HIV/AIDS Disclosure and Unprotected Sex: A Critical Issue for Counselors and other Mental Health Practitioners

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Abstract

This study found that African American males living with HIV/AIDS in rural southwest Alabama who did not disclose their HIV/AIDS seropositive status were more likely to engage in unprotected sex. Because much of the recent research is slanted to address homosexual behavior, which is still a taboo within the African American community, efforts to reach this population are being ignored. The stigma tied to HIV/AIDS, particularly in the rural south, complicates community mental health intervention strategies and secondary prevention methods.

Introduction

There have been a number of studies that focused on HIV/AIDS among African American males with respect to stigma, homosexuality, disparage in medical care, and drug addiction; however, the virus continues to thrive in the African American community. According to the Center for Disease Control's (CDC) most recent statistical report (2003), HIV/AIDS is the leading cause of death of African American males between the ages of 25 and 44. The public health messages about HIV/AIDS prevention among this population have been ineffective. The Center for Disease Control and Prevention's annual report for 1996 (CDC, 1997) stated that although African Americans make up only 12% of the United States population, they represented 41% of reported AIDS cases and the numbers continue to rise. Specifically, since 1993, African American males have comprised 66% of all newly reported cases of HIV infections (CDC, 2001).

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The purpose of this study was to examine if there is a relationship between those young African American males living with HIV/AIDS who had not disclosed their seropositive status and those HIV infected individuals who had engaged in unprotected sex within the previous six months. According to Chesney & Smith (1999) and Parson & Halkitis (2002), African American males infected with HIV seldom use condoms; therefore, they are at significantly high risk for reinfection as well as infecting others.

Disclosure and Unprotected Sex

A number of researchers have attempted to examine the effects of HIV/AIDS education in the African American community and have shown that there is difficulty among this population in understanding the seriousness of individual risk (Pickle, Quinn, & Brown, 2002), the major barrier being African American young men's refusal to acknowledge behaviors that may have put them at risk (Williams, Wyatt, Resell, Peterson, & Asuan-O'Brien, 2004); (Parks, Hughes, & Matthews, 2004). Recent studies show that because of the secrecy of their sexual behavior with multiple partners, HIV/AIDS is spreading through the African American community at uncontrollable rates and is devastating to the unsuspecting women in their lives (Parks, et al., 2004; Williams, et al., 2004). Because of this secrecy or denial, it has become extremely difficult to educate them on the dangers of their behavior, mainly because they do not see themselves as being at risk for HIV/AIDS infection (Williams, et al., 2004). Because they do not identify themselves as being at risk, they are less likely to heed safer sex messages targeted at those groups posing a health risk to themselves and their female partners. Another reason that this risky behavior persists is the fact that many African American men still associate HIV/AIDS with being gay and the African American community is too homophobic: from womanizing rappers to moralizing preachers, much of the African American community views homosexuality as a strike against a people already confronted with too many problems (Rosario, Schrimshaw, & Hunter, 2004; Fullilove & Fullilove, 1999).

The media has played a significant role in distorting African American perception of HIV/AIDS risk with its intense representation of the HIV/AIDS epidemic in association with homosexuality and intravenous drug use; thus, implicating that certain populations are solely responsible for the spread of the disease. Homophobia, the fear of same-sex relationships and associated behaviors, even among gay and bisexual African American young males, has stymied the prevention and educational process (Siegel & Reveis, 1997). Likewise, Capitanio and Herek (1999) reported that African Americans' attitude toward those individuals who are homosexual, bisexual, or drug users were negative due to moral responsibility and a lack of concern for the spread of the HIV/AIDS virus within the community.

