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Multifactorial discrimination, discrimination salience, and prevalent experiences of internalized homophobia in middle-aged and older MSM

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Abstract

Objectives: We sought to test whether discrimination salience and multifactorial discrimination were associated with prevalent experiences of internalized homophobia among middle-aged and older men who have sex with men (MSM).

Methods: We analyzed data from 498 middle-aged and older MSM from the Multicenter AIDS Cohort Study (MACS) who reported any lifetime discrimination experience. We estimated the prevalence ratio of current internalized homophobia using multivariable Poisson regressions, accounting for discrimination salience, multifactorial discrimination, and covariates. We then assessed whether multifactorial discrimination moderated the association between discrimination salience and internalized homophobia.

Results: Over half (56.4%) of our sample reported any current experience of internalized homophobia. More than two-thirds reported multifactorial discrimination (68.2%) and more than one-third (36.7%) reported moderate-to-high discrimination salience. Increases in discrimination

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salience (*PR* = 1.11; *95% CI:* 1.03-1.20) were associated with any current internalized homophobia among middle-aged and older MSM. Multifactorial discrimination was not statistically associated with internalized homophobia and did not moderate the association between discrimination salience and internalized homophobia.

Conclusions: Our study underscores internalized homophobia as a persisting concern among MSM in midlife and older adulthood. Our findings suggest that salience, as a characteristic of discrimination experiences, may have a greater impact on internalized homophobia compared with exposure. Future research efforts should assess facets of discrimination salience, such as severity, frequency, and chronicity, to better understand how discrimination shapes psychosocial well-being across the life course. Mental health advocates at policy, organizational, and community levels should aim to reduce intersectional stigma and address individual experiences of internalized homophobia.

Keywords

Middle-aged; internalized homophobia; stigma; MSM

Introduction

Across the life course, men who have sex with men (MSM) bear a greater burden of poor mental health conditions compared to their heterosexual counterparts (Fredriksen-Goldsen et al., 2014; Wight, LeBlanc, de Vries, & Detels, 2012; Yarns, Abrams, Meeks, & Sewell, 2016). These disparities are even more pronounced among racial/ethnic minority MSM and MSM living with HIV (i.e., multiple marginalized identities) (Yarns et al., 2016). One noticeable area that has received little attention and focus in prior research efforts is prevalent experiences of internalized homophobia among MSM as they age into older adulthood (Grossman, D'Augelli, & O'Connell, 2001; Herrick et al., 2013).

Internalized homophobia is the inward projection of societal-level homophobia and antigay discrimination and remains an important health concern for men who have sex with men across the life course (Newcomb & Mustanski, 2011). It is commonly classified as a sexual minority stressor (an excess stressor attributed to being a sexual minority) that for many MSM persists into older age and elevates one's risk for negative psychosocial outcomes (e.g., loneliness, diminished social support, suicide ideation), poor mental health (e.g., depression), and substance use disorders (Grossman et al., 2001; Jacobs & Kline, 2012; Kim & Fredriksen-Goldsen, 2016; Masini & Barrett, 2008; Meyer, 2013; Reisner et al., 2011; Wight et al., 2012; Yarns et al., 2016). Additionally, prior studies of primarily young adult samples have demonstrated a greater prevalence of internalized homophobia among racial minorities, particularly Black/African American MSM, compared to White/Caucasian MSM as well as among HIV-positive MSM compared to HIV-negative MSM (Amola & Grimmett, 2015; O'Leary, Fisher, Purcell, Spikes, & Gomez, 2007). Few efforts have elucidated these differences among MSM in middle-aged and older (Herrick et al., 2013).

Despite these risk factors, one prior study indicated that many MSM reconciled experiences of internalized homophobia since realizing their attractions to men. However, more than one-third of their participants aged 45 years and older reported current experiences of

internalized homophobia, which is a steep decrease from the 70% of MSM who indicated internalized homophobia at early stages of coming to terms with one's same-sex attractions (Herrick et al., 2013). This is likely a reflection of stigma competency; specifically, MSM learn to cope with and reconcile experiences of homophobia by tapping into sources of resiliency (David & Knight, 2008; Schope, 2005). Exhibiting stigma competency entails health promotive strategies in dealing with stigma as it emerges in various contexts of one's life, such as facing homophobia, racism, and ageism (David & Knight, 2008).

