Two vignettes of adolescent sexual disclosure: guidance for HIV clinical practice

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Abstract

HIV-positive adolescents are required by law to notify sexual partners, but can find it difficult to achieve this goal. This article offers practice guidance for counselling HIV-positive adolescents about sexual disclosure in clinical settings and for building confidence in managing sexual lives with HIV. We use two vignettes to illustrate key differences between perinatally and sexually infected adolescents in terms of readiness to disclose, and include a set of strategies for both groups that can be tailored to individual circumstances and contexts. The toolbox of strategies we describe include pre-counselling, focused counselling, social support groups and technical support. Pre-counselling helps to identify barriers and motivations to sexual disclosure and is followed by counselling sessions in which the focus is on role playing and sexual scripts for disclosure. Peer-led support groups are designed to boost adolescent confidence, and pre-paid cell phones, text messaging, ready-dial phone numbers and a private Facebook page provide back-up support and out-of-hours contact. Since sexual disclosure can be a risky proposition, safety plans, such as having an emergency contact person, should always be in place. These strategies are designed to empower vulnerable adolescents, foster trust between patient and provider, and reduce HIV transmission to sexual partners.

Keywords

HIV-positive adolescents, sexual disclosure, counselling strategies

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Introduction

A major dilemma in being diagnosed with HIV is when and how to notify sexual partners. U.S. public health codes require notification for HIV control regardless of age or circumstances, a task that can be daunting for adolescents whose sexual identity is emerging or in flux (Marhefka et al., 2011). Developmental factors in relation to social maturity, relationship stability and sexual empowerment all affect whether or not adolescents disclose to their sexual partners (World Health Organization [WHO], 2013). A defining factor for disclosure relates to the adolescent's age at diagnosis. In the United States, children who acquire HIV at birth are likely to have learned about their status before becoming sexually active (Butler et al., 2009). These children have become familiar with systems of HIV care from an early age and developed trust in health providers by the time they enter puberty. By contrast, newly

diagnosed adolescents are faced with the sudden realities of a medicalised future that mark 'a dramatic reconceptualization of their lives' (Fortenberry et al., 2012). Despite these differences, all adolescents face sociosexual dilemmas during puberty and levels of maturity are a defining factor in readiness for sexual activity and sexual disclosure.

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A host of individual, family and community-level factors influence sexual disclosure, each with their own sets of challenges for young people who are living with HIV. As noted by Wiener and Battles (2006): ‘each disclosure is complex and delicate, each disclosure encumbered with consequences’. Our purpose in writing this article is to present two vignettes about adolescent sexual disclosure and counselling strategies to help facilitate this process. These vignettes were developed from clinical experience in delivering HIV care and counselling services for young people in the rural U.S. South, a region with the highest HIV rates in the nation (Centers for Disease Control and Prevention [CDC], 2016). We describe the contexts in which disclosure or non-disclosure occur, the counselling strategies for disclosure that provide a margin of safety for vulnerable adolescents, and the disclosure journeys that unfold over time according to maturity, social context and other challenges in HIV-positive adolescents’ lives.

The burden of legal responsibility for sexual disclosure of HIV status in the United States lies solely with people who have been diagnosed with HIV. Public health codes require medical providers to counsel patients about their legal obligations (‘duty to inform’) and to report acquisition of sexually transmitted diseases to public health authorities. This enforcement role, together with community-based stigma, can make it difficult for patients to request help if problems arise in relation to non-disclosure (Lichtenstein et al., 2014). A patchwork of state public health codes and HIV-specific laws complicate clinic staff-patient relations across the country. Nevertheless, the vignettes in this article can inform existing clinical protocols on counselling, particularly for adolescents who fear rejection or lack the experience or confidence to disclose to sexual partners by themselves. Because sexual disclosure is a journey rather than a certain outcome, we also address the limitations of counselling for young people whose age, motivations and circumstances present a challenge to this task.

Clinical setting

The clinics from which the vignettes were developed specialise in medical and social support services for HIV-infected women, children and adolescents. The main clinic and two satellite clinics serve patients who reflect the overall demographics of the HIV epidemic in the region: an over-representation of African Americans and low-income families with few resources at their disposal. Over the past decade, the clinics have served 247 adolescents aged 13–25 years who received HIV services for social support and medical care.