Disclosure

Many HIV/AIDS seropositive African American young males find it advantageous not to disclose in public private matters such as past sexual experiences or transmittable diseases. Stein and Semet (1999) reported that during the advent of opportunistic infections when HIV/AIDS was first introduced to this country, there were no fundamental questions about disclosure to calculate the risk from a single encounter. However, understanding and estimating HIV/AIDS

infection risk factors would not be necessary if HIV/AIDS seropositive individuals were no longer sexually active. The research shows that 40% of all HIV/AIDS seropositive patients who entered an urban northeastern hospital had not disclosed their HIV/AIDS seropositive status to their sexual partners over the previous six months, as indicated by Stein and Samet, (1999).

Serovich and Mosack (2003) give several reasons for not disclosing HIV/AIDS seropositive status to casual sexual partners. Although the research is limited when investigating why gay and bisexual HIV/AIDS seropositive men do not disclose, one positive aspect for disclosure is that the sexual partner will have a choice as to whether or not to use a precaution. Hudson and Robinson (2001), who completed a study on African American gay and bisexual young men in the rural south, concluded that many of these young men are shunned from their families, churches, and communities. They reported that the Black churches have used the pulpit to attack HIV/AIDS in relation to gay activities. They also reported that many African American gay young men who did disclose their sexual orientation gave personal accounts of being asked to leave their churches. The study further stipulated that these young gay men had no outlet for frustration other than the “gay bars” or individual homes of others with similar concerns. According to Loiacano (1998), African American gay men are viewed as inferior within the White gay community and they are discriminated against in admittance to bars, employment, and in advertisement. Also, according to Loiacano (1998), African American gay males lack the beauty and flamboyance associated with the White gay lifestyle. Black and Miles (2002) postulated that HIV/AIDS seropositive men hide their status from sexual partners because of stigma and shame. Therefore a great many people are putting themselves at risk for HIV infection without knowing it.

Wolitski and Rietmeijer (1998) concluded that 66% of those infected with HIV/AIDS did not disclose their HIV/AIDS seropositive status to sexual partners nor did they use condoms. While discussing the necessity of condom use to potential sexual partners is a major deterrent to the increased compilations of HIV/AIDS cases among African American males, it also can help increase the motivation to seek medical care. Likewise, this can be a means for social support because sexual partners who decide to disclose their HIV/AIDS seropositive status will usually share this information only with close friends rather than family due to the seriousness of the stigma, shame, and guilt associated with the disease in the African American community (Wolitski & Rietmeijer, 1998). A potential benefit of being able to confide in trusted friends is during the testing process, particularly when getting test results because they can help in the decision to seek treatment. Again, because of stigma, it is becoming extremely difficult for African American males to disclose to recent sexual partners due to the lack of support, condemnation, and isolation.

Serovich and Mosack (2003) reported that medical advancements allow early detection and diagnosis of HIV/AIDS. However, there has been limited focus on the importance for African American males to disclose to potential sexual partners their HIV/AIDS seropositive status. Stein and Samet (1999) concluded that because those who are infected will not disclose their HIV/AIDS seropositive status, it is obligatory that sexually active African American males be responsible and protect themselves. Kalichman, Rompa, Luke, and Austin, (2002) revealed that despite the increase of HIV/AIDS infection among African American, they refuse to use condoms or other forms of protection consistently and are least likely to admit to HIV/AIDS exposure.

Unprotected Sex

Research reflects a growing concern for personal responsibility in the alleviation of the spread of HIV among African American young males who are sexually active yet fail to disclose their HIV seropositive status (Henderson, 2000; Hudson & Robinson, 2001). Semple, Patterson, and Grant (2003) postulated that more unprotected sex was associated with those individuals in monogamous relationships. Patterson, Shaw, and Semole (2003) also concluded that secondary prevention measures among those individuals in long-term relationships appear to be the most hopeful in educating African American young males living with HIV/AIDS in curbing the spread of the disease.

