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Barriers and Facilitators of HIV Disclosure: Perspectives from HIV-Infected Men Who Have Sex with Men

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Abstract

HIV disclosure among sexually active HIV-infected men who have sex with men (MSM) is a complex phenomenon. To better understand factors that impact the decision-making process regarding HIV disclosure among HIV-infected MSM, the present study analyzed content from previously conducted counseling sessions where HIV disclosure was selected as the primary focus of the session. The counselor/participant dialogue was audio-recorded, transcribed, and analyzed qualitatively using content analysis. Factors identified as barriers that deter HIV-infected MSM from disclosing include rejection, issues of confidentiality, possible missed sexual opportunities, partner's HIV status, deferred responsibility, sexual partner type, and public sex environments. Participants identified ethical obligation, the potential for a dating relationship, timing of disclosure, and bidirectional communication as facilitators of disclosure. Findings can be used for policy development as well as to guide social workers and other healthcare providers' assessment and development of clinical interventions addressing sexual health among HIV-infected MSM as it relates to HIV disclosure.

Keywords

HIV disclosure; HIV infected MSM; sexual risk

Despite a decline in HIV infection rates among men who have sex with men (MSM), this group continues to be at high risk for infection, accounting for 70% of estimated new HIV cases (Centers for Disease Control [CDC], 2006). The advent of highly active antiretroviral

therapy (HAART) dramatically improved the prognosis for individuals with HIV, changing the virus from a terminal illness to one that is treatable. The continued incidence of new HIV infections, along with the increased life expectancy for HIV-infected individuals, has resulted in a growing population of people needing to negotiate complex cognitive and behavioral challenges, including making decisions to disclose one's HIV status to others (Kalichman, 2000). Identifying and advancing behavioral theories that help explain and predict HIV disclosure are important to intervention development, because such disclosure may help reduce HIV transmission to sex partners among HIV infected MSM (Marks, Richardson, & Maldonado, 1991).

Disclosure of HIV status to sex partners continues to be a complex and pervasive problem for HIV infected MSM (Crepaz & Marks, 2003; De Rosa & Marks, 1998; Kalichman & Nachimson, 1999; Serovich & Mosack, 2003). Diminishing the spread of HIV is clearly an important public health matter, and understanding the dynamics associated with HIV disclosure may help in the development of effective prevention efforts that target individuals already living with HIV (i.e., secondary prevention). Choosing to disclose one's HIV status to sex partners can play an influential role in the sexual negotiation that occurs between partners. Furthermore, self-disclosure of one's HIV status may enhance trust and social acceptance in social relationships as well as reduce HIV transmission to sexual partners (Cusick & Rhodes, 1999). By consistently and confidently disclosing one's HIV-infected status, HIV-infected MSM allow their sex partners to make informed decisions about whether or not they want to engage in safer sex (Marks et al., 1991).

Studies conducted on disclosure to sex partners prior to HAART estimate disclosure rates to be between 48% (Marks et al., 1991) and 98% (Hays et al., 1993) of the time. Studies conducted post-HAART have shown more consistency and found disclosure to sex partners to occur on average 50% of the time (Crepaz & Marks, 2003; Prestage et al., 2001; Wolitski, Rietmeijer, Goldbaum, & Wilson, 1998). In samples containing HIV-infected MSM, some of the differences in these findings can be explained by the following variables: an HIV-infected MSM's feelings about his "duty to warn" partners about his status (Serovich & Mosack, 2003; Wolitski, Bailey, O'Leary, Gomez, & Parsons, 2003), his mood (Wolitski et al., 2003), his sense of self-efficacy (Kalichman & Nachimson, 1999), number of sex partners (Marks et al., 1991), characteristics of sex partners, contextual factors such as sex in bathhouses (Wolitski et al., 2003), partner type (Stempel, Moulton, & Moss, 1995; Wolitski et al., 1998), partner's HIV status (Prestage et al., 2001), casual nature of the relationship, need for privacy, feelings of shame of being infected with HIV (Serovich & Mosack, 2003), impact on the status quo, stigma, and disclosure to those with whom individuals have shared intimate information in the past (Cusick & Rhodes, 1999).

As research continues to focus on the topic of HIV disclosure among HIV-infected MSM, theory development remains a critical element in helping to understand this phenomenon. To date, few research studies have addressed theory development/testing in helping to understand this complex issue. A study conducted by Serovich (2001) examined two disclosure theories: disease progression theory and consequences theory. According to the disease progression model, individuals disclose their status as they become ill. More specifically, when HIV progresses to AIDS and there are signs of decreasing health and physical body changes, those living with HIV can no longer keep their status a secret (Kalichman, 1995). Consequences theory on the other hand, suggests that a person with HIV is more likely to reveal his or her HIV status to significant others and sex partners once the rewards for disclosing outweigh the associated costs (Serovich, 2001). However, Serovich concluded that neither the consequence nor disease progression model was able to predict disclosure to sex partners.