Middle-aged and older MSM came of age when there were few protections for sexual minorities, increasing their susceptibility to antigay discrimination; MSM were excluded or poorly treated because of their sexual orientation (Stuber, Meyer, & Link, 2008). Many were also the primary targets of HIV-related stigma given the pervasive stereotypes that linked MSM to the HIV epidemic (Herek, 1999). Middle-aged and older MSM experience social stress attributed to intersecting social identities, including age, race/ethnicity, sexual orientation, and HIV serostatus, across the life course (Bogart et al., 2017; Bowleg, 2013; Slevin & Linneman, 2010; Williams, Wyatt, Resell, Peterson, & Asuan-O'Brien, 2004). Interconnected experiences of stigma (e.g., stigma experienced by MSM who are also racial/ethnic minorities) likely contribute to the production and persistence of internalized homophobia over the years.

Although discrimination is a known correlate of internalized homophobia, to our knowledge, few studies have examined who may be most vulnerable in older adulthood among MSM. Many researchers have tested sexuality-specific stigma as the primary oppressive source that elicits internalized homophobia (Morrow, 2001). However, this theoretical approach ignores how multiple forms of marginalized identities affect oppression (Khan, Ilcisin, & Saxton, 2017; Szymanski, Kashubeck-West, & Meyer, 2008). A recent study of MSM demonstrated internalized homophobia reconciliation was associated with correlates that were not related to sexuality including the absence of a syndemic (composite of negative psychosocial conditions) and low general stress (related to job, finances, or health) (Herrick et al., 2013).

Persistent internalized homophobia in older MSM may also be determined by factors such as discrimination salience and multifactorial discrimination. *Discrimination salience* refers to an individual's perceived enduring effect of a stressor (e.g., discrimination), which may be a facet of the nature, degree, type, and chronicity of the event (Szymanski et al., 2008; Thoits, 1991). *Multifactorial discrimination* is the total number of discrimination types experienced by individuals accounting for their social identities such as race/ethnicity, sex, and sexual orientation (Khan et al., 2017). Multifactorial discrimination addresses how those who are a part of and identify with multiple marginalized groups experience oppression. Specifically, those who belong to multiple marginalized communities are at elevated risk for multifactorial discrimination.

In this investigation, we examine the associations between current experiences of internalized homophobia, discrimination salience, and multifactorial discrimination. We focus on middle-aged and older MSM who have reported any prior discrimination experience. In this study, we aim to:

- Describe the prevalence of lifetime multifactorial discrimination exposure and discrimination salience;
- Assess the main associations between multifactorial discrimination and discrimination salience with current experiences of internalized homophobia;
- Test whether multifactorial discrimination exposure moderates the association between discrimination salience and current experiences of internalized homophobia; and
- Examine how identifying with multiple marginalized communities is associated with current internalized homophobia.

We have 3 hypotheses. First, among middle-aged and older MSM, increased levels of multifactorial discrimination and discrimination salience will be associated with increased levels of current internalized homophobia. Second, multifactorial discrimination exposure will modify the association between discrimination salience and current experiences of internalized homophobia. Specifically, middle-aged and older MSM reporting both greater multifactorial discrimination and increased discrimination salience will be more likely to report current internalized homophobia compared with men who report fewer experiences of discrimination or lower discrimination salience. Third, we hypothesize that participants who identify with multiple marginalized identities will be more likely to report current experiences of internalized homophobia compared to those who do not. Specifically, compared with HIV-negative and non-Hispanic white MSM, HIV-positive and racial/ethnic minority MSM will be more likely to report internalized homophobia.

Methods

Multicenter AIDS cohort study

We use data from the Multicenter AIDS Cohort Study (MACS), a 33-year ongoing prospective study of the HIV epidemic among MSM in the United States. Procedures have been described in prior studies (Kaslow et al., 1987; Dudley et al., 1995). Nearly 7,000 (1984–1985: n = 4,954; 1987-1991: n = 668; 2001-2003: n = 1,350). MSM were recruited in Los Angeles, CA; Chicago, IL; Pittsburgh, PA; and Baltimore, MD/Washington, DC. Every 6 months, MACS participants completed a battery of assessments including physical examinations, blood tests, and a behavioral health questionnaire. Instruments for the MACS are accessible at www.aidscohortstudy.org.

