Formation of Personal HIV Disclosure Policies among HIV-Positive Men Who Have Sex with Men

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Abstract

Given the increasing emphasis on “prevention with positives” programs designed to promote HIV transmission risk reduction among people living with HIV/AIDS, better understanding of influences upon serostatus disclosure in sexual situations is needed. Based on grounded theory analyses of individual interviews, this exploratory research hypothesizes and interprets how 15 HIV-positive men who have sex with men (MSM) formed personal HIV disclosure policies for sexual situations. Participants described five elements influencing development of their personal policies, including: (1) making sense of having been infected, (2) envisioning sex as an HIV-positive man, (3) sorting through feelings of responsibility for others, (4) responding to views of friends and the gay community, and (5) anticipating reactions and consequences of disclosure. The article concludes with implications for current initiatives for prevention with positives.

Introduction

GIVEN THE SUCCESS of antiretroviral therapy in reducing AIDS morbidity and mortality, there is a burgeoning population of healthy and sexually active HIV-positive men who have sex with men (MSM) in the United States and other developed countries. Concomitantly, incidence of HIV infection and markers for HIV infection (e.g., syphilis, gonorrhea) are rising among urban MSM,^{1–3} which may indicate that prevention efforts are not keeping pace. Thus, it makes sense to extend efforts beyond infection risk reduction with presumably uninfected persons to transmission risk reduction.⁴ Accordingly, federal funding sources and state health departments are prioritizing “prevention with positives” along with “know your HIV status” campaigns in the United States.⁵ Although focusing transmission risk reduction interventions on HIV-positive persons is logical and increasing as evidenced by reports in the literature documenting individual, couple, group, social marketing, and community level approaches,^{6–12} serostatus disclosure as a prevention strategy has been less emphasized.

Mathematical modeling suggests the importance of focusing more heavily on disclosure than what is currently the norm in most prevention with positives approaches.¹³ Although discussing serostatus makes sense, it is unclear how well this strategy works among MSM, in part because of stigma, which is perceived by some MSM (particularly those who are HIV positive), as dividing the gay community by serostatus.¹⁴ The development of HIV testing in 1985, the

“de-gaying” of AIDS in the 1980s,¹⁵ and dissemination of life-saving highly active antiretroviral therapy (HAART) in the later 1990s may have contributed to erosion from a united gay community with a focus on community-inspired safer sex norms to a divided one with a focus on individual-level approaches based on serostatus.^{16,17} Before testing was widely available, gay men and other MSM banded together to face AIDS, largely in part because of institutional homophobia and a delayed government response to the emerging epidemic, and were encouraged to have candid discussions about safer sex. Then, as more MSM became aware of their serostatus and it became clear that AIDS was a worldwide pandemic affecting heterosexuals as well as homosexuals, public health messages promoted the responsibility of uninfected MSM to stay that way. It was not until after the advent and dissemination of HAART that safer sex interventions began being developed specifically for HIV-positive MSM. By this time, however, the concerns about HIV complacency and prevention fatigue among MSM,^{18–20} perhaps due in part to HAART optimism,^{21,22} prompted renewed community-level approaches to HIV prevention. However well intended, some that sought to unite gay men may have contributed to what was construed by some MSM as “victim blaming” and as focusing more on the sexual responsibilities of individuals rather than collective responsibility.²³

As is discussed below and presented in results, there is a variety of reasons HIV-positive persons do not disclose their serostatus to sexual partners (and HIV-negative persons are reluctant to ask), but a primary fear is of being rejected as a

sexual or romantic partner. Beyond the concerns of rejection of intimacy, however, loom larger concerns of stigma, including family and social exclusion as well as institutional and cultural manifestations. The literature is increasingly rich in discussions of the ways in which AIDS stigma is experienced, enacted, and internalized on a trajectory from individual status loss to structural discrimination around the world.^{24–30} It is clear that MSM continue to be scapegoats in the AIDS pandemic; however, HIV-positive MSM may feel less stigmatized than HIV-positive heterosexuals,³¹ perhaps especially in communities in which same-sex relationships are affirmed rather than criminalized. However, within gay communities, MSM do enact stigma upon one another, including judging one another for becoming HIV-positive.¹⁴ However, perceptions of stigma within the gay community do not appear to be associated with risky behavior itself, but are linked to pursuit of anonymous sex as well as negative mental health.¹⁴ Nonetheless, stigma, regardless of whether it is enacted, felt, or internalized, may result in social isolation and thereby be a barrier to disclosure among MSM.

Regardless of concerns about stigma, serosorting—the phenomenon of sex partner matching by HIV status—has become increasingly studied as a safer sex strategy. However, serosorting may paradoxically increase rather than reduce HIV transmission in environments of higher HIV prevalence, particularly by recently infected persons who incorrectly disclose as HIV negative and whose infectiousness may be higher.³² Serosorting as a prevention strategy is also flawed because of erroneous assumptions in perceptions rather than actual knowledge of a sex partner's serostatus.³³ For example, MSM may incorrectly assess a prospective or actual sexual partner's serostatus as being the same as their own based on physical, behavioral, normative, or circumstantial/associational attributes.³³ In addition, HIV-positive MSM who serosort to avoid using condoms may acquire different strains of HIV that are resistant to their current antiretroviral therapies. A related safer sex strategy may be seropositioning, which refers to choosing insertive or receptive anal intercourse to minimize risk of acquiring HIV (for HIV-negative MSM only) or transmitting it (for HIV-positive MSM). Data analyses from the EXPLORE study, a randomized trial of individual behavioral counseling for HIV-negative MSM, revealed no evidence that seropositioning was a significant protective factor for HIV acquisition. However, serosorting, practiced more commonly than seropositioning in the EXPLORE study, was associated with decreased risk of seroconversion.³⁴ Another intervention, the Health Living Project, 15 sessions of cognitive-behavioral counseling for HIV-positive MSM, was efficacious in reducing transmission risk acts, particularly given participants' sustained practice of serosorting.³⁵ In short, universal and consistent condom use remains far more effective than serosorting, but ideal risk communication would include discussing serostatus.

Revealing HIV status as part of sexual risk reduction has received mixed messages. MSM have long been urged to "assume everyone's positive and act accordingly," meaning that they should always use condoms. Simultaneously, however, they have been urged to communicate about risk factors, including sexual histories of current and prospective sex partners, to negotiate gradients of safer sex. If the first message about always enacting safer sex were sufficient, the second message to communicate about risk factors would be

unnecessary. The expectation for and burden of disclosure is disproportionately placed on those who are HIV-positive, which carries the fear of and actual felt stigma. In addition, HIV-negative men may be reluctant to ask about HIV status for fear of enacting stigma. In the absence of disclosure, it may well be that HIV-positive MSM assume others are positive if HIV is not discussed whereas HIV-negative men may assume the opposite. These concerns make all more important the need to continue to develop tandem prevention programs for HIV-negative as well as HIV-positive men.

Seropositive disclosure is often inconsistent^{36–41}; varies by partner type (with less disclosure to casual sex partners than to steady partners)^{36,39,40,42–44}; is inversely related to the number of sex partners³⁷; and is less likely to occur if the sexual partner's serostatus is negative or unknown rather than positive.⁴⁵ A review of 23 empirical studies through 2004 failed to establish a consistent relationship between disclosure and safer sex.⁴⁶ Pointing to a lack of methodological rigor in the available studies and mixed findings, the authors asserted that the inconsistent association nonetheless remains relevant and that uninformed protection and informed exposure should be further explored, particularly within the context of explicit discussions of safer sex rather than generalized HIV disclosure.^{46,47}

A variety of interpersonal and contextual factors have been associated with disclosure in sexual situations, including partner characteristics and behaviors, beliefs about viral load, and setting.^{48–50} For example, in a qualitative study of MSM with recent sexually transmitted infections in Los Angeles, California, and Seattle, Washington,⁵¹ participants tended to be more likely to disclose to sex partners if they had feelings for the other person, felt responsible for sex partners, or feared arrest. They were less likely to disclose if they minimized the importance of sex, believed having a low viral load reduced transmission likelihood, or feared rejection. Nondisclosure to an intimate partner has also been linked to the desire for privacy as well as difficulty in accepting being HIV positive.⁵²