Patterson, et al. (2003) also reported that the new medications have a profound effect on life expectancy contributing greatly to the rise in new cases of HIV/AIDS infections. African American males are now living longer and showing fewer symptoms of the disease. Because they look and feel better, they are more likely to infect unsuspecting casual sexual partners. Semple, Patterson, & Grant (2003) further hypothesized that unprotected sexual intercourse with casual partners tends to occur most frequently among those African American males who are either HIV/AIDS seronegative or who do not know their HIV/AIDS seropositive status; therefore, leaving those who have been diagnosed yet showing fewer symptoms of the disease distorted reasons for nondisclosure or safer sex practices.

Parsons and Halkitis (2002) concluded that with the rise in drug addiction among African American males, safer sex practices are often ignored. Their study reported that 66% of those individuals surveyed had at least one casual sexual partner within the past three months and they were more likely to have used amphetamines, ecstasy, or hallucinogens. Drug use was found to be a crucial factor when assessing HIV/AIDS infected African American men's sexual behavior.

Effective Treatment

While secondary prevention continues to be the most effective avenue to slow the spread of HIV infections, African American homophobia—particularly when associated with HIV/AIDS—remains a critical stumbling block in early detection, diagnosis, and treatment among African American young males. Many African American males refuse to acknowledge sexual practices and/or risk factors associated with their HIV/AIDS seropositive status. A critical issue in the African American community is "Down Low" men who participate in homosexual practices but refuse to identify themselves as gay (Loiacano, 1998). According to Lewis (2003), African Americans tend to view homosexuality as criminal behavior and that HIV/AIDS is God's punishment. This attitude has lead many African American males to hold secret their sexual orientation for fear of condemnation. Lewis (2003) further concluded that African American males who have sex with men tend to be confronted with condemnation from their families, communities, and churches. This disapproval places a greater burden on self-acceptance, disclosure, and safer sex practices. Although HIV/AIDS is transmitted through the exchange of body fluids (blood and semen) with an infected individual regardless of sexual preference, HIV/AIDS is more likely to be associated with homosexuality within the African American community. HIV/AIDS, since its introduction to this country, has been linked to homosexuality and many young African American males still embrace the belief that an

individual must be "gay" in order to become infected with HIV/AIDS. The undereducated and the hard to reach are more likely to hold to the concept that HIV/AIDS is a gay disease. For example, in rural Alabama that is heavily populated with low-income and undereducated African Americans with limited resources and access to HIV/AIDS educational materials and medical care, AIDS service organizations are inundated with new cases of HIV infections (CDC, 2003).

While secondary prevention appears to be the best solution to curbing the spread of HIV/AIDS, most intervention techniques have targeted those individuals who are HIV/AIDS seronegative (Patterson, Shaw, & Semple, 2003). According to the Center for Disease Control and Prevention (2001) Fact Sheet, HIV/AIDS is not a casual contact disease, but is transmitted through the sharing of needles and/or sexual intercourse (vaginal, oral, and anal) with an infected partner without taking proper precautionary measures. There are no vaccines to protect against HIV/AIDS (Patterson, et al., 2003); therefore, behavioral interventions designed to increase safer sex practices among those individuals who are HIV/AIDS seropositive would significantly reduce the numbers of new infections.

Methods

According to the Center for Disease Control and Prevention (2003), African American young males between the ages of 25 and 44 far outnumber their Caucasian counterparts in death accumulations per year due to complications from HIV/AIDS. Therefore, this research project used a modified version of the Young Men's Survey (MacKellar, Valleroy, Karon, Lemp, & Janssen, 1996) to address specific issues that complicate disclosure of HIV/AIDS seropositive status and safer sex practices among HIV/AIDS seropositive African American males living in rural southwest Alabama.

The Young Men's Survey in its modified form resulted in findings that are generalizable only to the population of African American males receiving services from the AIDS Service Organizations in the rural southwest section of Alabama. The population included in the YMS sampling frame was African American males between 25 and 44 and who were HIV/AIDS seropositive. Only those AIDS Service Organizations with representatives at the Community Planning Group (CPG) for Alabama Department of Public Health Areas VII and IX were included in the YMS frames. Another limitation is the inability to verify the truthfulness of participants' responses. Likewise, due to the sensitive nature of this research project, accuracy of the information collected could not be substantiated.