We recruited participants as part of an ongoing MACS sub-study, *Patterns of Healthy Aging Among Men Who Have Sex With Men.* Men were eligible to participate if they were present at 2 consecutive MACS visits, reported being 40 years of age or older, and if they reported sexual intercourse with another man at least once since enrolled in the MACS. The data for this analysis includes unique participants from the first 2 waves of the healthy aging sub-study (visits 65 [April 2016–October 2016] and 66 [October 2016–April 2017]). Responses to the healthy aging sub-study for each participant were linked to their demographic data (e.g., MACS identification number, age, HIV status, and race/ethnicity; originally collected at MACS enrollment and updated at subsequent MACS visit [e.g., visits 65 and 66]) housed at the Center for the Analysis and Management of MACS data (CAMACS; Johns Hopkins

Bloomberg School of Public Health). The final sample included 1,193 middle-aged and older MSM; however, this analysis reports only on men who reported any experience of discrimination. Our final analytic sample included 498 middle-aged and older MSM (41.7%).

Measures

Outcome..

Current Internalized Homophobia.: We included a 10-item scale assessing participants' positive (e.g., *I was happy to be gay/bisexual*) and negative (e.g., *I tried to stop being attracted to men in general*) attitudes regarding their sexual orientation and attraction to men (Herek, Cogan, Gillis, & Gunt, 1997). Items were scored on a 5-point Likert scale (0 = strongly disagree to 4 = strongly agree), with higher scores representing high levels of internalized homophobia. The internalized homophobia scale yielded high internal consistency (Cronbach's $\alpha = 0.88$). We subsequently recoded participants' internalized homophobia into a dichotomous variable (0 = no internalized homophobia or 1 = any internalized homophobia) (Herrick et al., 2013). A score of 1 (any internalized homophobia) reflected participants who reported *agree* or *strongly agree* to any of the internalized homophobia scale items. We dichotomized internalized homophobia for two reasons. First, this dichotomization remains consistent with prior analyses that explored internalized homophobia with the MACS sample (Herrick et al., 2013). Second, the primary objective of this analysis was to focus on the prevalence rather than the magnitude of internalized homophobia, given that prior findings indicated that many MSM reconcile experiences of internalized homophobia by midlife and older age (Herrick et al., 2013).

Primary Independent Variables..

Multifactorial Discrimination Exposure.: We asked participants 7 items from the Major Experiences of Discrimination Scale (Williams et al., 2008). These items ascertained sector-specific discrimination (e.g., employment, housing, and public accommodations) that participants might have experienced across the life course. Participants who reported any of these experiences then indicated up to 3 reasons why they believed the event occurred. These reasons included their age, sex, race, ethnicity/nationality, religion, height, weight, and other aspect of physical appearance, physical disability, sexuality, and HIV status. After collapsing race/ethnicity attributions and physical appearance — related attributions (height, weight, and other aspect of physical appearance), we created dichotomous variables to indicate attribution-specific discrimination (e.g., *Any Lifetime Sexuality-Related Discrimination;* 0 = none or 1 = any). For example, participants who reported sexuality-related discrimination in employment, housing, public accommodations, or any combination thereof would receive a score of 1 for the variable, *Any Lifetime Sexuality-Related Discrimination.* To create the multifactorial discrimination exposure variable, we summed the attribution-specific discrimination variables (i.e., sum of dichotomous variables for Any [1] Age-, [2] Sex-, [3] Race/Ethnicity-, [4] Sexuality-, [5] HIV-, [6] Physical Appearance-, and [7] Other-related discrimination; range, 0 to 7 types). After assessing the variation of this summation, we recoded participants who had a summation score of 4 or more with those who reported 3

types. The final scaling of multifactorial discrimination exposure was 1 = 1 discrimination type, 2 = 2 discrimination types, and 3 = 3 or more discrimination types.