Some persons with HIV report that they know they have infected others. For example, in a study of unsafe sexual behavior among HIV-positive men and women in Minnesota, 13% reported knowing they had infected others postdiagnosis.⁵³ In an Internet study advertised in the United States and internationally, the average MSM participant was 21% certain he had transmitted HIV to another person.⁵⁴ Willful exposure/transmission of HIV is a crime in many jurisdictions worldwide.⁵⁵ There are, however, documented differences in concern about passing the virus to others. Compared to others who attributed responsibility for having become HIV infected to themselves or as being shared with the person who passed the virus to them, persons who blame others for their infection or who have unresolved anger may use maladaptive coping, express less concern about potentially transmitting HIV, and have unprotected intercourse.^{56,57} The degree to which vengefulness contributes to nondisclosure or unprotected intercourse is vastly understudied. In the sole available study, HIV-positive MSM who reported feeling higher degrees of vengefulness disclosed their seropositivity less often, but vengefulness was not associated with condom use with casual partners.⁵⁴

HIV-positive persons, including MSM, may resolve to disclose their serostatus to sexual partners for emotional release, to educate others or out of a sense of obligation to

others,^{51,57} but contextual factors may conflict with a personal sense of responsibility.⁴⁸ For example, HIV-positive MSM may disclose more often than HIV-negative MSM to absolve themselves of responsibility for safer sex or to facilitate unprotected sex.¹⁶ In addition, responsibility for discussing serostatus has been modeled to have four orientations among HIV-positive MSM that include dimensions of responsibility for self as well as responsibility for the sexual partner.⁵⁹

Methods

To assist in better understanding facilitators and barriers to transmission risk reduction for persons living with HIV/AIDS (PLHA), this exploratory qualitative study sought to describe: (1) how HIV-positive MSM determined whether to disclose their serostatus to sexual partners and (2) situational factors that impeded or enabled disclosure. This article focuses on the first aim. A previously published article⁶⁰ focused on the second aim.

Audiotaped 1- to 2-hour semistructured interviews focusing on prior decision-making, motivational influences for telling or not telling, and the processes and outcomes of disclosure and nondisclosure were conducted with 15 HIV-positive MSM in Seattle in 2001. Recruited from participants in a study testing a two-session motivational enhancement prevention with positives individual counseling intervention, the sample for this article was purposively selected to loosely represent three serostatus disclosure categories: always disclose, sometimes disclose, never disclose. This sampling strategy was enabled by available records from the originating study, which included assessment questions about disclosure. Prospective participants identified for this study were asked if they would be interested in participating in an interview for a payment of \$25 that focused on their disclosure and nondisclosure experiences. Informed consent included a provision of a range of confidentiality/anonymity options. For example, participants in the intervention study could choose to participate in person or by telephone and elect to provide names and tracking information or not.

Participants ranged in age from 19 to 60 with most being in their 30s and 40s. Twelve were Caucasian and three were African American. Most lived in Seattle, but some were from smaller cities in the state of Washington. One lived in Canada and one in Chicago, Illinois; both of these men had spent significant time in Seattle. Several were white-collar professionals, one was a retired public professional, two were full-time students, and others struggled to make ends meet with a variety of seasonal work. Four had been diagnosed as HIV-positive within the previous 6 months, nine had been aware of their serostatus for several years, and two had been living with HIV/AIDS for more than 10 years. Ten were on HAART.

An interview guide outlined questions in four areas, but the interviews were designed to be flexible and reflexive in order to nurture collaborative meaning making. Primary content areas included: (1) decision making in sexual situations; (2) the process of experienced or hypothetical disclosure; (3) outcomes and expectancies for disclosure; and (4) a "guided discovery" of a recent sexual encounter. Data analysis followed a modified grounded theory approach informed by both Strauss and Glaser.^{61,62} I did not attempt to abandon previously held views about the nature of the problem and, in fact, believe that "practice wisdom" in tandem with data from in-depth interviews with members of the target population

was influential in generating new hypotheses and verifying previous ones. Glaser⁶¹ contends that grounded theory methodology can, in fact, be responsive to critical verification of existing hypotheses while simultaneously discovering "new" ones. I used ATLAS.ti, a qualitative data analysis software program, to conduct coding in three stages (coding, axial, and selective) and to generate memorandums. Following a reading of each transcript with no notation or coding, I began open coding wherein data were abstracted into categories, which were named either through the images they evoked or *in vivo*. During and after open coding, brief memorandums recapitulating what had been learned were drafted to aid both in analysis and to inform subsequent data collection. The second phase of analysis involved axial coding, whereby I sought to create relationships among within-participant phenomena, including hierarchically arranging concepts to represent causation, intervening, and contextually linked circumstances. Memorandums summarized these beginning levels of theory and hypothesized relationships between concepts and categories. In the third stage of analysis, selective coding, I compared data on a between-participant basis to integrate and refine the grounded theory model and determine if theoretical saturation had been reached. Although the quotation count function of Atlas.ti was used to determine if categories were coded across each participant, I did not rely on a quantitative benchmark to determine validity. Instead, I focused on how well the categories supported the emerging grounded theory model and the degree to which theoretical saturation had been reached.^{61,62}

Several methods of triangulation were utilized to bolster the credibility and acceptability of the analysis and interpretation. First, the data emerged from participants purposefully selected from a study of more than 300 HIV-positive MSM. During the conceptualization and analysis phases of the qualitative study, discussions were held with another researcher conducting quantitative analyses from the originating study. It would have been ideal to establish reliability between the two forms of data analysis; however, this was not feasible given study time frames. A second source of onsite triangulation were clinicians who were consulted during data analyses to discuss theory development and to monitor subjectivity. Third, AIDS scholars were consulted as key informants during conceptualization of the study and data analysis. Fourth, study results were presented at two national conferences to generate critical feedback on results. Member checking was not possible because the human subjects' approval did not provide permission for contacting participants following the close of the originating study, which occurred 1 week after this study's final interview.

Results

As summarized in Figure 1, the grounded theory model identifies two major disclosure processes evidenced in the experiences of the 15 research participants. First, all participants reported having thought about whether they should or should not disclose their status as a matter of future course. This particular process is conceptualized as Forming a Personal Disclosure Policy. A personal disclosure policy is driven by leanings, feelings towards, or convictions about divulging serostatus prior to or during sexual intimacy. The notion of personal policy is not meant to infer a rigid set of practices one

FIG. 1. A Grounded Theory Model of HIV Disclosure Decision Making for Sexual Situations.

adopts from which never to sway. Rather, it is meant to suggest a set of contingencies, which although fluid, represent tendencies or intentions to respond to various anticipated generalized or unique sexual situations. As will be illustrated, the reasons for disclosure vary. For some participants, personal disclosure policies reflected a keen desire to protect sexual partners, whereas for others it was about self-revelation. Personal disclosure policies seemed to be shaped by individual history before and after HIV infection as well as responses to contextual and community factors. They are clearly not total in their execution or invulnerable to context.

The second part of the grounded theory model, Enacting Disclosure, synthesizes the situations as well as facilitators and barriers for enacting personal disclosure policies. In brief, in the process of enacting disclosure, the participants—MSM with HIV—assess the environment for disclosure while simultaneously assessing a prospective sexual partner and his feelings toward this prospective partner. Next, a decisional balance is tilted by anticipations of the prospective sexual partner's reactions and the consequences of this disclosure. If disclosure continues to be warranted, plans for when and how to inform the other person are considered. Finally, post-decision evaluation takes place. That is, the HIV-positive man evaluates his own feelings about having disclosed or not disclosed. As indicated in the graphic representation of the grounded theory model, the two major components—formulating and enacting—are posited to be reflexive.

This article focuses exclusively on Forming a Personal Disclosure Policy, the first process in the grounded theory model. Details about the second process, Enacting Disclosure, are reported elsewhere.⁶⁰

As detailed in Table 1, five elements appear to influence the development of a personal disclosure policy: (1) making sense of personal infection story; (2) being altruistic; (3) envisioning sex as HIV positive; (4) hearing others; and (5) anticipating reactions and consequences. Given the aim of directing attention to the components of the grounded theory rather than individual participants' stories, individual quotations are not tracked by pseudonym. Likewise, personal characteristics are not provided unless they are essential to interpretation. In general, there was consistency in experiences among participants regardless of characteristics like age or race. Given the sample size of 15 as well as the lack of apparent differences, it seemed unwise to explore demographic characteristics as a variable. However, when participants themselves called attention to these characteristics in relating their stories, these details are included.