Research Question

The primary research question of this study was: Are African American males who do not disclose their Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome more likely to engage in unprotected sex?

Participants

There were 37 participants in this study. All were African American young males between the ages of 25 and 44, diagnosed with HIV/AIDS, and living in rural southwest

Alabama. These men were receiving services from an AIDS Service Organization (ASO) in Alabama Department of Public Health (ADPH) areas VII and IX. Because this group represents the fastest growing HIV/AIDS infection rate and is seldom addressed by national public health campaigns, it was ideal to address the needs and behaviors of this population.

The African American HIV/AIDS related risk behaviors among those young males receiving services at HIV/AIDS Service Organizations (ASO) in Alabama Department of Public Health (ADPH) areas VII and IX or rural southwest Alabama was addressed in the survey questions relative to nondisclosure of HIV/AIDS seropositive status and unprotected sex within the previous six months. Because the Young Men's Survey (MacKellar et al., 1996) is anonymous, limited demographic information was obtained. Of the 37 respondents, all were HIV/AIDS seropositive African American males between the ages of 25 and 44 living in rural southwest Alabama.

Disclosure of HIV/AIDS

The research question asked: Are African American males who do not disclose their Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome more likely to engage in unprotected sex?

Of the 37 (100%) respondents to the disclosure question, "Have you ever told anyone that you are HIV/AIDS positive?" (Table 1), 21 (56.8%) responded "yes". The research survey revealed that of those African American males in rural southwest Alabama who were living with HIV/AIDS and receiving services for their illness, 41% reported that they had not told anyone of their HIV/AIDS seropositive status outside of the agency where they receive treatment.

Unprotected Sex

Of the 37 (100%) respondents to the question of having sex without a condom within previous 6 months (Table 2) who also admitted that they had not told anyone of their HIV/AIDS seropositive status (Table 1), a cross-tabulation analysis was conducted to see if there was a statistical relationship between the two groups: those who did not disclose their HIV/AIDS seropositive status and those who reported having sex without a condom. The data analysis revealed that of the 37 (100%) African American males responding to the survey, 15 (41%) reported that they had not told anyone of their illness and 23 (62%) also reported that they had sex within the previous six months without the use of a condom. The significance level reported in Pearson chi-square was .042; therefore, it is very unlikely that the frequency differences occurred by chance (see Table 3).

Discussion

The results of this study revealed that there was a significant relationship between unprotected sex and nondisclosure of HIV/AIDS seropositive status among African American males living with HIV/AIDS in rural southwest Alabama. These findings are consistent with other findings in larger metropolitan areas of the United States. The rate of unprotected sex without disclosure of HIV/AIDS seropositive status found in this sample of African American men receiving HIV/AIDS care in Alabama Public Health Areas VII and IX translated into

unprotected sex among 62% of those responding. The data analyzed is consistent with the literature in that there are many African American males who refuse to disclose their HIV/AIDS seropositive status, yet continue to put others at risk by continuing to engage in unprotected sex. The literature also reported that African American males have difficulty accepting that there is, in fact, a serious risk of becoming infected with HIV/AIDS. This is also consistent with the findings in this study in that greater than three-fifths of those reporting sexual activity within the past six months did not use protection.

This study documents a clear reflection of a continuing dilemma in the African American community: greater than half (52%) of those individuals responding to the survey in this study who disclosed their HIV/AIDS seropositive status reported unprotected sex within the previous six months. However, this data was not reported without limitations. Because this survey is anonymous and the accuracy of the responses could not be verified, the disclosure may not have been to their sexual partners.

When the focus narrowed to African American males with the greatest risk of transmission of HIV/AIDS, that is, those African American men between the ages of 25– 44 living with HIV/AIDS who reported having unprotected oral, anal, or vaginal sex without disclosure of their HIV/AIDS seropositive status, the results indicated that 62% of those responding reported that they had engaged in this behavior during the six month reporting period. These estimates may be higher because the variables in this study would misclassify those who engaged in protected sex before disclosure and unprotected sex after disclosure during the six-month interval.

