	0.11	0.95	0.44 -- 2.07	0.90
Self-identified as gay	**2.65**	1.47 -- 4.78	< .001	**3.58**	1.00 -- 12.82	0.05
Income is over $60K	1.43	0.91 -- 2.26	0.12	0.71	0.33 -- 1.54	0.39
Has at least college education	**2.11**	1.34 -- 3.31	< .001	**2.66**	1.17 -- 6.02	0.02
HIV-positive	**0.30**	0.17 -- 0.55	< .001	**0.10**	0.01 -- 0.80	0.03
STI diagnosis						
Genital warts	1.32	0.71 -- 2.44	0.38	0.39	0.08 -- 1.81	0.23
Crabs	**2.54**	1.56 -- 4.15	< .001	0.79	0.32 -- 1.96	0.62
Hep. B	1.43	0.57 -- 3.62	0.45	0.56	0.06 -- 4.95	0.60
Perceives penis size as average	1.22	0.81 -- 1.86	0.34	**2.73**	1.28 -- 5.81	0.01

	White		
SECTION C. Referent outcome group: Asian/Pacific Islander men	AOR	95% CI	*p*
Age 40 or over	1.52	0.76 -- 3.03	0.23
Self-identified as gay	0.74	0.22 -- 2.54	0.63
Income is over $60K	**2.01**	1.02 -- 3.94	0.04
Has at least college education	0.79	0.37 -- 1.69	0.54
HIV-positive	2.95	0.39 -- 22.50	0.30
STI diagnosis			
Genital warts	3.40	0.79 -- 14.49	0.10
Crabs	**3.21**	1.44 -- 7.14	0.004
Hep. B	2.58	0.33 -- 20.00	0.36
Perceives penis size as average	**0.45**	0.23 -- 0.89	0.02

All independent variables are coded "1 = yes" and "0 = no"

AOR: Adjusted Odds Ratio, CI: Confidence Interval

[1] Club Drugs include ecstasy, ketamine, cocaine, methamphetamine, and GHB

Significant odds ratios ($p \leq .05$) in **bold**