Making sense of personal infection story

Although not originally conceived as a standard topic for the interviews, participants seemed to want to tell the interviewer how they believed they were infected with HIV and how they received and coped with their diagnoses. Almost all

TABLE 1. CODE FAMILIES AND INITIAL CODING
SUBTHEMES: FORMING A PERSONAL DISCLOSURE POLICY

<i>Making Sense of Personal</i>	<i>Being Altruistic</i>
Infection Story	Concern for sexual
Finding out	partners
Infection attribution	Disclosure reasons
HIV-positive tenure	Lying
Outness as positive	Honesty
and gay	<i>Hearing Others</i>
Dealing with being positive	Community attributes
<i>Envisioning Sex as HIV Positive</i>	Social standing
Barebacking	Societal cues about
Condoms	disclosure
Infecting others	Treatment of people
Sex dysfunction	with HIV
Safety strategies	Stereotypes
Types of sex	Professional advice
Sex venue	
<i>Anticipating Reactions &</i>	
Consequences	
Anticipated reactions	
Rejection	
Disclosure reactions	
Feelings after disclosure	
Feelings after nondisclosure	

participants said they could identify their infectors and some were specific in relating the occasion on which they were exposed and subsequently infected. Some discovered their seropositivity as part of regular HIV testing, whereas others had enrolled in safer-sex counseling programs in which they received testing. The latter recalled their diagnoses as being shocking and ironic at the time given their conscious decisions to seek support in remaining HIV negative. Other participants were less surprised at their diagnoses when they were made during part of physician visits for gastrointestinal difficulties or other medical concerns. Regardless of initial shock or confirmation of suspicions, most of the research participants reported expecting the words from the testing agent, "You are HIV positive," to be life altering, either as an opportunity to ponder life's meaning or in not having a sense of what it would mean for the future, particularly regarding romantic and sexual relationships. None of the research participants recalled having had meaningful dialogue with their testing counselors or physicians about serostatus disclosure. However, several suggested that such a dialogue would have been ill timed given the shock of the news.

As part of the interviews, participants often discussed attributions for their infection. Some expressed anger—resolved and unresolved—toward the person they believed had infected them. One participant described his self-hate for having allowed himself to be infected by someone he believes intentionally exposed others to HIV. Others discussed having held resentment for long periods of time toward committed partners they had believed to be HIV negative but who infected them. A common adaptive response to this anger was cognitively and emotionally coming to terms with the shared responsibility of sex: "It takes two to tango...so there's shared responsibility out there. If you want to dance in the rain with no raincoat, then, you know, you gonna get wet!" Others worked to integrate this new part of their identities

within metaphysical or religious contexts. For example, one participant waxed almost poetic through most of this interview and seemed interested in making meaning from his experience of having become infected as a result of casual sex to guide his outlook on life and love. This, he said, is directly related to his new practice of getting to know sexual partners socially before sex so that he can work toward revealing his HIV status. On the other hand, some participants suggested their shame has likely led to infrequent serostatus disclosure to sexual partners. "I guess I'm probably embarrassed that, okay, it's like, here's somebody who should know better, that, uh, okay, you have the information in front of you and like, how come you slipped up? And, you know, this is only your fault. That, that's one of the reasons that I was not telling people."

Being altruistic

Preliminary coding suggested that the participants weighed concern about and responsibility for further transmission. Because social psychology conceptualizes behavior borne of concern for others as "altruism," that term is imported. Participants described feelings about disclosure in terms of responsibility for averting new infections, being honest to themselves and others, and having concern for others including those with identifiable vulnerabilities such as age or cognitive ability.

Each of the 15 participants said they did not wish to infect others because of the obvious gravity of consequence upon physical and psychological health. Guilt was a major factor. "I would never want to give it to anybody... I would want to die. I just can't imagine that I'd want to give it to someone. So I always want them to know [I am HIV positive]." Even the participant who had disclosed least frequently among the sample had weighed the personal consequences of nondisclosure, if not for himself, at least for other HIV-positive persons: "If you can live with yourself going around possibly killing people, go ahead." However, some participants assuaged this concern when they witnessed disregard for personal safety from sexual partners, especially those seeking sex through barebacking websites. "I'm not fuckin' and thinkin,' 'Oh, God, I'm HIV positive. I should have told him.' Oh, hell no. I mean he's where he wants to be, too."

This dilemma of protecting others stems from uncertainties about responsibility. People with HIV question whether they should have a greater responsibility for initiating sexual risk negotiation than persons who are seronegative or have not been tested. There was a variety of expressions of responsibility—for disclosure, for risk negotiation, for using condoms, and for providing emotional support following disclosure.

Some participants established "blanket policies" for always disclosing their seropositivity before intimacy begins. One did so because he remembered how difficult it was as a seronegative man to initiate such conversations. "Now that I'm positive, I feel as if I have [a] disclaimer edge. I can say it a lot easier than someone who is negative can... I think it's a nice gesture. I think it's easier, at least for me, to mention it... then [to be HIV negative] and sit thinking, 'Okay, I'm negative, what is the other person,' and agonize over it."

However, others believed that adults are responsible for their own decisions. A participant, in his early 20s, described how he would first disclose his serostatus and then refer

potential dates or sexual partners to clinics or websites about AIDS, concluding, "I'd rather have [him] go find out all that information [about sexual risks] before we do anything. That way [he] can make an informed decision." Even those with a tendency to not disclose would do so if they viewed the potential sex partner as particularly vulnerable. A 45-year-old participant admitted feeling protective of young persons or those with low mental acuity. "I know this sounds corny . . . I have a thing about protecting the innocent."

Regardless of track records of disclosure and/or safer sex, the research participants discussed honesty both from the perspective of altruism and self-respect. For some, the desire to disclose stemmed from social marketing of HIV-prevention messages. "There was a lot of education in 1996 and 1997, of really a lot of talk of how can we [as MSM] stop the spread of HIV infection. And one was to be honest and divulge." The same participant, in his early 60s, went on to describe how MSM do not talk openly about sex. "There's still some Victorian kind of plague that we have that won't allow us to enjoy talking about sex . . . and be open and honest." Delaying disclosure can be hard on the soul, according to several participants. "I think it's a little, a strain on my [conscience], especially if I get to know them . . . one thing about friendship is about being open and honest . . . I wasn't being honest with myself either."

Participants often suggested they would be honest if they were asked their serostatus. Unfortunately, as one participant smirked while mocking official U.S. government policy toward gays in the military, "They're not asking. So I'm not telling." However, he quickly added that HIV-positive MSM need to deconstruct such rationalizations. "[AIDS] is part of us today. We just need to learn to deal with it honestly. It's just rationalization when, when you think about, 'Well, they didn't ask.' We need to give each other choices."

Envisioning sex as HIV positive

Participants described how their seropositivity influenced choices around representing themselves to others, views about safer sex, where they sought sexual experiences, and sex practices themselves, including barebacking (the preference of some men—both HIV negative and positive—to seek sexual partners who choose to not use condoms). Some of the study participants went through varying periods of time where they felt like "damaged goods" and avoided sex either because they felt like "biohazards" or had no sexual libido, sometimes due to pharmaceutical side effects. Insensitive or insecure sexual partners and nervous medical professionals can unintentionally reinforce feelings that people with HIV are corporeally dangerous. However, one participant who originally felt stigmatized by HIV now jokes about how he reveals his serostatus on MSM personals websites. "I chose the one that I'm biohazard, and [website visitors] sort of got offended by it . . . that I was 'degrading' myself . . . I look at it pretty light-heartedly . . . I was down about it for years, and then, you know, life is too short I guess, you know, to, to be so serious about it."