Discrimination Salience.: We offered 1 item that asked the extent to which participants' discrimination experiences interfered with their ability to live a full and productive life. This item was scored on a 4-point Likert scale (0 = not at all, 1 = a little, 2 = some, and 3 = a lot).

Covariates..—Participants self-reported their birth date (age), race/ethnicity (0 = non-Hispanic white or 1 = non-Hispanic black), sexual identity (0 = Gay, 1 = Bisexual, 2 = Other MSM Identity), HIV serostatus (0 = Negative, 1 = Positive), and level of educational attainment (0 = High School or Less, 1 = More than High School/GED). We also recoded their unique participant identification number to indicate in which wave of the MACS (0 = before 1987; 1 = after 2001) they enrolled.

Data analytic strategies

Using IBM SPSS Statistics for Windows, Version 24.0 (IBM Corp., Armonk, NY), we generated descriptive reports of internalized homophobia by participants' sociodemographic characteristics, experiences of multifactorial discrimination, and discrimination salience scores (aim 1). Given the distribution of internalized homophobia scores, we performed Poisson regression models with robust error variance to estimate the unadjusted prevalence ratios (*PR*) of current internalized homophobia by multifactorial discrimination exposure, discrimination salience, and covariates, respectively (Barros & Hirakata, 2003; Coutinho, Scazufca, & Menezes, 2008; Knoll, Le Cessie, Algra, Vandenbroucke, & Groenwold, 2012). For aim 2, we developed a model to estimate the adjusted prevalence ratio for current internalized homophobia accounting for multifactorial discrimination exposure and discrimination salience on current internalized homophobia, adjusted for sociodemographic covariates. For the last aim, we developed a subsequent model to determine whether exposure to multifactorial discrimination moderated the relationship between discrimination salience in estimating current internalized homophobia, adjusted for sociodemographic covariates. We also included the interactions of race/ethnicity by HIV serostatus to account for identification with multiple marginalized statuses (Bogart et al., 2017; Bowleg, 2013). Lastly, we tested an interaction between age and enrollment wave given a potential cohort effect in estimating internalized homophobia arising from age differences at wave of enrollment. Specifically, those enrolled after 2001 are more likely to be in middle age than those enrolled before 1987. Therefore, if the reconciliation of internalized homophobia decreases over time, those enrolled in after 2001 may report greater internalized homophobia.

Results

Participants

Sample characteristics were generated and presented by internalized homophobia group in Table 1. The mean (SD) age of our sample was 60.18 (8.47) years. Our sample was predominantly non-Hispanic white (64.5%), with smaller numbers of non-Hispanic black men (25.5%) and those of other races/ethnicities (10.0%). Eighty-seven percent of

participants identified as gay, while only 5.2% identified as bisexual and 7.4% identified with another MSM-related sexual identity. More than half (52.8%) were HIV positive. More than two-thirds reported an education level beyond a high school level. Most participants (63.5%) enrolled in the MACS prior to 1987. The distribution for the exposure to multifactorial discrimination variable was 41.8% reporting 1 type of discrimination, 32.5% reporting 2 types, and 25.7% reporting 3 or more types. Nearly 70% of the sample reported that their discrimination experiences affected their ability to live full and productive lives, including 10% who reported that their experiences affected them a lot.