PURPOSE OF THE STUDY

The purpose of this study was to explore factors having an influence on the disclosure of HIV serostatus of HIV-infected MSM to their sex partners. The findings identified in this article can be used to instruct and provide knowledge to social workers and healthcare professionals working with HIV-infected MSM in secondary HIV prevention as well as to guide public health efforts in reducing rates of HIV infection. Understanding the decision-making process of disclosure for HIV infected MSM is another step toward developing a theoretical position to further broaden our understanding of sexual relationships among this population (Serovich & Mosak, 2003). The information obtained in this study also may be used to assist in tailoring clinical interventions on HIV disclosure and guide future theory building and testing.

Furthermore, the prior studies have examined various factors related to HIV disclosure across different samples and have asked questions derived from the perspective of the researcher rather than obtaining data that is self-directed from the perspective of HIV-infected MSM. These studies have utilized hypothesis-driven quantitative assessments examining factors associated with disclosure, or have used qualitative research asking specific questions about disclosure (Kalichman & Nachimson, 1999; Serovich & Mosack, 2003). However, no known study has directly examined barriers or variables that facilitate disclosure among HIV-infected MSM who are involved in primary care where the data was derived from counseling sessions.

Examining the content of issues related to disclosure in counseling sessions may be particularly useful for several reasons. First, it allows for discovery of the types of concerns that are raised by HIV-infected MSM versus testing an a priori hypothesis of a researcher from an outside perspective. Accordingly, the self-identified issues that HIV-infected MSM bring to counseling sessions are ones with which they are struggling. Second, examining the issues HIV-infected MSM bring to counseling sessions has direct implications for clinical practice, as these will be the very concerns with which clinicians need to become familiar to better help them provide client-centered services and support. Further insight on factors influencing or deterring HIV disclosure practices among HIV-infected MSM to their sex partners will augment and bring clarity to previously conducted studies.

METHOD

Overview of Parent Studies

The current study utilizes data gathered from two parallel secondary HIV prevention studies that targeted HIV-infected MSM, which were conducted at Fenway Community Health (Boston, MA). One was a peer-driven intervention model funded by Health Resources Services Administration (HRSA), and the other was a randomized control trial funded by National Institute of Mental Health (NIMH). Both studies utilized a modularized workbook to facilitate dialogue in each counseling session. The structure of the modularized workbook is based on the information, motivation, and behavioral skills model ([IMB]; Fisher & Fisher, 1993) of behavioral change. These studies consist of nine individual counseling sessions, which occur over a one-year time frame. The initial five sessions take place in the first three months, while the other four are delivered at three-month increments. Participants have one mandatory module they all receive, which involves education about HIV transmission and a discussion of their sexual risk limits. In the remaining sessions, participants self-select the topics that are most relevant to their needs (topics include HIV Disclosure; Getting the Relationships You Want; Party Drugs; Stress Management; Triggers; Having Sex; and Cultures, Community, and You). The counseling sessions ranged from 50 to 90 minutes and the structure of the sessions was based on the use of a behavioral

intervention workbook. Further details of the methods and conceptualization of the study are published elsewhere (Knauz et al., 2007).

Current Study Design

To gain a better understanding of HIV disclosure practices among HIV-infected MSM, staff members from the two parallel parent studies identified counseling sessions where participants chose HIV disclosure as the primary topic of conversation. A phenomenological approach was implemented as the method of inquiry. A total of three interventionists (two male and one female) selected participants with whom they conducted counseling sessions where the focus was on HIV disclosure to sex partners. This is a suitable form of inquiry, as it allowed use of a small number of HIV-infected MSM to bring forth formative information about the perceptions, attitudes, and motivations (Creswell, 1998) of this population about the ways they relate to HIV disclosure to their sex partners. Furthermore, we were able to give voice to those who have experienced HIV disclosure in the context of sexual situations with other men and to incorporate their perspectives in the development of intervention strategies. A secondary objective was to provide additional findings that would augment what is already known about HIV disclosure.

In this study, disclosure conversations were extracted from one-on-one counseling sessions that occurred within the context of primary care. The study team generated a list of eligible counseling recordings based on topics that were covered during the individual counseling sessions. Audio recordings were selected from participants who had completed anywhere between one and four counseling sessions where HIV disclosure was selected as the primary topic of conversation.

Sample

A convenient sample of nine HIV-infected MSM who previously participated in counseling sessions associated with the parent studies was chosen. The sample included participants who (a) are HIV infected, (b) are over 18 years of age, (c) have engaged in sexual activity with another man in the previous 6 months, (d) have completed at least one counseling session where HIV disclosure was the primary topic of the counseling session, and (e) signed the informed consent. When participants consented to take part in one of the two parent studies, they also gave the study team permission to use audio-recorded counseling sessions for additional study-related analysis.