Frequency of sexual activity among the participants ranged from rare sexual encounters to one participant, who had been keeping a log to track his sexual history and activity in an effort to reinforce sexual safety, who estimated he had had anal sex with about 10 male sexual partners monthly. All participants said they had pondered with what types of sex, with whom, and under what circumstances they would be comfortable

knowing they could potentially expose and infect others. What was considered "safe" or "safer" varied; accordingly, some men who considered themselves tops (insertive partners) prior to seroconversion adapted their sexual roles to be bottoms (receptive partners) to reduce transmission risk.

Some participants suggested that by now, MSM have had AIDS so ingrained in their minds that everyone "knows what's out there." Many struggled with their feelings of obligation to disclose and commonly concluded that as long as they used a condom for anal sex, withdrew before ejaculating, or avoided insertive oral intercourse, then nondisclosure was okay. "So as far as my, my, uh, not divulging, I would rationalize, well, I'm just going to be very, very safe. I was very comfortable with uh, telling myself as long as you're really safe with, with your partner, your sexual partners, um, you don't really have to tell." Of course, participants also expressed the view that condoms are not failsafe. "Is condom use a hundred percent safe during anal sex? Hell no. It's better than nothin,' but it's not a hundred percent safe and I know that. . . . It's some sort of protection, but it's still, we should make [HIV status] clear."

Another rationalization for not using condoms stems from misconceptions or misinterpretations of undetectable or low viral loads. Although medicine and public health have attempted to provide clear messages that there is no evidence that HIV can be completely eradicated from the body, some participants construe undetectable viral load as a factor in safer sex and for nondisclosure. "I'm glad that [I don't have] a viral load of two million, but, in a way, I think if that were the case, I would probably be more likely to say right away I'm HIV positive. But because of this extensive time being undetectable and a higher T-cell level, I've, in my sick head, managed to convince myself that I'm nearly negative. . . . I've rationalized it to mean that basically you're almost negative, so, why bring this up and spoil a nice evening?"

As described below in "Hearing others," "doing the right thing" is contextually complicated given the increasing number of men complacent about protecting themselves from HIV. It is further complicated by the social phenomenon of barebacking. Encountering resistance to using condoms for anal intercourse has angered some of the study participants. "I just wonder who most of these people are. Just 'cause they're almost, you listen to 'em, they're almost arrogant about it. . . . [I]f somebody came up to me like that or I ended up in a situation where somebody was like, 'It's barebacking and da-da-da,' that's it, I'd have to slap him and say, 'Get the hell out of my bed.'"

On the other hand, some of the participants advertise for bareback sex and assume that men who seek bareback sex "know what they are getting into." However, according to several participants, this leads to faulty generalizations about serostatus. "Negative guys assume that a guy using a condom is negative and a poz guy assumes that if condoms are being used the other guy is positive." As was the case with the participant quoted above who is concerned about some sexual partners being naïve or particularly vulnerable, another participant who knows that he has infected others in the past said that although he does not identify his serostatus in personal ads, he will ignore Internet instant messages from persons who identify as HIV negative. If they persist, he then advises them that he's HIV positive. "[T]hey'll write they're HIV negative . . . and then I'll write to them, 'Well, I'm HIV positive, so I don't think it will really work out.' And this [web]site

is an unsafe sex site. So that's why you know exactly what they're there for. Unsafe sex. And then they'll email me back and say, 'Well, that's okay, I still want you to fuck me.' And I'll be like, 'Oh, I can't do that.'" When prompted to further elaborate why he doesn't just list his serostatus, the participant tersely responded, "It's nobody's business. I don't want people to know."

Hearing others

Health and social service professionals, other people with HIV, community attributes, and perceptions of AIDS complicity contribute to the formation of personal disclosure policies. From the moment of diagnosis, people with HIV begin discerning what others think they should do in terms of their sexual activity and serostatus disclosure. Although the United States-mandated protocol for HIV testing requires testing counselors to assist newly diagnosed seropositive persons in thinking about contact tracing and future behavior, it is often ill timed. Testing counselors sometimes give mixed messages. Some participants recalled being told that they needed to become responsible for others by practicing safer sex and communicating about HIV status, but that they should also be extremely mindful of privacy.

One participant recalled the efforts of a clinician to enroll him in partner counseling and referral services to notify previous sex partners they should consider being tested for HIV. This led to oppositional behavior. "[T]hey were tryin' to make me go back and tell every person that I had sex with that, you know I was positive, and I'm like, hmm! There's no way . . . they were just sort of ruthless about it."

Following initial posttest counseling, none of the participants recalled ever talking about disclosure ever again in a medical setting, even though nearly all of them had regular contact with medical case managers, physicians, and nurses. The participants suggested that it is almost as if these professionals wished not to know if patients are potentially spreading HIV. Outside the medical clinic, some participants reported receiving messages about condoms, but not about disclosure with their psychologists or psychiatrists, even when they were seeking assistance for sexual communication. For them, this seemed to reinforce the rationalization that "as long as you use condoms, you don't need to tell."

HIV-positive peers seem a likely source of assistance for formulating a disclosure policy, but unfortunately, few of the research participants found professionally facilitated support groups useful.

I go up to [an AIDS support group], and it's like "Oh, we just tell them." It just doesn't seem like it's that easy, you know, for me, for some reason. I've kind of dealt with the frustration with [the support group], they don't want to talk about it. That why I put it on the back burner. I'm probably dealing with some things that they were dealing with when they first were diagnosed. . . . I'm not going anymore. In fact, I really got angry with them about this.

Another participant's story was similar. He signed up for a time-limited, multiple session counseling group and found that the group members were more interested in dating him than in providing support for making decisions about things like serostatus disclosure. So, he tried another venue, one more geared toward socializing with other HIV-positive MSM than coping with HIV. Unfortunately, because this

event was held in a bar, he was uneasy about the publicness of the event and the caliber of men who attended.

[T]hey seemed to be havin' a really good buzz by the time I got there at 6:00. Not that I'm something better than anyone. . . . I was a little uncomfortable, I didn't like how they advertised it when you were there, how they'd talk on the intercom, "We're havin' an HIV positive thing here." Big old sign. . . . And when I saw that sign, you know, and they did the announcements, it was just too much. I had to slam a few drinks down.

The best support for deciding how to deal with issues of disclosure seems to be provided by long-time friends. A participant described the importance of friends who were HIV positive. "I had two wonderful [HIV-positive] exes. The one [who lives locally], I'm glad he was around when I found out about my status. He was a rock. He'd known about his [seropositivity] for years. So that really helped, that was a good support network."

Seronegative friends can also be supportive. One participant described how his roommates check in with him about important issues, including serostatus disclosure to men he is dating. "My roommates know, and so they're always like, 'Have you told him yet?' I'm like, 'I'll tell him this week.' . . . Three weeks I think is my longest with not telling one that I was gonna go into a relationship with that. That's when my one roommate, who I've known the longest . . . he pushes me [to disclose] . . ."

Sometimes, however, it can feel like friends and acquaintances are meddling. One participant described how he enjoys the support from his friends in a community theater group, but also worries about gossip and potential judgment.

It's a great group of guys. . . . [W]hen I first joined the [theater group], people were very friendly to me. . . . They're different now. Cause now that I'm with [the director], they treat me differently and, and it, I'm thinking about dropping out for a while. . . . I don't want people to know [I'm HIV positive], because . . . they already talk about me as it is. About me and [the director]. I don't need to be talked about, I don't want to be talked about. [laughs nervously] I just want to be left alone. They know I sleep around. You know, and people have warned other guys about that and that has hurt my feelings.

In terms of receiving advice or support from families, there was a split among the research participants in terms of having disclosed their serostatus to family members. Among those that have shared their serostatus, some reported warm relationships and others not so warm. However, none reported that disclosure to sexual partners is a topic they have discussed with brothers or sisters, mothers or fathers.

Community attributes also influenced participants' personal disclosure policies. Most of the participants lived in Seattle, which they described as a liberal enclave and generally receptive both to homosexuality and HIV seropositivity. Some of the participants from smaller communities in the Northwest had moved specifically to Seattle to avoid being a "social pariah" even among other MSM. However, even Seattle was viewed as having a small gay community where "there are no secrets." HIV-positive MSM who fear loss of privacy may be inclined to not disclose their serostatus for fear of this news being spread.