Project development

The vignettes and counselling strategies for this project were developed by a working group of seven authors: three

counsellors with a total of 32 years of experience in HIV care and support services with children and adolescents, a health educator, an adolescent medicine physician, a medical sociologist who conducts HIV research and a legal advisor who advocates for HIV-infected patients. The vignettes reflect common scenarios for counselling perinatally and sexually infected adolescents. Each story is an amalgam of case histories rather than the actual experiences of individual patients whose privacy was protected by adopting this approach. Ethics approval for the project was granted by the authors’ universities.

The working group agreed that sexual disclosure should be considered in a relational context, that is, while the law places sole responsibility for disclosure on patients, mitigating factors such as adolescent development and relational factors such as family context and fear of abuse must be taken into account. The vignettes describe tailored approaches to counselling adolescents who resist disclosure or deny their HIV diagnosis. These accounts illustrate why resistance to disclosure (which might otherwise be attributed to immaturity or oppositional behaviour) occurs within a matrix of power relations in which adolescents acquire and live with HIV infection. HIV is universally stigmatising and power differentials are often exacerbated in sexual relationships in which a positive diagnosis is known (Gielen et al., 2000).

A final step in developing the project involved a series of meetings to refine the counselling strategies for each vignette. The guidelines initially were developed from CDC protocols for personalised counselling according to: age, race/ethnicity, gender, sexual orientation and social context (Sheon, 2006). We modified the guidelines over time to include role-playing for adolescents who were ready to self-disclose, as well as confidence-building and safety plans for adolescents who were fearful, alienated or exposed to violence. The vignettes make use of these formal and experiential approaches to counselling adolescents and include action points for legal disclosure as required by state law. We note the limits of counselling when adolescents drop out of care or are lost to follow-up.

Vignettes

The first vignette involves a perinatally infected adolescent whose fear of death and pressure to maintain the family secret is described in ‘Coping with fear’. The second vignette, ‘Coming out’, reflects the experience of a sexually infected adolescent whose reactions to diagnosis calls for patience, support and trust-building before sexual disclosure can be achieved. These selections do not cover all possibilities but do address the complexities of sexual disclosure among adolescents with HIV. The names of adolescents in the vignettes are fictitious and do not refer to our patients.

Each vignette is followed by critical points for counselling and a description of counselling strategies and

outcomes. The strategies have some elements in common, but have been tailored to the circumstances of perinatally and sexually infected adolescents in order to reflect a range of approaches and outcomes in HIV clinical practice. This section is followed by a tabulated list of scripts, resources and strategies for adolescents who face complex challenges from family or intimate partner violence, intellectual impairment or mental illness.

The perinatally infected adolescent

The ideal approach to counselling perinatally infected adolescents is preparation for disclosure before they become sexually active. Counselling about HIV management during pre-puberty should be age-appropriate, with discussions that centre on bodily changes and sexual health. During puberty, the discussions should be less about 'what you are supposed to do' and more about taking responsibility for personal healthcare and protecting sexual partners. The dilemma for counselling these adolescents is that HIV is often a closely guarded secret at home. In reality, some caregivers (who have legal control over when minor children are disclosed) keep the child's diagnosis to themselves for fear of discrimination. Even when such children learn about the HIV diagnosis, they are expected to keep this knowledge within the family.

The legal transition from 'innocent child' to 'criminally liable adolescent' is difficult for some adolescents who react to their revealed diagnosis through denial and refusing to take antiretroviral treatment (ART). HIV-related secrecy becomes a source of conflict when staff members ask adolescents to consider breaking a code of silence about HIV that they tacitly or explicitly endorsed prior to puberty. The following vignette illustrates the disclosure journey of a perinatally infected adolescent who entertained the idea of partner notification after extensive counselling, but whose family problems were an obstacle to achieving this goal.