All study procedures were reviewed and approved by the institutional review board at Fenway Community Health. Fenway is an Urban Community Health Center, which provides health care services to the lesbian, gay, bisexual, and transgender (LGBT) community. Table 1 summarizes demographics of the sample.

The nine participants' ages ranged from 25 to 55 years with an average of 36.6 years. The majority of the sample were White (44%) with the remainder identifying as either undetermined, Latino, Asian, or other (56%). This is consistent with the population who is served at Fenway Community Health. The number of years participants had been diagnosed with HIV ranged from 2 to 13 years with an average of 5.5 years (see Table 1).

Data Analysis

All counseling sessions were transcribed verbatim and reviewed multiple times by the study team prior to implementing the final coding system. NVIVO software (QSR International, Melbourne, AU) was used for data organization, content analysis, and coding purposes. The fundamental goal of using content analysis was to help break down the large amount of conversational text into manageable categories and to identify concepts and themes (Miles

& Huberman, 2002). To maintain authenticity, accuracy of data interpretations, and for quality control (Padget, 1998), strategies to ensure rigor were implemented. First, all transcribed text was reviewed for quality purposes. Second, a total of three individuals from the research team independently conducted open coding of the counseling sessions, which resulted in the identification of initial themes related to disclosure. Third, a preliminary codebook was developed, which contained the initial codes and definitions. Prior to the final analysis, conversations among the coders occurred in order to address any discrepancies in each other's findings. Discussions continued until there was an agreement on the final coding system and standardized code definitions. Last, to address inter-rater reliability and reduce coder bias, multiple coders were used to enhance accuracy of the conversational text (Denzin, 1978). This iterative process allowed the study team to identify and detect patterns, themes, concepts, and generate tentative hypotheses.

RESULTS

Within the two broad categories of barriers and facilitators that impact disclosure, several themes emerged. These findings provide a better understanding of factors that influence or deter HIV-infected MSM from disclosing to their sex partners. These results are provided in a narrative format.

Perceived Barriers to Disclosure

During the first step in the analysis process, themes were extracted that represented barriers to HIV disclosure as it relates to the participant and his sex partner(s). Barriers can be defined as interpersonal and contextual variables that hinder disclosure. These barriers include concerns with being rejected, concerns related to confidentiality, missed sexual opportunities, HIV-positive status assumed in risky sexual situations, deferred responsibility, type of relationship with the sex partner, and the environmental context in which the sexual activity took place.

Rejection/Missed Sexual Opportunity

A commonly identified theme was a fear of being rejected by potential sex partners. The following passage illustrates a common concern for several of the participants in this study. Jimmy expressed, "As I am thinking about it, it's like why would someone say they have it [HIV] and if everyone they tell is going to reject them. It would be an automatic rejection." Building on the fear of being rejected, if an individual chooses to disclose, then concerns arise that one's personal and private information about his HIV status will be shared with other men in the community.

In order to have one's sexual needs met, some of the participants felt it was necessary to forgo disclosure to their potential sexual partner(s). Hank shared his fear on this issue by stating, "I don't want to disclose, because then I'm afraid that I'm not going to ... he's not going to go home with me, and I'm not going to tell him at the bar." On the other hand, Peter felt that, "If I can reel them in, I'm not going to say; by the way, I am HIV-infected." Hank similarly stated, "It would be an awkward situation just because I felt like I needed to take advantage of a sexual encounter when I knew I could have one."

In order to avoid a missed sexual opportunity it was common for rationalizing statements to be made among the participants. For example, Bill expressed, "A lot of my fuckbuddies are bottoms. Because of that, I don't want to disclose and alarm them." At the same time, Bill rationalized his reasoning for not disclosing by stating, "That is another major reason I don't disclose (due to the sexual behaviors I engage in) I don't feel like I am endangering anyone." Bill felt that, "My not disclosing is a matter of survival, emotional and physical,

you know and social.” Peter feared for his emotional safety in sexual situations by stating, “But then, why should I stick my neck out and risk a lot of pain when you are just treating me like a sex toy.”

Confidentiality

In conjunction with a fear of rejection, Jimmy had concerns about those he disclosed to spreading the news of his status to others in the community. Jimmy stated, “But I don’t want the people I tell to go and tell others. It’s not so much that I don’t think they have a right to know, it’s just that I don’t want it to get everywhere.” Alex also discussed this fear as he verbalized, “The only way I am going to be able to do this (disclose) is not to be so worried about, you know, my privacy issues with it.” It is clear that participants struggle with the potential stigma associated with being identified as a person living with HIV.