Prevalent internalized homophobia

The prevalence of current internalized homophobia among middle-aged and older MSM in our sample was 56.4%. Unadjusted models indicated that an increase in age (by 5-year intervals) was protective against reporting any current internalized homophobia (prevalence ratio [*PR*] = 0.93; *95% CI:* 0.90, 0.97) (Table 2). Racial/ethnic minority participants were more likely to report current internalized homophobia compared with non-Hispanic white participants (non-Hispanic Black: *PR* = 1.51; *95% CI:* 1.29–1.77; all other races/ethnicities: *PR* = 1.61; *95% CI:* 1.32–1.95). Both bisexual (*PR* = 1.67; *95% CI:* 1.42–1.97) and those reporting other MSM sexual identity (*PR* = 1.43; *95% CI:* 1.17–1.75) were more likely to report current internalized homophobia compared with gay-identified participants. Men who enrolled after 2001 were more likely to report current internalized homophobia compared with men who enrolled prior to 1987 (*PR* = 1.41; *95% CI:* 1.22–1.64). Reporting 3 or more discrimination types was associated with increased odds of reporting any internalized homophobia compared with those who reported only 1 type (*PR* = 1.28; *95% CI:* 1.06–1.53). Furthermore, an increase in discrimination salience was associated with increased odds of reporting any current internalized homophobia (*PR* = 1.13; *95% CI:* 1.05–1.22). We observed no statistically significant association between education level and current internalized homophobia. In the main effects model (Table 2, Adjusted Model 1; Model Fit: Likelihood Ratio $\chi^2(11) = 21.70$, $p = 0.027$), non-Hispanic black men (*PR* = 1.26; *95% CI:* 1.04–1.52) and men of all other races/ethnicities (*PR* = 1.39; *95% CI:* 1.12–1.73) had increased odds of reporting current internalized homophobia compared with non-Hispanic white men. Compared with gay-identified men, bisexual men (*PR* = 1.42; *95% CI:* 1.17-1.72) and those reporting other MSM sexual identities (*PR* = 1.23; *95% CI:* 1.01-1.51) reported increased odds of reporting current internalized homophobia. Further, discrimination salience remained associated with reporting any current internalized homophobia (*PR* = 1.11; *95% CI:* 1.03–1.20). In the second adjusted model (Model Fit: Likelihood Ratio $\chi^2(15) = 22.26$, $p = 0.101$), we observed no statistically significant interaction between multifactorial discrimination exposure and discrimination salience to be associated with current experiences of internalized homophobia among middle-aged and older MSM. We observed no statistically significant interaction between race/ethnicity and HIV status and no statistically significant interaction between age and wave of MACS enrollment.

Discussion

To our knowledge, this is the first study to explore the respective associations of multifactorial discrimination and discrimination salience on participants' current experiences of internalized homophobia. Although prior studies have acknowledged the potential role of discrimination salience (Choi, Steward, Miège, Hudes, & Gregorich, 2016; Crawford et al., 2014), these efforts primarily focused on identity salience with respect to marginalization exposure rather than salience of the oppressive event (Ghabrial, 2017; Quinn & Chaudoir, 2009). Among our sample of middle-aged and older MSM who reported any lifetime discrimination, nearly 60% reported multifactorial discrimination (2 or more types) and more than one-third indicated moderate to high discrimination salience. More than half of our sample reported any current feelings of internalized homophobia. This is especially alarming given the association of internalized homophobia with poor mental, physical, and psychosocial health in older adulthood (Fredriksen-Goldsen et al., 2013; Hoy-Ellis & Fredriksen-Goldsen, 2016; Masini & Barrett, 2008).

By juxtaposing the main associations of discrimination salience with exposure, our findings challenge commonly applied theoretical approaches that conflate the 2 constructs (Fingerhut, Peplau, & Gable, 2010; Williams, Neighbors, & Jackson, 2003). Furthermore, our results yielded no evidence that multifactorial discrimination moderated the association between discrimination salience and internalized homophobia. Discrimination salience in our sample carried greater weight with current experiences of internalized homophobia compared with discrimination exposure. The association between discrimination salience and current internalized homophobia indicate that those who reported currently being affected by discrimination also continue to be affected by internalized homophobia. Further, although our findings call attention to the importance of discrimination salience, our results in no way detract from the potential association of identifying with multiple marginalized statuses and prevalent experiences of internalized homophobia in midlife and older age. Furthermore, our findings may reflect stigma competent strategies that men built up across their life course. Prior studies indicate that MSM are able to cope with social stress in old age, embracing and accepting their social identities, and adopting or maintaining a positive future orientation (Brown & Grossman, 2014; David & Knight, 2008; Halkitis, Krause, & Vieira, 2017; Schope, 2005). Lastly, assessing discrimination exposure may yield greater relevance when comparing samples of MSM who reported discrimination vs those who did not, since assessing only those who reported discrimination suggests a baseline elevated risk.