Vignette one: coping with fear. 'Jane' (aged 17 years) was often symptomatic throughout childhood and was worn out by her diagnosis. Although she feared dying of AIDS, Jane was tired of going to the doctor, having to take medicine and being unable to live a normal teenage life. Jane was typical of many perinatally infected adolescents who struggle with social maturity, peer acceptance and taking ART in order to keep healthy. She became sexually active at the age of 16 years, but these encounters consisted of short-lived 'hook-ups' that were not intimate enough, in Jane's opinion, for sexual disclosure. Jane's mother (Rose), who was diagnosed while pregnant with Jane, urged her daughter to keep HIV a secret in order to protect the family. Rose and Jane had formed a tight bond in childhood, but Jane's struggles to become independent were a growing source of conflict that related to Rose's directives to Jane about not travelling alone or socialising with other adolescents at sleepovers, movies or the mall. Rose's tight rein on her daughter's behaviour and

her anxiety about keeping HIV a secret made disclosure seem both disloyal and dangerous. Jane's fear of dying and fatalistic outlook also interfered with any meaningful discussions about how to plan her sexual future with HIV.

Critical points for counselling

- Fear of dying
- Social isolation
- Need for independence
- Family secrecy
- Hooking up without disclosure

Counselling outcomes (some progress). In response to Jane's fear of dying and lack of social maturity, her counsellor focused on helping Jane to develop healthy self-esteem as she transitioned to womanhood. Jane also received sex education, information about sexual development and was counselled about using condoms for protection. In countering Jane's fatalism about living with HIV, the counsellor helped Jane to set goals for the future, such as earning a General Education Diploma (GED) and getting a job. For Jane, these efforts brought a host of emotions to the fore – fear, uncertainty and confusion over what it meant to be both sero-positive and sexually active. The counsellor addressed these concerns by dispelling myths about HIV being a death sentence when ART is taken regularly, and by setting goals for healthy relationships, including using condoms for protection. Jane continued to resist disclosure because of her mother's wish to keep their HIV diagnoses a secret.

Guiding Jane toward disclosure involved strategies such as a monthly peer support group in which she and other adolescents engaged in role-playing for condom use and notifying sexual partners. Participation in these groups was supplemented by counselling sessions that focused on sexual self-efficacy. Separate counselling sessions with Jane's mother focused on helping Rose to accommodate Jane's growing need for independence. Rose was invited to attend her own appointments at the same clinic as Jane, which finally broke the stalemate between mother and daughter. These strategies were beneficial for two reasons: Jane and her mother grew closer and both women became more diligent about keeping appointments and taking ART. At her most recent visit, Jane revealed that she had been ready to disclose during a recent sexual encounter but backed out at the last minute. In preparation for next time, Jane and her counsellor have revisited her scripts in bi-monthly meetings, a strategy that is designed to improve the chance of success through support, repetition and confidence-building.

The sexually infected adolescent

Typical reactions to an HIV diagnosis in this group of patients include shock, disbelief, anger and denial. As with HIV-infected adults, sexually infected adolescents often seek to attribute blame for their illness and pose questions

such as: ‘Who infected me?’ ‘Did they know they had HIV?’ ‘Will someone reveal my diagnosis and/or my sexual orientation if I tell them?’ and ‘Will they become violent toward me?’ Because trusting relationships with HIV providers have yet to develop, these adolescents are often reluctant to discuss private matters and require extensive education about HIV transmission, disease progression, sexual disclosure and treatment plans. Progress toward disclosure depends on trust levels, maturity and psychosocial functioning, and is often incremental in nature.

Counselling about disclosure is tailored to the patient’s specific situation and the implications for HIV risk or personal harm. For example, priority is given to a patient who is highly infectious and continues to have unprotected sex with partners who are unaware of their risk. The patient is counselled during clinic hours and outreach involves contact by cell phone and text messages for out-of-hours support. Patients who are not currently sexually active (many newly diagnosed, sexually infected adolescents choose abstinence for a time) do not receive such intensive counselling or cell phone access and outreach, although the importance of sexual disclosure is addressed during routine clinic visits. The following vignette describes a sexually infected adolescent whose disclosure journey illustrates the complexity of dealing with young people who avoid disclosure because of denial or fear of being rejected by family, friends or lovers.