Partner’s HIV Status

Assumptions about a sexual partner’s status were influential in the disclosure decision-making process. Most of the references made by participants were done so in the context of public sex environments. Ryan offered an example, “It’s almost like you assume ... I just assume everybody in there (adult bookstore) is kind of in the same boat.” The previous belief was supported by Tom as he “Figured most of these guys already must be positive. You know, because they all pretty much do this a lot (referring to sex in a bathhouse).” Carl expressed his thoughts about playing it safe by stating, “I don’t have to tell them (sex partners) because I think they should know ... should play it safe.” It is assumed that men who seek out sex in adult bookstores or bathhouses must be HIV-infected because the sexual activity that occurs in these locations tends to be sexually risky.

Deferred Responsibility

The concept of responsibility was identified by one of the participants “as a value he felt should be upheld by each individual sex partner.” According to Jimmy, regardless of HIV status and in each anonymous sexual encounter, sex partners need to be responsible for themselves. He captured the concept of responsibility by stating,

... each person is 100% for themselves and if you choose to hook up with someone you don’t know, then you need to assess your risk and, you know, mitigate that however you feel like it’s appropriate ... I feel like for somebody that’s really random like that it’s kind of each person needs to take care of themselves and there’s not really an expectation.

This belief supports the idea that sharing or inquiring about an individual’s HIV status is each person’s own responsibility. Jimmy’s belief further supports the idea that those living with HIV should not have to bear all the responsibility in terms of disclosing and initiating safer sex practices with sex partners.

Sexual Partner Type

The majority of the sample expressed that sexual partner type had a significant influence on their disclosure decisions. Random hookups, as in anonymous/one-time encounters and “fuckbuddies” (regular sex partners who an individual does not necessarily have an emotional relationship with), were identified as partner types that would deter one from disclosing his HIV status. Bill stated that, “I am not going to be disclosing it with a fuckbuddy who I’m only going to be seeing only one night ... a one night stand.” Jimmy supported this belief by expressing, “But on the outside, if it were a random hookup that’s one time and anonymous or whatever, I would not tell someone like that, but if it’s someone that I just feel like we might talk again or something then I might tell more.” Jimmy

continued this thought by stating, “I don’t feel like there’s any kind of expectation or obligation there because if you’re going to hook up randomly with someone, even if ... if a third of the people who have HIV don’t know it, then if they ask me and I say no, maybe I’m lying and why not?” The amount of emotional connection to a sex partner also has an influence on whether or not to disclose. Hank stated that, “The only reason why I wouldn’t (disclose) is if it was going to be somebody that I didn’t care about, who, you know, if there was going to be a one-time person.” Furthermore, Alex struggled with disclosure in relation to potentially dating partners. Alex expressed, “Maybe I am going to be interested and maybe ask him out on another date. And I just see one nightmare after another and I just don’t even want to deal with it.” As captured in the above statements, an individual’s connection or relationship to his sex partner has an influence on his decision whether or not to disclose his being HIV infected.

Public Sex Environments

Participants identified that disclosure practices may be influenced by social norms and communication within specific public sex environments. Ryan stated, “I don’t think anyone I have hooked up with (in an adult bookstore) has ever told me their status. So if I’m ... if I say, I’m in the mood to get fucked or fuck raw, and I am asked, I would probably lie.” He went on to say, “Well, if you are into, you know, sort of a sleazy scene like that and the escapism of it, the last thing you’d probably want to do is bring reality into that kind of trashy fantasy.” Others held beliefs about discussing status in bathhouses. For example, Jimmy stated, “I don’t expect people I hook up with (in bathhouses) to tell me they have it or not and so I don’t really expect myself to tell them.” While Tom held the belief when seeking out sex in a bathhouse, “If they don’t ask, I don’t tell.”

Facilitators of Disclosure

Facilitators of disclosure are factors under which disclosure is more likely to occur. This process is seen as moving individuals towards a desire to disclose rather than feeling like disclosure is something they should avoid. Facilitators to disclosure include ethics, potential for dating, timing of disclosure, and bidirectional communication.

Ethical Obligation

In order to stay true to their values, several of the participants felt an ethical obligation to disclose their HIV status to sex partners. Hank expressed his feelings by stating, “I feel like, obligated to tell people. I feel that’s sort of a moral fence. I guess disclosing up front is the benefit to that you know one way or another where people stand.” He continued by stating, “I feel sort of morally obligated to disclose because every time I hook up with someone, I am potentially exposing them to HIV.” Jimmy and Carl demonstrated a sense of morality as they expressed, “Being honest, you know, letting them know what’s going on. Like letting them be more informed about whatever choices they might make.” For example, Jimmy explained, “The guy I was in a sexual relationship with, I told him just because I felt he kind of had a right to know about that.” Jimmy continued by stating, “Before when I was not positive, I always assumed that everyone was positive, so I would play with condoms. But now, because I am positive, I have to tell people that.” Carl expressed that as a result of disclosing, “It lifted a lot of responsibility and guilt off of me if something were to happen.”