Limitations

Our study has limitations. With respect to construct measurement, additive (e.g., multifactorial discrimination) and multiplicative (e.g., social identity interactions) approaches to measuring multiple marginalization are criticized as methodologically discordant to their theoretical basis; specifically, social identities are intertwined (Khan, Ilcisin, & Saxton, 2017; Robinson & Ross, 2013; Veenstra, 2011; Yuval-Davis, 2006). Although these approaches provide an attempt to capture identity interconnectedness, data on social identify classifications are treated as distinct constructs. However, experts acknowledge that with respect to survey methodology, there exists no accepted or

standardized best practice for quantitatively assessing how experiences of multiple marginalization shape overall health and well-being (Robinson & Ross, 2013). We also used an *a priori* assumption that any experience of internalized homophobia, irrespective of severity, is worse than no experience of internalized homophobia. Although dichotomizing current experiences of internalized homophobia (e.g., none vs any) is consistent with prior analyses conducted with the MACS sample, these categorizations may mask the complexities of navigating internalized homophobia in older age (Herrick et al., 2013). Internalized homophobia is a mental health concern; however, there is no existing clinical threshold that defines the point in which internalized homophobia becomes problematic (Andresen, Malmgren, Carter, & Patrick, 1994; Herrick et al., 2013).

Inherent issues with our study design may also limit the interpretation of our findings. First, our findings may be an underestimate of the association between multifactorial discrimination and current internalized homophobia. Many of the discrimination experiences of middle-aged and older MSM were likely present yet undetected, and therefore largely underreported (Contrada et al., 2000; Huebner, Rebchook, & Kegeles, 2004; Meyer, 2003). In addition, prior studies suggest that discrimination exposure in the form of everyday stressors have a greater impact on current psychological well-being than isolated events across the life course (Williams et al., 2003). Second, the cross-sectional nature of our study design limits our ability to describe causal relationships among discrimination, discrimination salience, and current experiences of internalized homophobia. Although prior studies have demonstrated that experiences of internalized homophobia are reconcilable in middle-aged and older MSM, we are unable to ascertain how discrimination salience (or lack thereof) contributes to this process (Herrick et al., 2013). Alternatively, our findings may reflect studies that suggest people with greater psychological distress are more likely to report discrimination compared with those with lower distress levels (Ruggiero & Taylor, 1997). Middle-aged and older MSM who currently experience internalized homophobia may be greater attuned to discrimination or report greater discrimination salience than those who are not experiencing internalized homophobia. Third, our findings have unknown generalizability for a few reasons. Participants in the MACS cohort are a convenience sample of MSM who are linked to clinical care at their respective recruitment clinics and may therefore have increased access to or heightened awareness of ancillary services that promote health and sexual identity affirmation. In addition, the investigators in charge of study design at the inception of the MACS noted that the intention was not to obtain a representative sample and that many participants likely volunteered their participation based on their perceived high susceptibility to HIV (Kaslow et al., 1987). In fact, many participants in the initial cohort were recruited from STI clinics that served MSM (Kaslow et al., 1987).

Implications for future research

Taken together, future research may benefit from addressing the limitations of our study. First, qualitative efforts may provide greater insight into ways to improve measuring the experiences of multiple marginalization/multifactorial discrimination among middle-aged and older MSM. Second, mental health and psychometric experts should explore measurements of internalized homophobia to inform practical clinical assessments.

Identifying clinical cutoffs for when internalized homophobia becomes debilitating would inform service provision approaches for providers that serve middle-aged and older MSM.

Our findings also support the need to address additional markers of stigma and discrimination beyond superficial indicators such as exposure. Although our study was only able to capture salience, factors such as discrimination severity, frequency, and chronicity (e.g., acute versus chronic) may affect how internalized homophobia persists during older adulthood (Szymanski et al., 2008). These alternative factors would provide a comprehensive account of the discrimination experiences of midlife and older MSM and facilitate intervention efforts aiming to improve internalized homophobia reconciliation.