Recommendations

Based on the findings in this study, the following recommendations are made. First, secondary prevention and treatment efforts must be culturally sensitive and designed to promote disclosure of HIV/AIDS seropositive status in addition to reducing unsafe sexual practices among African American males living in the rural south. That is, counselors and other mental health practitioners must become better prepared to address the complicated needs, concerns, and other issues associated with African American young males already infected with this illness particularly the stress related to poverty, undereducation, and the lack of community resources significant to the rural south. This process may yield important public health benefits. For example, more national public health campaigns must be taken into the rural African American community. There is a dire lack of information in this area regarding how to contract HIV/AIDS, practicing safer sex, and availability of medical services. Likewise, in addressing the needs of the African American community, public health information should target both heterosexual and homosexual behavior. Too often the implication is that HIV/AIDS only affects the gay or bisexual community. The emphasis should be on safer sex practices regardless of sexual orientation.

Secondly, culturally specific education and training should be offered to counselors and other mental health practitioners about how to deal with the unique factors that face African American males particularly in the rural south living with HIV/AIDS. Many counselors are

simply unaware of the dynamics, strategies, and therapeutic methods designed to most effectively address this population. Culturally trained counselors and HIV/AIDS educators would offer these males tools for coping with the impact of infection and the resulting stigma and isolation. Not only must HIV infected African American males be taught how to live healthy lives but counselors and mental health workers must also be given methods for compassionately addressing issues related to death and dying in the face of HIV infection. Culturally skilled counselor training programs have shown to be effective in helping those with HIV/AIDS express their feelings of frustration and despair while trying to live with their illness. Furthermore, culturally specific education and training should be uniquely shaped to promote a sensitive understanding of the African American gay culture and the backlash that the HIV/AIDS epidemic has had on the gay community.

Thirdly, in an effort to curb this debilitating and fatal disease, more research is definitely needed to identify and address the thought processes and behavior patterns of African American males living with HIV/AIDS. State and federal government agencies, public health officials, and researchers, including the CDC, should work closely with African American community leaders to gain a clearer understanding of ways to better serve this population. This is especially true of the African American churches which have a strong impact in the community; their presence has been largely missing in the fight against HIV/AIDS. Because of their potential to reach thousands weekly, African American churches could be valuable in relaying the message of how HIV/AIDS is transmitted and spread, as well as, ministering to those individuals who are afflicted. Clearly with the rate of infection increasing daily, every possible avenue of dispensing accurate, knowledgeable information about the HIV/AIDS epidemic must be exhausted. Similarly, every effort must be made to address the needs and concerns of African American males in the rural south, as well as, other underserved populations.

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Table 1

General Description for Disclosure of HIV/AIDS Seropositve Status

	N	Yes	No	NA/Refused
Disclosed HIV/AIDS	37 (100%)	21 (56.8%)	15 (40.5%)	1 (2.7%)

Table 2
General Description for Unprotected Sex

	N	Yes	No	NA/Refused
Unprotected Sex	37 (100%)	23 (62.2%)	12 (32.4%)	2 (5.4%)

Table 3
Crosstabulation of Disclosure of HIV/AIDS and Unprotected Sex Within Past Six Months

Unprotected Sex Past Six Months	*Disclosure of HIV/AIDS Status*	
	Yes	No
Yes	11 (52.4%)	12 (85.7%)
No	10 (47.6%)	2 (14.3%)
Total	21 (100%)	14 (100%)

Pearson Chi-Square	Value	df	Asy. Sig. (2-sided)
	4.143[b]	1	.042

Although the original Young Men's Survey (MacKellar, et al., 1996) did not report reliability for all sections of the instrument, this modified version reported reliability at Alpha = .9522.