Potential for Dating

Most participants expressed that if their sexual “hook ups” could result in dating, they would be more likely to disclose. It is clear that participants valued honesty within the context of dating relationships. Several participants expressed this value in relation to sexual encounters:

But if I see potential in a relationship, you know, I would probably find a way of disclosing it.—Bill

I think not only would I (disclose) ... would I want to, um disclose, it would be much easier to disclose to somebody that I was pursuing a relationship with.—Hank

Like anyone that I would be dating I would definitely want to tell. I think that you have got to have this honesty if you're going to be dating someone for long term.—Jimmy

It's going to be when I ... when I feel secure in the relationship, when I feel I can disclose.—Hank

Partner type influenced an individual's sense of responsibility in relation to disclosure decisions. The security of having a potentially honest dating relationship in which participants felt comfortable expressing their HIV status was identified as a strong motivator for disclosure.

Timing of Disclosure

Identifying the most appropriate time to disclose was an issue expressed in relation to potential dating partners. If there was an interest in dating a potential sex partner, participants were more likely to demonstrate rational reasoning by weighing the pros and cons. As stated by Tom,

I mean it would certainly be better to tell him before we moved in there, rather than after. If I tell him after and he freaks out, God, it's going to get me screwed ... and how much harm would that do down the road if you started, you know, withholding information, and especially in this big area of my life right now (in relation to dating)?

Another factor was the anticipation of a potential negative outcome as a result of disclosure, but actually ended up being a supportive and positive experience. Jimmy discussed his feelings by stating, "I was afraid that he would be real judgmental or something and be like oh I told you so or whatever, but it wasn't like that at all. He was like, who gave this to you? I am going to beat them up (in relation to an ex boyfriend/fuckbuddy). At the same time, Hank felt that, "I guess disclosure up front is best. The benefit to that is you know one way or another where you stand." The result of positive disclosure experiences, the potential for a dating relationship, and early disclosure may contribute to improved overall mental health, which could in turn result in the negotiation of safer sexual practices between sex partners.

Bidirectional Communication

The interaction between communication and sex partners is a dynamic process based on a combination of asking versus telling. In this study, it was identified that if sex partners initiated the conversation about HIV status, participants were more likely to mutually disclose. Peter stated with enthusiasm, "If someone was to tell me, oh by the way I'm positive I would be blown away. I would definitely not be rejection at all. I would definitely be like totally cool. I think I would be like oh I'll tell you now that I am." On the other hand, if a sex partner does not disclose his status, but inquires about the participant's status, the result again was mutual disclosure. For example, Bill hooked up with a guy and this was his experience, "This top guy, he asked me, so I said, Yes, I am Positive. And he's also positive." The context in which disclosure occurs also seems to have an influence on an individual's confidence level. Jimmy and John felt, "It made it much easier online (Jimmy)." "I think online it was much better to disclose (John)." Jimmy went on to express,

I mean, the one time someone did ask, I told them, so I think it would be a different thing like if you were still talking online and we haven't met and you don't really know who I am. I'd probably be more likely to say it than if we meet in person because if you meet in person it gets ugly. If you are online, they just stop talking to you or something.

The initiation of open dialogue regarding HIV status between sex partners is critical in terms of negotiating sexual practices. For some, disclosing online seems to be a safer approach, as it offers more anonymity.

DISCUSSION

The primary purpose of this study was to explore and gain an understanding of both the barriers and factors that facilitate HIV disclosure to sex partners from the perspectives of HIV-infected MSM. Understanding the unique themes identified in this study can provide insight on disclosure decisions among HIV-infected MSM to their sex partners. Social workers who provide counseling or other types of support services to HIV-infected MSM can use these study findings for assessment and intervention strategies in order to meet the individualized needs of this population and to help anticipate the types of issues surrounding HIV disclosure that may arise. In addition, the themes can help guide and construct future quantitative studies. Implications of the findings are discussed below.

Many of the results are consistent with findings from previous research in that HIV disclosure is multidimensional with several factors influencing the decision-making process. This underscores the need for a client-centered approach that addresses the unique needs of MSM living with HIV as it pertains to HIV disclosure to their sex partners. Furthermore, awareness should be drawn on how HIV disclosure may play an important role in reducing rates of HIV transmission between sex partners.

As identified by the majority of the men in the study, there are significant barriers to disclosing to sex partners. Similar to other study findings, the fear of being rejected (Gorbach et al., 2004; Serovich & Mosack, 2003), fear of losing out on a potential sexual opportunity, concern over an individual's status being shared with the community (Serovich & Mosack, 2003), and potential emotional pain were common disclosure barriers. In the present study, participants felt that the fears associated with disclosure were not worth the emotional consequences. As a result, they chose not to disclose to their sexual partners. The current study findings suggests that coping with the emotional distress of not being accepted, loss of sexual connections to other men, and the possible stigma associated with being HIV-infected are emotional hurdles often encountered in these men's disclosure experiences.