Given that a substantial proportion of our participants reported no current internalized homophobia, our findings suggest that there are unaccounted factors of resilience that assist in internalized homophobia reconciliation processes over the life course. Future studies warrant investigation of multilevel (e.g., individual and interpersonal) factors that protect against experiences of internalized homophobia among MSM in middle age and older adulthood. Last, the lack of generalizability of our findings warrants a need to replicate our analyses with other community samples of middle-aged and older MSM.

Implications for public policy and practice

Multilevel efforts are critical for assisting in the prevention of discrimination experiences as well as treatment of associated consequences such as internalized homophobia among MSM in middle age and older adulthood (Arístegui, Radusky, Zalazar, Lucas, & Sued, 2018). From a policy standpoint, policymakers and others involved in the justice system should enforce anti-discriminatory policies from local to national levels and in both public and private sectors. The reduction of stigma toward same-sex–attracted people is evidence of sociopolitical progress. However, there remains a need to maintain political advocacy efforts that target stigma reduction for individuals who experience marginalization across multiple social identities. Our findings suggest that this is especially important as younger generations of MSM transition into midlife and older adulthood.

At the organizational level, social and mental health care agencies that serve middle-aged and older MSM should be diligent to screen and address current experiences of internalized homophobia as well as explore the potential contribution of discrimination. The capacity for providers to elicit increased positive attitudes of sexual identity requires deconstructing negative images and stereotypes (Morrow, 2001). Providers' ability to unpack experiences of internalized homophobia through trauma-informed psychotherapy in middle-aged and older MSM may inform pragmatic service provisions including referrals to sexuality-affirming resources and identifying health-promotive coping strategies.

By capitalizing on community and organizational leadership, agencies may also develop interventions that seek to improve access to sexuality-affirming resources among MSM in middle age and older adulthood. Linking these men to safe, social spaces may increase social integration and participation while fostering sexual identity affirmation (Arístegui et al., 2018). Prior research has suggested that MSM in older age fear and experience ageism from younger generations of MSM, which inhibits social engagement with the larger MSM

community (Slevin & Linneman, 2010). Community and organizational leadership targeting MSM health should develop efforts that decrease division between subgroups of MSM, facilitating community dialogue that encourages the values of within-group diversity (Cook, Purdie-Vaughns, Meyer, & Busch, 2014).

Conclusions

MSM now in midlife and older adulthood came of age during periods when there was greater permissibility for societal stigma toward same-sex–attracted individuals. For many of these men, prior stigmatizing experiences remain salient factors related to poor psychosocial well-being. Furthermore, middle-aged and older MSM continue to be part of age-specific generations that are the least likely to endorse sexuality-related equality (e.g., same-sex marriage) and most likely to endorse antigay discriminatory policies (Pew Research Center, 2016; Maccio, DeRosa, Wilks, & Wright, 2014; Grossman et al., 2001). Our findings demonstrated prevalent experiences of internalized homophobia and the need to address stigma management in middle-aged and older MSM. Multilevel intervention efforts by political, organizational, and community mental health advocates to reduce internalized homophobia is critical for MSM given that it is a correlate of poor mental, physical, and psychosocial health in old age.

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Table 1.

Sample characteristics of 498 middle-aged and older MSM.

Variable	Internalized Homophobia		
	None (*n* = 217) *N* (%)	Any (*n* = 281) *N* (%)	Total (*N* = 498) *N* (%)
Age, years			
Mean (SD)	61.43 (8.11)	59.21 (8.62)	60.18 (8.47)
Race/Ethnicity			
Non-Hispanic white	169 (52.6)	152 (47.4)	321 (64.5)
Non-Hispanic black	36 (28.3)	91 (71.7)	127 (25.5)
All other races/ethnicities	12 (24.0)	38 (76.0)	50 (10.0)
Sexual Identity			
Gay	205 (47.1)	230 (52.9)	435 (87.3)
Bisexual	3 (11.5)	23 (88.5)	26 (5.2)
Other MSM sexual identity	9 (24.3)	28 (75.7)	37 (7.4)
HIV Status			
Negative	117 (49.8)	118 (50.2)	235 (47.2)
Positive	100 (38.0)	163 (62.0)	263 (52.8)
Education Level			
High school or less	15 (31.9)	32 (68.1)	163 (32.7)
More than high school/GED	202 (44.8)	249 (55.2)	335 (67.3)
Wave of MACS Enrollment			
Before 1987	161 (50.9)	155 (49.1)	316 (63.5)
After 2001	56 (30.8)	126 (69.2)	182 (36.5)
Multifactorial Discrimination			
1 Discrimination type	101 (48.6)	107 (51.4)	208 (41.8)
2 Discrimination types	72 (44.4)	90 (55.6)	162 (32.5)
3+ Discrimination types	44 (34.4)	84 (65.6)	128 (25.7)
Discrimination Salience			
Not at all	85 (52.8)	76 (47.2)	161 (32.3)
A little	68 (44.2)	86 (55.8)	154 (30.9)
Some	46 (34.6)	87 (65.4)	133 (26.7)