Most participants described Seattle as having plentiful AIDS-related support and medical services. Not all participants agreed. One participant lamented the disappearance

of prevention messages in the media and the demise of formerly popular and well-attended AIDS fundraisers in Seattle. Another participant, aged 21, suggested a generational difference where AIDS is abstract and people with HIV are invisible to younger MSM who were not witness to activism in the 1980s and 1990s.

I really don't know anyone who's positive so it's not really, I'm not up front for them, but I think in a lot of ways it's dangerous, too. Because I have met people who are my age or younger who haven't had the life experiences, who are little bit more insecure and being positive just adds to those insecurities, and even more if they're in the closet about it. So they don't tell people, there's that whole fear factor there. So I think younger people being that way are even more likely to have sex without telling someone or more likely to have unprotected sex and not be careful and maybe spread it to someone.

Stereotypes about people with HIV apparently abound in Seattle. Participants described others' expectations of them as either promiscuous or as damaged goods to be perhaps pitied, but not as someone to date. "[There is still] the stereotype around HIV and AIDS as a gay disease, as . . . an indication of promiscuity. [Also] the stereotype of HIV-positive people being sickly and weak. I am NOT the type of person that sits really well with being characterized as a weak, sickly person."

Anticipating reactions and consequences

As part of forming personal disclosure policies, participants suggested that thinking through the past and potential consequences of telling or not telling sexual partners was a major component of deciding what to do as a routine course of action in various circumstances. Not knowing what to expect with disclosure confounds newly diagnosed HIV-positive MSM. Some recalled having framed their policies based upon previous concerns about risk negotiation as seronegative. "When I was negative, it was embarrassing to bring up. It was like . . . we have to get past this hurdle. What are we gonna find out? Is he going to go running? Am I going to go running away? I would never have run away."

Regardless of seropositivity tenure, the participants all agreed that even after a decade or more of being HIV positive, disclosure is always anxiety provoking because the outcome is uncertain. Thus, it is commonplace to "always expect the worst," which translates as rejection of some sort. Being rejected for sex was a ubiquitous fear. "Disclosure would sort of null many of my chances for a prospective encounter or whatever. I don't want it to possibly limit the sexual encounters that I would like to have." Beyond sex, newly diagnosed men may fear they will never have an enduring romantic relationship ever again. "It's like when you meet somebody you're in this sort of elevated fantasy . . . just a heightened sense of joy. And you realize that all can be gone, once you [disclose]."

As described earlier, participants emphasized they dread being regarded as sickly or handicapped following serostatus disclosure. Being pitied is not acceptable, and anticipating that a sex partner may engage in "pity sex" is demeaning.

The degree to which anticipating reactions is weighted in forming a personal disclosure policy is reinforced or mitigated by actual reactions to disclosure. For the most part, the participants reported that disclosure reactions were far less dramatic than they anticipated and that the act of disclosure is less daunting after the first few times. Thus, first experiences

with disclosure may be particularly influential in deciding what to do in the future. However, for some, even when things go well, they continue to experience anxiety about the next time because the fear of rejection is so pervasive.

Although being rejected for any type of sex was unusual, the way that sexual partners handle disclosure affects whether the participants would consider doing it again. In general, there is a moment of silence while the sexual partner decides how to respond. Most often, sexual activity resumed again, but with an understanding that only safer activities would happen. This, of course, feels respectful and rational. However, some reactions are confusing, concerning or cause anger. "I did get brave and tell a guy before anything happened and his response was, 'So?' I was like, 'So? I didn't just tell you I had a head cold.' And just, just dismissing it so quickly as not a big deal." Another participant was dumbfounded by a similar reaction. "Are they saying 'so what' because they don't give a damn? They're that reckless? Or they, too, are positive? Or what? . . . And if they don't care about my status of their own, and they show it, I take that as acceptance of anything that if I'm HIV positive they don't particularly care. And that's probably not a good idea."

The research participants reported a wide range of feelings postdisclosure and also following not disclosing, including shame, pride, anger, happiness, and sadness. Frequently, participants reported the process was relieving.

Discussion

Given great successes in pharmacologically treating HIV disease since 1996, the number of seemingly healthy, sexually active MSM with HIV has been increasing. It is critically important to connect a thicker description of serostatus disclosure to inform prevention with positives, an increasingly studied common-sense prevention approach. Forming a Personal Disclosure Policy verifies previously published accounts of factors influencing serostatus disclosure and offers a framework for understanding the process of establishing a personal disclosure policy to guide sexual behavior.

Data analysis revealed five complementary components of the process of forming a personal disclosure policy. Through the iterative process of developing rationales to guide their behavior and experiencing interpersonal and societal cues about what they should do, HIV-positive MSM develop personal disclosure policies, or sets of contingencies for coping with the possibility of transmitting HIV infection to other persons. These individual policies range from plans to always disclose seropositivity prior to sexual behavior, to disclose only to particular sex partners (e.g., those perceived as naive or those with whom romance may ensue or is desirable), to never disclosing under any circumstances.

These varying policies could be operationalized to bear similarity to the construct of "intention" that is part of models of rational decision making, including the Theory of Reasoned Action and the Theory of Planned Behavior that theorize sexual behavior and communication.⁶³ In brief, rational decision-making models theorize that individuals intend to engage or not engage in a particular behavior based on how much they desire to execute the behavior, how strongly they adhere to norms in favor of the behavior, and in some of the models, their confidence in executing the behavior. The analysis and its interpretation suggest harmony of the themes

that constitute the first part of the grounded theory model, Forming a Personal Disclosure Policy, with rational decision-making models. "Hearing others" is similar to the concept of social norms and "Anticipating reactions and consequences" and "Envisioning sex as HIV positive" both reflect the idea of weighting potential outcomes of behavior, the time-honored backbone of rational decision making. Of course, it is important to be critical of rational decision-making models because sex is laden with emotion, spontaneity and uncertainty, and is perhaps spiritually transcendent.⁶⁴ Building theories of disclosure on rational models is likely useful only if a fuller exploration of values is undertaken. Attempts to control sexual behavior, especially among MSM who are so grossly over-defined by others as prioritizing sex over everything else in life, often meets with resistance. Barebacking is a primary example: it may have become fetishized as an appealing danger⁶⁵ and transgressive.¹⁷ Thus, the internal dialogue about what one "should do" can be contradictory. In the end, it may well be that community norms may have less to do with what happens with sex and serostatus disclosure than does instrumentality (e.g., having sex to release feelings) or power.⁶⁶ Paradoxically, some MSM fully intend to engage in unsafe behavior to privilege desire over safety, which for them is, in fact, rational.⁶⁷

However, the grounded theory also suggests two other themes, "Making sense of personal infection stories" and "Being altruistic," which are less represented in theories commonly used to understand HIV risk behavior and structure HIV-prevention interventions. "Making sense of personal infection stories" emerged as a potentially powerful aspect of disclosure decision making. Participants who seemed not to have resolved feelings of anger toward the person who had infected them, or individuals who seemed especially prone to suffer from family or friends' predictions that they would be the "type" of person to get infected, seemed to form personal disclosure policies of either using condoms and not disclosing or completely abdicating safety decisions to sexual partners. The idea that individuals who have not resolved their feelings about their own infection has been explored in reference to sexual behavior that is likely to expose others to HIV.^{56,57} Coping with HIV and internalized stigma likely occurs along a continuum of acceptance that may correspond with a trajectory of illness.⁶⁸ Although there are several styles of coping, including social, physical, emotional, cognitive, and spiritual strategies, the coping literature suggests the critical importance of a social support network in maintaining or recovering health. AIDS theorists have described the health benefits of accessing others for support after being diagnosed, and as suggested earlier, HIV-testing counselors are charged with assisting their newly diagnosed HIV-positive patients with identifying support persons. Such support networks may play a central role in assisting individuals toward psychological resolution of their infection stories. This resolution seems important, not just from the point of view of successful adaptation to living with HIV, but also in regards to transmission risk reduction. As public health moves onward with "Prevention with Positives" and "Know Your Status" initiatives⁵ designed to prevent new infections and enroll HIV-positive persons in care earlier in the HIV disease trajectory, it is important to realize that the participants in this study described HIV posttest counseling as too poorly timed to really be useful. The second theme also less traditionally included in

standard models of HIV risk behavior etiology and, rather surprisingly, HIV prevention interventions, is altruism. Theorized to be indicators of altruism, "being responsible," and "having concern for others" as often voiced by the participants, seem critical to the formation of pro-disclosure policies. Long held to be a predictor of pro-social behavior in the social sciences, altruism could be credited as a primary reason that not more MSM died in the first wave of AIDS in the United States and other Western countries. During the early and mid-1980s, omnipresent fear gripped gay communities, the media stigmatized MSM, and governments unofficially ignored the growing AIDS epidemic. Because few outside gay communities would, MSM had to care for themselves. Within-group altruism created a figurative and literal safety net; MSM not only cared for one another when no one else would, but more pointedly to the issue of prevention, also constructed the notion of safer sex, which to date has been the only truly successful barrier to sexual transmission of HIV.