Vignette two: coming out. ‘Paul’ was diagnosed with HIV at the age of 18 years, after which he engaged in frequent episodes of unprotected sex with casual partners in live today, die tomorrow abandon. When Paul was diagnosed with gonorrhoea and chlamydia, he was treated and then referred to the Health Department for contact tracing. Over the next 18 months, Paul continued to drop in and out of HIV care, deny his HIV diagnosis to health workers and other people, refuse counselling for sexual disclosure and ignore his doctor’s treatment plan for viral suppression. Paul’s denial ended only when he openly identified as a gay man at the age of 20 years. The act of coming out proved transformative. Paul changed from being defiant, uncooperative and sexually reckless to keeping regular appointments, using condoms, having fewer partners and gaining support from trusted friends in the gay community. He also became vigilant about taking ART. Paul still refused to disclose to sexual partners, reportedly because his viral loads were undetectable. Over a period of time, Paul was able to voice his fear of being rejected or abused by a sexual partner if he disclosed, something that he believed had happened to other men in his social circles. He also believed that being rejected was a greater and more present danger than being prosecuted for non-disclosure.

Critical points for counselling

- Safety concerns
- Fear of rejection

- Ethical and legal obligations
- Safety zone for disclosure

Counselling outcomes (successful). Paul’s example highlights how life transitions, such as coming out as openly gay, can be extremely meaningful in terms of HIV self-acceptance. Paul’s experience also reflects the journey from defiant adolescence to growing maturity. For Paul, this journey began with what he called frequent episodes of ‘don’t care’ sex that led to becoming infected with sexually transmitted infections. Counselling about sexual disclosure intensified at this point, although care was taken to avoid heavy-handed you-must-disclose messages that run the risk of alienating clients. The conversation centred instead on identifying on barriers to disclosure, such as anticipated rejection by friends and lovers.

While non-disclosure was a heavy burden to bear alone, Paul opted for secrecy while being fully compliant with his doctor’s advice for treatment, using a mobile phone for text messaging and after-hours support services, and attending support groups or weekend retreats with other HIV-infected adolescents. Paul felt that he had made important gains in keeping well and that sexual disclosure was the last piece of the puzzle. He maintained that he would disclose only if he met someone who could be trusted and who wanted a committed relationship. When Paul turned 21, he met a seronegative man with whom he fell in love. After conferring with clinic staff by text, Paul brought his partner to the clinic where he disclosed his HIV status in the counsellor’s presence. His counsellor assured the partner that regular condom use was protective, as was Paul’s diligence in taking ART for viral suppression. The partner received a prescription for pre-exposure prophylaxis (PrEP) and the couple left the clinic on good terms.

This section has addressed the motivations and barriers to sexual disclosure for perinatally and sexually infected adolescents and described counselling strategies that are tailored to their needs. Disclosure indicates an acceptance of HIV status and growing social maturity. This association indicates the importance of counselling for sexual disclosure and living openly with HIV. Table 1 expands on the strategies, scripts and resources that help adolescents come to terms with their HIV status, sexual identity and sexual disclosure in different contexts. In addition to the points already covered (e.g. role-playing, peer support, and use of cell phones and text messaging), we include information about safety plans in the event of domestic violence or when or a violent reaction to disclosure is feared, especially when knives and guns are in the vicinity.

Discussion

Counsellors are expected to facilitate disclosure in young patients, often under challenging circumstances. The vignettes presented here illustrate why disclosure journeys

Table 1. Strategies and scripts for disclosure.