A second commonly reported theme centered on personal responsibility and an ethical obligation to protect sex partners from contracting HIV. Upholding an ethical obligation as a highly held value was critical for these men in the context of sexual situations. Results from previous research support this finding by indicating that responsibility was a common and influential factor impacting disclosure decisions (Marks, Burris, & Peterrman, 1999; Serovich & Mosack, 2003; Wolitski et al., 2003). In contrast, a minority of the sample felt it was each individual's responsibility—all men who have sex with men should be responsible for their own sexual safety and disclosure. Grounded in a sense of ethical obligation, disclosure was facilitated by a desire to allow others to make informed decisions around safer sexual choices post disclosure. As stated by Wolitski et al., "Given that the majority of these men perceive themselves as having a special responsibility for protecting their sex partners, these men can be powerful allies in efforts to limit further spread of HIV" (2003, pp. 371).

Among the participants, sexual partner type had a significant influence on disclosure decisions. Specifically, it was identified that disclosure of HIV status was more likely to occur if participants sensed a romantic connection or possible relationship with their partners. It was clear that developing and maintaining a romantic relationship was a desire for most of the participants, and the risk of disclosing was worth the price for a possible dating relationship. However, most of the reported sexual experiences of the participants had to do more with casual sex encounters and less with dating. Moreover, the constant desire to have their short-term sexual needs met often became an obstacle to achieving relationship goals such as developing long-term romantic relationships built on trust. In contrast, sexual encounters involving anonymous or one-time partners more often resulted in nondisclosure, as participants felt it was a privacy issue.

Public sex environments, which have been a historical venue for gay men as a sexual outlet, can impact whether or not disclosure will occur with sex partners. Our study findings are similar to other studies that addressed disclosure in the context of public sex environments (Stempel et al., 1995; Wolitski et al. 2003; Wolitski et al., 1998). The men in the sample specified that verbal communication in bookstores, public sex arenas, and bathhouses is not the norm. It is believed that individuals in these particular environments choose to remain anonymous and can do so by not sharing any personal information, including HIV status. Given this, discreteness is maintained, and no one is held accountable for his behaviors. Going against communication norms by discussing HIV status or safer sex would put the participant at risk of losing out on a possible sexual connection.

HIV disclosure may indeed trigger conversations on negotiating sexual safety between sex partners. HIV-infected MSM may need to be reminded of their risks of contracting secondary infections, which is why reciprocal disclosure is important, as it could result in the negotiation of safer sex practices. The majority of participants indicated they assumed those who seek out sex in venues such as bathhouses or bookstores are either already HIV-infected or are willing to engage in high-risk sexual activity. Furthermore, frequenting such public venues allows for the opportunity to engage in high-risk sexual behaviors while escaping the reality that one is living with HIV/AIDS. The perception that everyone in these environments is either HIV-infected or engaging in high-risk sexual behavior allows men to make sexual decisions without considering health status information and/or emotional consequences.

Limitations and Strengths

Limitations—Although there are several strengths embedded within the study, there are also several limitations to be addressed. First, by using a phenomenological approach and by taking a nonrandomized sample, these findings can not be necessarily generalized, but should be seen as potential hypotheses to be tested in future research. Second, due to a limited sample size, there may be additional barriers and facilitators of HIV disclosure that were not captured. Third, as the majority of the sample for this study was white men who live in a large urban city, there may be cultural differences that were not captured in the sample both in terms of race and geographical location. Last, although we were able to capture factors that help explain the barriers and facilitators of disclosure, we were unable to capture the sexual activities that took place between our sample and their sex partners in relation to disclosure. This information would have been useful in identifying the level of risk taken by our sample as it pertains to HIV disclosure.

Strengths—These findings can be used to strengthen secondary prevention efforts by specifically assessing clients' disclosure beliefs and addressing the ambivalence and discrepancies HIV-infected MSM and non-infected MSM may experience around disclosure

practices. Second, study participants self-initiated and self-selected the topic of disclosure for discussion with their counselors, indicating that it is clearly an area of importance and relevance to their lives, because it can cause emotional distress. As a result, social workers and those working in public health can use this material to anticipate disclosure issues for these individuals, which will also help guide any support or interventions needed. Third, the gathered data regarding factors impacting disclosure decisions were prompted and provided by participants who felt it was an important issue related to their sexual health and not from a set of structured interview questions. Last, an iterative process was taken to ensure accuracy, intersubjective agreement on data interpretations, and quality control by having multiple independent coders at the onset of data analysis.