Developing a personal disclosure policy could be understood using frameworks inherent in theories of moral development such as Kohlberg's and Gilligan's. Indeed, "personal disclosure policy" might well be termed "disclosure conscience." However, it may be prudent to distance the theorizing of disclosure from concepts of moral development given how stigmatized the disease already is,^{24-30,69-77} and referenced by participants who described their ostracism and social descent after being known to be HIV positive by peers, especially in smaller communities. In addition, stage theories of moral development tend to "stop" once adolescents reach adulthood and may not be a good fit for understanding complex decision making of mature adults.

On the other hand, as suggested by some HIV-positive men's policies of not disclosing as long as they always use condoms for anal intercourse, further study of this particular rationale through the lens of moral development could be useful. Many of the participants suggested they bear some responsibility in the "two-way streets" of sexual situations, but simultaneously voiced a dread of infecting others. Thus, understanding moral development from the perspective of reinforcing responsibility toward others is not only warranted, but also indicated by the participants themselves, many of whom looked inward, to higher powers, and to peers and social services to assist them in the process of becoming strong enough to do the "right thing" even in the face of community resistance or complacency.

The inquiry also verified that "prevention complacency"²⁰ exists among HIV-positive MSM and concerns some of them. Better understanding how personal disclosure policies are developed in tandem with community dynamics would be useful. Using theories of moral development to invite increased disclosure will not be effective if disclosure is considered unnecessary or gauche by community referents. What is needed more than a focus on influencing individual attitudes is perhaps an emphasis on more macro-level campaigns designed to reignite community consciousness for HIV prevention—for both HIV-negative and HIV-positive MSM.

Limitations

Interviewees were invited to participate based more on a selective than a theoretical sampling strategy. This was for

three reasons: availability, timing, and resources. First, an intermediary from the originating clinical study was used to secure permission to contact prospective participants. Rather than "stockpiling" potential participants to theoretically sample, it was determined early in the data collection process that some participants, given their sometimes unstable lives, could be "lost" if not interviewed in close proximity to the time they participated in the clinical study. Thus, if an individual seemed a good candidate for the research, contact was made immediately and an interview was conducted, rather than waiting until the process of data analysis suggested it was time for another interview, or that a possible participant represented a particular category of interest or likelihood for consecutive theory building on any particular theme. Second, time became an issue given the imminent end of the clinical study that served as the participation conduit. Thus, rather than conducting data analysis simultaneously with data collection, it was necessary to complete interviews with the last available, willing, and appropriate participants before the clinical study ended. Third, financial resources were limited for participation incentives and transcription.

During data collection and coding, memorandums were generated to begin to form mini-hypotheses to be later explored in further data analysis, and tested (if possible) during subsequent interviews with other participants. The memorandums became guideposts for developing the explanatory framework of the emergent grounded theory. Theoretical saturation, a rather ambiguous and uncomfortable decision point, is generally described as the point at which no new information emerges. Given the above-described time and resource issues, themes might well have been further clarified with additional interviews. The issue of "how many participants is enough?" is thorny in the best of circumstances in making claims about generalizability. However, the themes are empirically grounded as evidenced by direct quotations. Nevertheless, given the sample size of 15 as well as the diversity of experience and demographic characteristics represented among the participants, results may not be generalizable. Other potential sources of methodological bias include the sample being selected from a clinical trial of a motivational enhancement prevention intervention; self-selection into the clinical trial may have limited the potential for greater representation.

In summary, despite the constraints of time and resources that may have limited the density of the data overall, this exploratory research presents a useful framework. It is only with the test of time and further in-depth inquiry that the grounded theory model itself will be judged for its relevance to other research endeavors and practice.

Implications

Conducting contextual research using a life-course perspective would be helpful in understanding how HIV-positive MSM adapt their personal disclosure policies over time. As suggested in the grounded theory, good or bad experiences with disclosure can reinforce or weaken desires to disclose in the future. In general, the study participants suggested that, over time, disclosure becomes easier. Although explored in some detail in the second part of the grounded theory,⁶⁰ a more in-depth inquiry is needed to contextualize further strategies for timing and staging disclosure to avoid rejection

and enhance possibilities of serostatus-discordant relationship commitment.

It was disheartening to learn that so many of the participants felt their initial experiences with HIV testing counselors were not helpful, and occasionally stigmatizing. Rather than maligning these professionals for incompletely executing their responsibilities for assisting persons who test HIV positive, it is suggested that an examination of the timing of such counseling be conducted. It may be that such immediate efforts are not useful given the shock of the diagnosis. Instead, crisis intervention and referral to a case manager might be more useful.

The findings support the exploration of feelings of responsibility and attributions for personal infection in individual transmission prevention counseling. Because of the linkages described between mental and physical health, as well as the hypothesized connections between attributions of responsibility for infection, mental health therapists would be well served to consider exploring personal infection stories with their HIV-positive clients.

Several participants suggested they would benefit from a supportive environment wherein they could talk about and learn ways to disclose their HIV status and to garner support following rejection. After a period of as-needed crisis intervention counseling for newly diagnosed HIV-positive people, cognitive-behavioral counseling techniques could be used both in individual and group settings to assist persons in determining ways to cope successfully with disclosing their serostatus. However, care should be taken in composing such groups: Several participants described poor experiences with support groups in which members who had been coping with HIV for many years were not interested in supporting their more recently diagnosed peers.

Beyond individual-level counseling, greater attention should be paid to community level interventions. Examples of social marketing campaigns for encouraging transmission risk reduction exist, including "AIDS Stops with Me," a community-level program that uses testimonials by HIV-positive people in a user-friendly website (see www.hivstopswithme.org/). However, as often has been the case in the history of HIV prevention and sex education in general, frank and open messages, such as those in "AIDS Stops with Me," are not always viewed kindly by funders, politicians, and communities.¹²

According to the participants, transmission risk reduction was never a topic of discussion by the case managers, physicians, nurses, acupuncturists, or other AIDS service professionals with whom participants worked. Health professionals are urged to invite such conversations with their HIV-positive clients or patients. All of the participants agreed that it was unlikely they would be offended if their doctor, nurse, or social worker invited them to consider talking about safer sex or HIV disclosure. However, health professionals themselves may be uncomfortable with or unprepared to discuss these topics.^{47,78} Furthermore, there are often inherent conflicts of interest for case managers in the dual roles of brokering services and discussing behavior change.⁹ Recent innovations suggest medical care providers themselves can be effective in counseling PLHA to reduce unsafe sexual behavior.⁷⁹ Professional recertification should include courses with content designed to assist a variety of health service practitioners with becoming comfortable discussing matters of sexuality and to

confront internalized oppressions that may militate against sympathetic responses to those seeking help.

Legislation criminalizing not disclosing seropositivity to sexual partners is increasing.⁵⁵ However, nearly all the participants said that they had no idea if such laws existed or if they were enforceable. A greater awareness is needed of what these policies and laws mean for individuals who, for example, adopt personal disclosure policies of telling sexual partners except in the case of sex venues where people are assumed knowledgeable of the HIV transmission risks. UNAIDS⁸⁰ warns that using criminal law to regulate sexual risk behavior can backfire if public health laws are not complemented by protections of human and civil rights. In brief, UNAIDS suggests that legal remedies often are inappropriate and only result in further stigma of people with HIV. As described by the participants, some people with HIV are socially constructed as "biohazards" and threats to the general public. It is not unreasonable to postulate that some persons might be deterred from being tested for HIV if they feared prosecution for past or current sexual behavior. Furthermore, for populations already mistrustful of public health, worrying that a testing counselor could refer a case to law enforcement might result not only in not being tested, but also in not receiving palliative care as well as focused transmission reduction counseling.