Strategies ^a	Scripts and resources ^a
<p><i>Pre-counselling</i></p> <p>Rapport-building begins with developing a sense of trust. Initial discussions should be adapted to age, motivation and level of parental involvement. Give reasons for starting to think about sexual activity as a teenager with HIV.</p>	<p><i>Perinatally infected adolescents</i></p> <p><i>Counsellor:</i> 'Now that you are growing up, we can talk about what it means to have a boyfriend/girlfriend.' 'If you are thinking about having sex with someone, you should know how to tell the person about having HIV. We can talk about how to do that.'</p>
<p><i>Pre-counselling</i></p> <p>Rapport-building begins with supportive counselling about living with HIV. Consider assigning an HIV-positive advocate to guide the adolescent through early diagnosis. Offer client-centred reasons for disclosing to sexual partners.</p>	<p><i>Sexually infected adolescents</i></p> <p><i>Counsellor:</i> 'Disclosing can protect you from being infected with another strain of HIV. It can also protect you from other sexually transmitted infections that could harm you. We can talk about how you can disclose in the best possible way.' 'Disclosure lets someone know that you care about his or her health. You will also know if someone really cares about you.' 'It means that you can tell someone in your own way, and also that you won't have to worry if the person hears about it from someone else.'</p>
<p><i>Role-playing</i></p> <p>Involves hypothetical scenarios in which the counsellor and adolescent practice how to disclose to a romantic partner.</p>	<p><i>Regular partner</i></p> <p><i>Client:</i> 'I want to tell you something important. I want you to know that I really care about you and don't want to have any secrets between us.' <i>Partner:</i> 'What's wrong?' <i>Client:</i> 'If we have sex, we have to be careful and use condoms.' <i>Partner:</i> 'I don't like condoms, so what's up?' <i>Client:</i> 'Do you remember me asking what you thought about people with HIV and you said it was okay with you?' <i>Partner:</i> 'Yeah.' <i>Client:</i> 'Well, I have HIV and I wanted you to know because I care about you. Would you like to talk about it with me?'</p>
<p><i>Role-playing</i></p> <p>Involves hypothetical scenarios in which the counsellor and teenager practice scripts for managing disclosure with hook-ups and casual partners.</p>	<p><i>Casual partner</i></p> <p><i>Client:</i> 'Let's play it safe by using condoms. I have HIV, so I have to be responsible for keeping myself safe. If you don't want to have sex now, I can understand. If you do, then let's use a condom.'</p>
<p><i>Non-clinical settings</i></p> <p>The counsellor's support for disclosure in a neutral setting can be arranged with client consent, usually in cases in which a regular partner is unaware of the HIV diagnosis.</p>	<p><i>Community locations</i></p> <p>Ask the adolescent if setting up a meeting outside the clinic would be useful in helping to disclose. Plan ahead according to how the partner is likely to react. Select a public area such as a park bench.</p>
<p><i>Clinic visits</i></p> <p>Clinics can be a safe and useful setting for counselling about disclosure. This strategy also offers proof of disclosure.</p>	<p><i>Mediating disclosure</i></p> <p>The client asks his or her partner to visit the clinic as a couple. The counsellor provides support for the discloser, addresses the partner's questions and concerns, helps to defuse any tension and acts as a witness to disclosure, perhaps with a signed form. Regular partners are probably more open to this approach. Health departments are useful contacting past or casual partners and for protecting a client's identity.</p>
<p><i>Peer support</i></p> <p>Peer support consists of gender-specific teen support groups. Other approaches involve buddy dyads, weekend retreats with HIV-positive peers and organised outings or events with other teens.</p>	<p><i>Support groups</i></p> <p>Groups provide teenagers with a supportive environment for learning how to disclose. Include non-disclosing teens along with self-disclosers who can share experiences and lead the way. Tips and strategies can be discussed in ways that are relevant to teens. Groups should meet monthly in order to provide friendship and confidence boosting. A private Facebook page is useful for discussions and contact between members.</p>

(Continued)

Table 1. (Continued)