Practice Implications

In primary care settings, it is not routine for social workers or other healthcare providers to address issues of disclosure with their clients. Integrating disclosure discussions into routine care is critical and could provide support and skill-building opportunities that specifically address HIV disclosure to sex partners. Training social workers and public health professionals to take a client-centered approach by implementing motivational interviewing (Prochaska, Redding, Harlow, & Rossi, 1994) could help address ambivalence and discrepancies in disclosure practices among HIV-infected MSM.

Conducting a thorough assessment of values held by individuals living with HIV in terms of responsibility, as well as assessing contextual factors and possible transmission risk behaviors, could provide a therapeutic direction by identifying those who are inconsistent and struggle with disclosure. Furthermore, supporting individuals in understanding effective strategies for how, when, or whether to disclose their HIV status as well as an assessment of the cost and benefits associated with disclosure should be addressed in behavioral interventions (Kalichman & Nachimson, 1999). For those who are adamant about not disclosing due to reasons of confidentiality or due to the sexual environment such as a bathhouse, discussing harm reduction strategies with these individuals would be critical, as it could result in reducing HIV transmission. These newly adopted skills would likely help build motivation, reduce emotional distress, and enhance the ability to disclose and to negotiate safer sex practices in potentially adverse situations.

Policy Implications

Findings from this study have important secondary prevention implications for policy, research, and for future development of behavioral interventions. As public health policy continues to focus its attention on secondary prevention efforts in encouraging those living with HIV to disclose to all sex partners, it is important that well positioned professionals working in health care settings and AIDS service organizations (ASOs) play a critical role in acknowledging and supporting HIV-infected MSM who struggle with disclosure. A public health approach that encourages HIV disclosure may be premature, as prior research has provided mixed results when addressing the relationship between HIV disclosure and safer sex practices (Ciccarone et al., 2003; Kalichman, 1999; Kalichman, Greenberg, & Abel, 1997; Marks et al., 1994). Moreover, there is the potential for legal implications for nondisclosure, as 31 states have implemented legal sanctions that make nondisclosure of HIV status to sex partners a criminal offense (Ciccarone et al., 2003). These policy implications support the need for further research on factors that act as barriers and facilitators of disclosure.

Research Implications

Continued research is needed to investigate factors that promote and deter HIV disclosure to sex partners and their subsequent relationship to transmission risk behaviors. These findings

will be beneficial in contributing to the construction of a theoretical model that helps to explain and predict this phenomenon. Continuing to explore motivational and behavioral factors, such as the relationship between self-efficacy, disclosure, and condom use, could be a pivotal step in prevention efforts and theory building. Future research should address the following questions:

1. What are the characteristics of HIV infected MSM who practice inconsistent disclosure to their sex partners?
2. What is the relationship between transmission risk behavior and HIV disclosure across sex partners HIV status?

Findings can help determine if the association between HIV disclosure and high-risk sexual activity is strong enough to develop and implement HIV prevention interventions that place considerable emphasis on disclosure.

CONCLUSION

In the third decade of this pandemic, HIV-infected MSM continue to struggle with HIV disclosure to their sex partners. Understanding factors that act as barriers and facilitators of HIV disclosure can have important implications. Social workers providing therapeutic counseling and support to HIV-infected MSM can benefit from this knowledge, as the findings will provide valuable insight into the experiences of these men in the context of sexual health. By gaining a client-centered perspective, social workers are able to implement the appropriate intervention tailored to their unique needs of this population as it relates to disclosure. As a result, incorporating continuity of care within ASOs and healthcare facilities that address sexual health related topics is necessary. Furthermore, it is critical that professionals working with HIV-infected MSM assess disclosure practices and that they be adequately equipped with the skills to address the concerns and needs of this population.

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REFERENCES

- Centers for Disease Control and Prevention. [July, 19, 2006] HIV/AIDS Surveillance Report. 2006. from <http://www.cdc.gov/hiv/topics/surveillance/resources/reports.htm>
- Ciccarone DH, Kanouse DE, Collins RL, Miu A, Chen JL, Morton SC, et al. Sex without disclosure of positive serostatus in a U.S. probability sample of persons receiving medical care for HIV infection. *Journal of Public Health*. 2003; 93:949–954.
- Crepaz N, Marks G. Serostatus disclosure, sexual communication and safer sex in HIV-positive men. *AIDS Care*. 2003; 15(3):379–387. [PubMed: 12745398]
- Creswell, JW. *Qualitative inquiry and research design: Choosing among five traditions*. Sage; Thousand Oaks, CA: 1998.
- Cusick L, Rhodes T. The process of disclosing positive HIV status: Findings from qualitative research. *Culture, Health and Sexuality*. 1999; 1(1):3–18.
- Denzin, NK. *The research act: A theoretical introduction to sociological methods*. 2nd ed. McGraw-Hill; New York: 1978.
- DeRosa CJ, Marks G. Preventive counseling of HIV-positive men and self-disclosure of serostatus to sex partners: New opportunities for prevention. *Health Psychology*. 1998; 17(3):224–231. [PubMed: 9619471]