The successes in treating HIV continue to be exciting, but unfortunately are not shared by all the world's citizens. Given the growing population of seemingly healthy, sexually active people with HIV, more funding is needed to continue to support not only advances in pharmacotherapy, but also in prevention with positives at state, national, and international levels. Better understanding the dynamics and contexts of disclosure communication within sexual situations is vital to success with prevention with positives interventions.

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References

- Centers for Disease Control and Prevention. Trends in primary and secondary syphilis and hiv infections in men who have sex with men—San Francisco and Los Angeles, California, 1998–2002. *MMWR Morb Mortal Wkly Rep* 2004;53:575–578.
- Buchacz K, Greenberg A, Onorato I, Janssen R. Syphilis epidemics and human immunodeficiency virus (HIV) incidence among men who have sex with men in the United States: Implications for HIV prevention. *Sex Transm Dis* 2005;32(10 Suppl):S73–S79.
- Sasse A, Defraye A, Ducoffre G. Recent syphilis trends in Belgium and enhancement of STI surveillance systems. *Euro Surveill* 2004;9:6–8.
- Kok G. Targeted prevention for people with HIV/AIDS: Feasible and desirable? *Patient Educ Couns* 1999;36:239–246.
- Centers for Disease Control and Prevention. Advancing HIV prevention: new strategies for a changing epidemic—2003. *MMWR Morb Mortal Wkly Rep* 2003;52:329–332.
- Gasiorowicz M, Llanas M, DiFranceisco W, et al. Reductions in transmission risk behaviors in HIV-positive clients receiving prevention case management services: findings from a community demonstration project. *AIDS Educ Prev* 2005;17(1 Suppl A):40–52.
- Kalichman SC, Rompa D, Cage M, et al. Effectiveness of an intervention to reduce HIV transmission risks in HIV-positive people. *Am J Prev Med* 2001;21:84–92.
- Margolin A, Avants SK, Warburton LA, Hawkins KA, Shi J. A randomized clinical trial of a manual-guided risk reduction intervention for HIV-positive injection drug users. *Health Psychol* 2003;22:223–228.
- Mitchell CG, Linsk NL. Prevention for positives: Challenges and opportunities for integrating prevention into HIV case management. *AIDS Educ Prev* 2001;13:393–402.
- Rutledge SE. Single-session motivational enhancement counseling to support change toward reduction of HIV transmission by HIV positive persons. *Arch Sex Behav* 2007;36:313–319.
- Wolitski RJ, Janssen RS, Onorato IM, Purcell DW, Crepaz N. An overview of prevention with people living with HIV. In: Kalichman SC, ed. *Positive Prevention: Reducing HIV Transmission Among People Living with HIV/AIDS*. New York: Kluwer, 2005:1–28.
- Palmer NB. "Let's talk about sex, baby": Community-based HIV prevention work and the problem of sex. *Arch Sex Behav* 2004;33:271–275.
- Pinkerton SD, Galletly CL. Reducing HIV transmission risk by increasing serostatus disclosure: A mathematical modeling analysis. *AIDS Behav* 2007;11:698–705.
- Courtenay-Quirk C, Wolitski RJ, Parsons JT, Gomez CA. Is HIV/AIDS stigma dividing the gay community? Perceptions of HIV-positive men who have sex with men. *AIDS Educ Prev* 2006;18:56–67.
- King E. *Safety in Numbers: Safer Sex and Gay Men*. New York: Routledge, 1993.
- Sheon N, Crosby MG. Ambivalent tales of HIV disclosure in San Francisco. *Soc Sci Med* 2004;58:2105–2118.
- Sheon N, Plant A. Protease dis-inhibitors? The gay bareback phenomenon. www.managingdesire.org/sexpanic/ProteaseDisInhibitors.html (Last accessed August 28, 2008).
- Stockman JD, Schwarcz SK, Butler LM, et al. HIV prevention fatigue among high-risk populations in San Francisco. *J Acquir Immune Defic Syndr* 2004;35:432–434.
- Heavner KK, Shaw B, Battles H, McClamroch K, Tesoriero J, Birkhead GS. HIV prevention fatigue: Men who have sex with men (MSM) are tuning out HIV prevention messages. Paper presented at: Annual Meeting of the American Public Health Association. Washington, D.C: November 5, 2007.
- Valdiserri, RO. Mapping the roots of HIV/AIDS complacency: Implication for program and policy development. *AIDS Educ Prev* 2004;16:426–439.
- Huebner, DM, Rebechook GM, Kegeles SM. A longitudinal study of the association between treatment optimism and sexual risk behavior in young adult gay and bisexual men. *J Acquir Immune Defic Syndr* 2004;37:1514–1519.
- Sullivan PS, Drake AJ, Sanchez TH. Prevalence of treatment optimism-related risk behavior and associated factors