Strategies ^a	Scripts and resources ^a
<p><i>Technical support</i></p> <p>Social media are a powerful tool for counselling and retention. Technical support requires a dedicated staff member for outreach and support through Facebook (or another platform), and by cell phone, texting and email. An HIV-positive advocate who is culturally similar to the client population is ideal for this position.</p>	<p><i>Literate adolescents</i></p> <p>After-hours texting, phone calls or emails can build rapport and trust in the advocate/educator. Provide a phone number for access to emotional support, information and crisis intervention. Appointment reminders can be sent by text message. Privacy protections, including emails without the clinic's name in the address line, should be used for this type of communication.</p>
<p><i>Technical support</i></p> <p>Impaired teenagers can benefit from having pre-paid cell phones for making and receiving calls from their advocate.</p>	<p><i>Impaired adolescents</i></p> <p>Provide pre-paid cell phones to impoverished, homeless and impaired teenagers with the advocate's number in ready-dial. A pre-paid phone does not require the client to pay for it and overcomes the problem of transience or temporary or chronic homelessness. Outreach should be more frequent if the teenager is significantly impaired or needs prompting in order to attend counselling or clinic appointments.</p>
<p><i>Safety plans</i></p> <p>Sexual disclosure can lead to violence and safety plans should be in place before notifying regular partners. If contacting a past or casual partner is a barrier to disclosure, then this task can be handled anonymously by specialists at the health department.</p>	<p><i>Partner violence</i></p> <p>In all cases involving the above tips and strategies, 'what if' scenarios must be addressed in order to prevent violence during and after disclosure. The plans include ensuring that the advocate is present during disclosure, making sure that guns and other weapons are locked and secured, having an emergency signal so that the discloser can indicate distress, disclosing in a public place, keeping the address of a domestic violence shelter in a pocket or purse, having ready access to a vehicle with a full tank of gas and having someone check on the discloser at regular intervals. Safety includes ensuring that the discloser has more than one way to make emergency contact, such as by phone, signal, vehicle or friend/advocate's intervention.</p>

^aYoung people often initiate self-disclosure on their own terms or after sustained counselling. However, teenage relationships are typically short lived, and re-counselling might be necessary at routine visits. Role playing and strategies are useful for learning how to disclose as a life-long practice.

can be long and arduous, and why success is not always assured. Although the examples do not cover every response or strategy, they help to explain why many adolescents who are living with HIV find it difficult to notify partners of their diagnosis, despite U.S. state laws that frame disclosure as mandatory for HIV control.

The vignettes illustrate that patient motivation and supportive relationships that foster trust, openness and respect for a partner's wellbeing can facilitate disclosure. Having a steady partner is important as well and, as suggested by our clinical experience and published research (e.g. D'Angelo et al., 2001), adolescent disclosure is more common with regular partners than with hook-ups or casual partners. Time itself can facilitate disclosure, perhaps because hiding an HIV diagnosis for long periods of time is psychologically challenging. Disclosure can be a welcome relief that garners surprising levels of support from intimate partners (Atuyambe et al., 2014). Supportive partners can also foster better condom use and ART adherence, and improved communication between patient, partner and clinic staff (Atuyambe et al., 2014; Weiner and Battles, 2006).

HIV stigma remains a potent barrier to disclosure and medical care. Silver et al. (1990) referred to disclosure as a 'cruel paradox' because the putative benefits of disclosure in relieving the psychological burden of a closely kept secret are negated if disclosure becomes a source of damaging gossip and social rejection. Brems et al. (2010) reported that levels of HIV stigma are high in rural communities, which echoes our experience of rurality and provides the rationale for outreach through phone calls, text messaging and home visits to patients around our state. As the vignettes indicate, adolescents are concerned about being stigmatised by other people, and it is likely that counselling for sexual disclosure would be less fraught if HIV were perceived as less threatening or socially discreditable in their communities.

Conclusion

Supportive counselling is a crucial component of HIV care for infected adolescents. There is little question that skilled counselling in adolescent-friendly settings can be immensely helpful in guiding HIV-infected adolescents toward

maturity, self-disclosure and a more confident future with HIV. This goal is not only relevant for young people's well-being but for breaking the chain of HIV transmission. Typically speaking, an incremental relational approach to counselling is more effective than simple directives to follow the law. A patient's first experience with disclosure also predicts willingness to notify future partners, with setbacks such as rejection involving a further period of support in order to restore self-esteem. In other words, the path to disclosure is a staged process for many adolescents.

As the vignettes indicate, successful outcomes can be difficult to achieve with adolescents such as Jane and Paul, whose life contexts interfere with progress toward disclosure to sexual partners. Counsellors must contend with these realities in order to promote disclosure for ethical and legal reasons. In many jurisdictions, counsellors are also required to notify the health department if their patient is diagnosed with a sexually transmitted infection or if they identify a partner who is unaware of the patient's HIV status. Health departments are responsible for contact tracing in such cases.