- Fisher, WA.; Fisher, JD. A general social psychological model for changing AIDS risk behavior. In: Pryor, JB.; Reeder, GD., editors. *The social psychology of HIV infection*. Erlbaum; Hillsdale, NJ: 1993. p. 127-153.
- Gorbach PM, Galea JT, Amani B, Shin A, Celum C, Kerndt P, et al. Don't ask, don't tell: Patterns of HIV disclosure among HIV-infected men who have sex with men with recent STI practicing high-risk behavior in Los Angeles and Seattle. *STI Journal*. 2004; 80:512–517.
- Hays RB, McKusick L, Pollack L, Hillard R, Hoff C, Coates TJ. Disclosing HIV seropositivity to significant others. *AIDS*. 1993; 7:425–431. [PubMed: 8471207]
- Kalichman, SC. *Understanding AIDS: A guide for mental health professionals*. American Psychological Association; Washington, DC: 1995.
- Kalichman SC. HIV transmission risk behaviors of men and women living with HIV/AIDS: Prevalence, predictors and emerging clinical interventions. *Clinical Psychology: Science and Practice*. 2000; 7:32–47.
- Kalichman SC, Greenberg J, Abel GG. HIV-seropositive men who engage in high-risk sexual behaviour: Psychological characteristics and implications for prevention. *AIDS Care*. 1997; 9(4): 441–450. [PubMed: 9337888]
- Kalichman SC, Nachimson D. Self-efficacy and disclosure of HIV-positive serostatus to sex partners. *Health Psychology*. 1999; 18(3):281–287. [PubMed: 10357509]
- Knausz RO, Safren SA, O'Cleirigh C, Capistrant BD, Driskell JR, Aguilar D, et al. Developing an HIV-prevention intervention for HIV-infected men who have sex with men: Project Enhance. *AIDS and Behavior*. 2007; 11(Suppl. 1):117–126.
- Marks G, Burris S, Peterrman. Reducing sexual transmission of HIV from those who know they are infected: The need for personal and collective responsibility. *AIDS*. 1999; 13:297–306. [PubMed: 10199219]
- Marks G, Richardson JL, Maldonado N. Self-disclosure of HIV infection to sexual partners. *American Journal of Public Health*. 1991; 81:1321–1323. [PubMed: 1928534]
- Marks G, Ruitz MS, Richardson JL, Reed D, Hyacinth RC, Sotelo M, et al. Anal intercourse and disclosure of HIV infection among seropositive gay and bisexual men. *Journal of Acquired Immune Deficiency Syndromes*. 1994; 7:866–869. [PubMed: 8021820]
- Miles, MB.; Huberman, AM. *The qualitative researcher's companion*. 2nd ed. Sage Publications; Thousand Oaks, CA: 2002.
- Padgett, DK. *Qualitative methods in social work research: Challenges and rewards*. Sage Publications; Thousand Oaks, CA: 1998.
- Prestage G, Van De Ven P, Grulich A, Kippax S, McInnes D, Hendry O. Gay men's casual sex encounters: Discussing HIV and using condoms. *AIDS Care*. 2001; 13(3):277–284. [PubMed: 11397329]
- Prochaska JO, Redding CA, Harlow LL, Rossi JS. The trans-theoretical model of change and HIV prevention: A review. *Health Education Quarterly*. 1994; 21(4):471–486. [PubMed: 7843978]
- Serovich JM. A test of two HIV disclosure theories. *AIDS Education and Prevention*. 2001; 13(4): 355–364. [PubMed: 11565594]
- Serovich JM, Mosack KE. Reasons for HIV disclosure or non-disclosure to casual sex partners. *AIDS Education and Prevention*. 2003; 15(1):70–80. [PubMed: 12627744]
- Stempel RR, Moulton JM, Moss AR. Self-disclosure of HIV-1 antibody test results: The San Francisco General Hospital Cohort. *AIDS Education and Prevention*. 1995; 7:116–125. [PubMed: 7619642]
- Wolitski RJ, Bailey CJ, O'Leary A, Gomez CA, Parsons JT. Self-perceived responsibility of HIV seropositive men who have sex with men for preventing HIV transmission. *AIDS and Behavior*. 2003; 7(4):363–372. [PubMed: 14707533]
- 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(5):599–610. [PubMed: 9828956]

TABLE 1

Demographics

Name	Age	Race	Year Diagnosed*
Bill	55	Asian	2003
Tom	35	White	1998
Hank	26	White	2004
Jimmy	25	White	2004
Peter	40	Other	2003
Ryan	39	White	1998
Carlos	46	Latino	2005
John	52	Undetermined	1994
Alex	40	Undetermined	2004

Note. Names are pseudonyms to protect confidentiality.

*
The counseling sessions took place between 2005–2007.