- among men who have sex with men in 11 states, 2000-2001. *AIDS Behav* 2007;11:123-129.
23. Katzman J, Gulati H, Higa DH, Welch Q, Wood RW. A "community manifesto" for gay and bisexual men: An appeal to control HIV/STDs. *J Public Health Management Practice* 2007;13:244-251.
 24. Herek GM, Capitanio JP. AIDS stigma and sexual prejudice. *Am Behav Sci* 1999;42:1130-1147.
 25. Valdiserri RO. HIV/AIDS stigma: An impediment to public health. *Am J Public Health* 2002;92:341-342.
 26. Herek GM, Capitanio JP, Widaman KF. HIV-related stigma and knowledge in the United States: Prevalence and trends, 1991-1999. *Am J Public Health* 2002;92:371-377.
 27. Devine PG, Plant EA, Harrison K. The problem of "us" versus "them" and AIDS stigma. *Am Behav Sci* 1999;42:1212-1228.
 28. Parker R, Aggleton, P. HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. *Soc Sci Med* 2003;57:13-24.
 29. Henkel KE, Brown K, Kalichman SC. AIDS-related stigma in individuals with other stigmatized identities in the USA: A review of layered stigmas. *Soc Pers Psychol Compass* 2008;2:1586.
 30. Mahajan AP, Sayles JN, Patel VA, et al. Stigma in the HIV/AIDS epidemic: A review of the literature and recommendations for the way forward. *AIDS* 2008;22(Suppl 2):S67-79.
 31. Sayles JN, Hays RD, Sarkisian CA, Mahajan AP, Spritzer KL, Cunningham WE. Development and psychometric assessment of a multidimensional measure of internalized HIV stigma in a sample of HIV-positive adults. *AIDS Behav* 2008;12:748-758.
 32. Butler DM, Smith DM. Serosorting can potentially increase HIV transmissions. *AIDS* 2007;21:1218-1220.
 33. Parsons JT, Severino J, Nanin J, et al. Positive, negative, unknown: Assumptions of HIV status among HIV-positive men who have sex with men. *AIDS Educ Prev* 2006;18:139-149.
 34. Philip S, Donnell D, Yu X, Vittinghoff E, Buchbinder S. Serosorting, but not seropositioning, is associated with decreased risk of HIV seroconversion in the EXPLORE study cohort. Paper presented at: 15th Conference on Retroviruses and Opportunistic Infections. Boston, MA: February 4, 2008.
 35. Morin SF, Shade SB, Steward WT, et al. A behavioral intervention reduces HIV transmission risk by promoting serosorting practices among HIV-infected men who have sex with men. *J Acquir Immune Defic Syndr* 2008;49:544-551.
 36. Klitzman R, Exner T, Correale J, et al. It's not just what you say: Relationships of HIV disclosure and risk reduction among MSM in the post-HAART era. *AIDS Care* 2007;19:749-756.
 37. Marks G, Richardson JL, Maldonado N. Self-disclosure of HIV infection to sexual partners. *Am J Public Health* 1991;81:1321-1323.
 38. Parsons JT, Schrimshaw EW, Bimbi DS, Wolitski RJ, Gomez CA, Halkitis PN. Consistent, inconsistent, and non-disclosure to casual sexual partners among HIV-seropositive gay and bisexual men. *AIDS* 2005;19(Suppl 1):S87-97.
 39. Perry SW, Card CA, Moffatt M, Ashman T, Fishman B, Jacobsberg LB. Self-disclosure of HIV infection to sexual partners after repeated counseling. *AIDS Educ Prev* 1994;6:403-411.
 40. Semple SJ, Patterson TL, Grant I. Partner type and sexual risk behavior among HIV positive gay and bisexual men: Social cognitive correlates. *AIDS Educ Prev* 2000;12:340-356.
 41. Wolitski RJ, Rietmeijer CAM, Goldbaum GM, Wilson RM. HIV serostatus disclosure among gay and bisexual men in four American cities: General patterns and relation to sexual practices. *AIDS Care* 1998;10:599-610.
 42. Harawa NT, Williams JK, Ramamurthi HC, Bingham TA. Perceptions towards condom use, sexual activity, and HIV disclosure among HIV-positive African American men who have sex with men: Implications for heterosexual transmission. *J Urban Health* 2006;83:682-694.
 43. Schnell DJ, Higgins DL, Wilson RM, Goldbaum G, Cohn DL, Wolitski RJ. Men's disclosure of HIV test results to male primary sex partners. *Am J Public Health* 1992;82:1675-1676.
 44. Sullivan KM. Male self-disclosure of HIV-positive serostatus to sex partners: A review of the literature. *J Assoc Nurse AIDS C* 2005;16:33-47.
 45. Marks G, Ruiz MS, Richardson JL, et al. Anal intercourse and disclosure of HIV infection among seropositive gay and bisexual men. *J Acquir Immune Defic Syndr* 1994;7:866-869.
 46. Simoni JM, Pantalone DW. Secrets and safety in the age of AIDS: Does HIV disclosure lead to safer sex? *Top HIV Med* 2004;12:109-118.
 47. Marks G, Crepaz N. HIV-positive men's sexual practices in the context of self-disclosure of HIV status. *J Acquir Immune Defic Syndr* 2001;27:79-85.
 48. van Kesteren NMC, Hoppers HJ, Kok G, van Empelen P. Sexuality and sexual risk behavior in HIV-positive men who have sex with men. *Qual Health Res* 2005;15:145-168.
 49. Rhodes T, Cusick L. Accounting for unprotected sex: stories of agency and acceptability. *Soc Sci Med* 2002;55:211-226.
 50. Wolitski RJ, Bailey C, O'Leary A, Gomez CA, Parsons JT; Seropositive Urban Men's Study Group. Self-perceived responsibility of HIV-seropositive men for preventing HIV transmission to sex partners. *AIDS Behav* 2003;7:363-372.
 51. Gorbach PM, Galea JT, Amani B, et al. Don't ask, don't tell: Patterns of HIV disclosure among HIV positive men who have sex with men with recent STI practising high risk behaviour in Los Angeles and Seattle. *Sex Transm Infect* 2004;80:512-517.
 52. Derlega V, Winstead B, Folk-Barron L. Reasons for and against disclosing HIV-seropositive test results to an intimate partner: a functional perspective. In: Petronio S, ed. *Balancing the Secrets of Private Disclosures*. Mahwah, NJ: Lawrence Erlbaum; 2000:53-69.
 53. Rosser BRS, Gobby JM, Carr WP. The unsafe sexual behavior of persons living with HIV/AIDS: An empirical approach to developing new HIV prevention interventions targeting HIV-positive persons. *J Sex Educ Ther* 1999;24:18-28.
 54. Moskowitz DA, Roloff ME. Vengeance, HIV disclosure, and perceived HIV transmission to others. *AIDS Behav* 2008;12:721-728.
 55. Worth H, Patton C, McGehee MT. Legislating the pandemic: A global survey of HIV/AIDS in criminal law. *Sex Res Social Policy* 2005;2:15-22.
 56. Bingman CR, Marks G, Crepaz N. Attributions about one's HIV infection and unsafe sex in seropositive men who have sex with men. *AIDS Behav* 2001;5:283-289.
 57. Clement U, Schønnesson LN. Subjective HIV attribution theories, coping and psychological functioning among homosexual men with HIV. *AIDS Care* 1998;10:355-363.
 58. Serovich JM, Mosack KE. Reasons for HIV disclosure or nondisclosure to casual sexual partners. *AIDS Educ Prev* 2003;15:70-80.

59. Wolitiski RJ, Flores SA, O'Leary A, Bimbi DS, Gomez CA. Beliefs about personal and partner responsibility among HIV-seropositive men who have sex with men: measurement and association with transmission risk behavior. *AIDS Behav* 2007;11:676-686.
60. Rutledge SE. Enacting personal HIV disclosure policies for sexual situations: HIV-positive gay men's experiences. *Qual Health Res* 2007;17:1040-1059.
61. Glaser B. *Basics of Grounded Theory Analysis: Emergence vs. Forcing*. Mill Valley, CA: Sociological Press, 1992.
62. Strauss A, Corbin J. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*, 2nd ed. Thousand Oaks, CA: Sage, 1998.
63. Fisher JD, Fisher WA. Theoretical approaches to individual-level change in HIV risk behavior. In: Peterson JL, DiClemente RJ, eds. *Handbook of HIV Prevention*. New York: Kluwer Academic/Plenum, 2000:3-55.
64. Martin JL. Transcendence among gay men: Implications for HIV prevention. *Sexualities* 2006;9:214-235.
65. Gauthier DK, Forsyth CJ. Bareback sex, bug chasers, and the gift of death. *Deviant Behav* 1999;20:85-100.
66. Ridge DT. 'It was an incredible thrill': The social meanings and dynamics of younger gay men's experiences of barebacking in Melbourne. *Sexualities* 2004;7:259-279.
67. Slavin S, Richters J, Kippax S. Understandings of risk among HIV seroconverters in Sydney. *Health Risk Soc* 2004;6:39-52.
68. Alonzo AA, Reynolds NR. Stigma, HIV and AIDS: An exploration and elaboration of a stigma trajectory. *Soc Sci Med* 1995;41:303-315.
69. Fullilove MT, Fullilove II RE. Stigma as an obstacle to AIDS action. *Am Behav Sci* 1999;42:1113-1125.
70. Goldin CS. Stigmatization and AIDS: Critical issues in public health. *Soc Sci Med* 1994;39:1359-1366.
71. Herek GM, Mitnick L, Burris S, et al. Workshop report: AIDS and stigma: A conceptual framework and research agenda. *AIDS Public Policy J* 1998;13:36-47.
72. Kaplan AH, Scheyett A, Golin CE. HIV and stigma: Analysis and research program. *Curr HIV/AIDS Rep* 2005;2:184-188.
73. Madru N. Stigma and HIV: Does the social response affect the natural course of the epidemic? *J Assoc Nurse AIDS* 2003;14:39-48.
74. Mawar N, Saha S, Pandit A, Mahajan U. The third phase of HIV pandemic: Social consequences of HIV/AIDS stigma & discrimination & future needs. *Ind J Med Res* 2005;122:471-484.
75. Ogden J, Nyblade L. *Common at its core: HIV-stigma across contexts*. Washington, D.C.: International Center for Research on Women, 2005.
76. Taylor B. HIV, stigma, and health: Integration of theoretical concepts and the lived experiences of individuals. *J Adv Nurs* 2001;35:792-798.
77. Worthington T, Myers C. Factors underlying anxiety in HIV testing: Risk perceptions, stigma, and the patient-provider power dynamic. *Qual Health Res* 2003;13:636-655.
78. Marks G, Richardson JL, Crepaz N, et al. Are HIV care providers talking with patients about safer sex and disclosure?: A multi-clinic assessment. *AIDS* 2002;16:1953-1957.
79. Fisher JD, Fisher WA, Cornman DH, Amico RK, Bryan A, Friedland GH. Clinician-delivered intervention during routine clinical care reduces unprotected sexual behavior among HIV-infected patients. *J Acquire Immune Defic Syndr* 2006;41:44-52.
80. Elliott R, Maluwa M. *Criminal Law, Public Health and HIV Transmission: A Policy Options Paper*. 2002. www.unaids.org/publications/documents/human/JC733-CriminalLaw-E.pdf (Last accessed July 11, 2002).

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