On a final note, we draw attention to the fact that HIV laws in many jurisdictions do not account for factors such as mental illness, developmental readiness, impairment or trauma and the high levels of HIV stigma that are a barrier to non-disclosure. HIV criminalisation not only legitimises stigma but, as Paul's story suggests, has the opposite effect of its intended outcome when well-informed patients opt for secrecy over the risks of rejection. In a heartening development, we know now that ART for persons with HIV and their sero-discordant partners reduces transmission and weakens the case for HIV criminalisation. Early initiation of ART for these patients and the availability of PrEP for sero-discordant partners are being hailed as potent tools for ending the HIV epidemic (Park, 2014). Our vignettes suggest that modifying HIV laws in light of such advances could increase uptake for HIV testing and treatment and perhaps lessen the social stigma that is such a potent barrier to sexual disclosure.

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References

- Atuyambe LM, Sseguija E, Sali S, Tumwine C, Nekesa N, Nannungi A, Ryan G and Wagner G. (2014) HIV/AIDS status disclosure increases support, behavioural change, and HIV prevention in the long term: a case for an Urban Clinic, Kampala, Uganda. *BMC Health Services Research* 14: 276–287.
- Brems C, Johnson ME, Warner TD and Roberts LW. (2010) Health care providers' reports of perceived stigma associated with HIV and AIDS in rural and urban communities. *Journal of HIV/AIDS & Social Services* 9: 356–370.
- Butler AM, Williams P L, Howland LC, Storm D, Hutton N and Seage GR. (2009) Impact of disclosure on health-related quality of life among children and adolescents living with HIV infection. *Pediatrics* 123: 935–943.
- Centers for Disease Control and Prevention (CDC). (2016) *Lifetime risk of HIV diagnosis in the United States*. Atlanta, GA: CDC. Available at: <http://www.cdc.gov/nchhstp/newsroom/docs/factsheets/lifetime-risk-hiv-dx-us.pdf> (accessed 27 January 2016).
- D'Angelo LJ, Abdalian SE, Sarp M, Hoffman N, Belzer M and The Adolescent Medicine HIV/AIDS Research Network (2001) Disclosure of serostatus by HIV infected youth: the experience of the REACH study. *Journal of Adolescent Health* 29: 72–79.
- Fortenberry JD, Martinez J, Rudy BJ, Monte D and The Adolescent Trials Network for HIV/AIDS Interventions. (2012) Linkage to care for HIV-positive adolescents: a multisite study of the adolescent medicine trials units of the adolescent trials network. *Journal of Adolescent Health* 51: 551–556.
- Gielen AG, McDonnell KA, Burke JG and O'Campo P. (2000) Women's lives after an HIV-positive diagnosis: disclosure and violence. *Maternal and Child Health Journal* 4: 111–120.
- Lichtenstein B, Whetten K and Rubenstein C. (2014) Notify your partners – it's the law: mandatory disclosure and HIV providers. *Journal of the International Association of Providers in AIDS Care* 13: 372–378.
- Marhefka S L, Valentin CR, Pinto RM, Demetriou N, Wiznia A and Mellins CA. (2011) "I feel like I'm carrying a weapon." Information and motivations related to sexual risk among girls with perinatally acquired HIV. *AIDS Care* 23: 1321–1328.
- Park A. (2014) The end of AIDS. *Time* 184: 44–50.
- Sheon N. (2006) *Theory and practice of client-centered HIV testing and counseling*. Available at: <http://hivinsite.ucsf.edu/InSite?page=kb-07-01-04#S9.1X> (accessed 7 February 2016).
- Silver RL, Wortman CB and Crofton C. (1990) The role of coping in support provision: the self-presentational dilemma of victims of life crises. In: Sarason BR, Sarason IG and Pierce GR (eds) *Social Support: An Interactional View*. New York, NY: John Wiley & Sons, pp. 397–426.
- Wiener L and Battles H. (2006) Untangling the web: a close look at diagnosis disclosure among HIV-infected adolescents. *Journal of Adolescent Health* 38: 307–309.
- World Health Organization (WHO). (2013) *HIV and adolescents: Guidance for HIV testing and counselling and care for adolescents living with HIV*. Geneva: WHO. Available at: <http://www.who.int/hiv/pub/guidelines/adolescents/en/> (accessed 10 January 2016).