Variable	Internalized Homophobia		
	None (n = 217) N (%)	Any (n = 281) N (%)	Total (N = 498) N (%)
A lot	18 (36.0)	32 (64.0)	50 (10.0)

Abbreviations: GED, general equivalency development; MACS, Multicenter AIDS Cohort Study; MSM, men who have sex with men.

Table 2.

Poisson models for current internalized homophobia (0 = None, 1 = Any) among middle-aged and older MSM, $N = 498$.

	Unadjusted Model			Adjusted Model 1			Adjusted Model 2		
Variable	***PR***	***95% CI***	***p***	***PR***	***95% CI***	***p***	***PR***	***95% CI***	***p***
Age (5-year intervals)	**0.93**	**0.90-0.97**	**0.002**	1.00	0.95-1.06	0.967	0.98	0.90-1.06	0.580
Race/Ethnicity									
Non-Hispanic white	REF			REF			REF		
Non-Hispanic black	**1.51**	**1.29-1.77**	**<0.001**	**1.26**	**1.04-1.52**	**0.018**	1.35	0.75-2.42	0.319
All other races/ethnicities	**1.61**	**1.32-1.95**	**<0.001**	**1.39**	**1.12-1.73**	**0.003**	1.06	0.45-2.50	0.900
Sexual Identity									
Gay	REF			REF			REF		
Bisexual	**1.67**	**1.42-1.97**	**<0.001**	**1.42**	**1.17-1.72**	**<0.001**	**1.43**	**1.17-1.74**	**<0.001**
Other MSM sexual identity	**1.43**	**1.17-1.75**	**0.001**	**1.23**	**1.01-1.51**	**0.049**	1.21	0.99-1.49	0.066
HIV Status									
Negative	REF			REF			REF		
Positive	**1.23**	**1.05-1.45**	**0.009**	1.11	0.95-1.31	0.201	1.10	0.87-1.38	0.463
Non-Hispanic black by HIV Status							0.96	0.69-1.34	0.811
Other Races/Ethnicities by HIV Status							1.18	0.74-1.88	0.476
Education Level									
High school or less	REF			REF			REF		
More than high school/GED	0.81	0.66-1.00	0.053	1.07	0.86-1.32	0.552	1.05	0.85-1.30	0.683
Wave of MACS Enrollment									
Before 1987	REF			REF			REF		
After 2001	**1.41**	**1.22-1.64**	**<0.001**	1.17	0.97-1.42	0.104	1.19	0.98-1.43	0.073
Age by Wave of Enrollment							1.05	0.94, 1.17	0.382
Multifactorial Discrimination									
1 Discrimination type	REF			REF			REF		
2 Discrimination types	1.08	0.89-1.31	0.429	1.01	0.84-1.22	0.882	1.01	0.84-1.22	0.925
3+ Discrimination types	**1.28**	**1.06-1.53**	**0.009**	1.05	0.88-1.27	0.576	1.05	0.86-1.27	0.629
Discrimination Salience	**1.13**	**1.05-1.22**	**0.001**	**1.11**	**1.03-1.20**	**0.006**	1.14	0.94-1.38	0.175
Multifactorial Discrimination by Discrimination Salience							0.99	0.90-1.08	0.762

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Abbreviations: GED, general equivalency development; MACS, Multicenter AIDS Cohort Study; MSM, men who have sex with men.

Note. Bold values signifies statistically significant associations.