Journal of the Gay and Lesbian Medical Association, Vol. 3, No. 2, 1999

Original Research

Self-Disclosure of HIV Status to Sexual Partners: A Qualitative Study of Issues Faced by Gay Men

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Objective: This study aimed to explore the range of issues faced by HIV-positive and HIV-negative gay men concerning HIV serostatus self-disclosure to sexual partners. *Methods:* In-depth semistructured interviews of 1–2 hr each were conducted with 26 HIV-positive and 15 HIV-negative gay men who were recruited from a larger cohort of gay men followed longitudinally for several years at a major medical center. Interviews were audiotaped, transcribed, and content-analyzed by two independent raters. *Results:* Several themes emerged concerning how disclosure was viewed, who and what was told, why disclosure occurred, and how disclosure decisions related to sexual behavior. Variations occurred in when and why men disclosed, and in the contents and definitions of their disclosures. Men disclosed using codes and indirect hints. Various rationalizations arose for not telling as well. Many men adopted the position that they do not tell, but practice safer sex, yet definitions of safer sex varied such that what some men consider safe, others do not. *Conclusion:* Recognition thus needs to be increased among clinicians, researchers, patients, and others that definitions of disclosure and of safer sex can vary significantly. The data have critical implications for designing appropriate interventions to limit the further spread of HIV.

KEY WORDS: HIV; self-disclosure; gay men; risk behaviors; stigma.

INTRODUCTION

HIV infection—private, confidential information—if revealed, can lead to rejection and stigmatization. Yet when HIV status is not disclosed to sexual partners, safer sexual practices may not be followed, and further spread of the disease may result. Thus, HIV-positive individuals often experience significant conflict and distress over what to say about their serostatus to others, particularly sexual partners. HIV-negative men may feel uncomfortable asking their partners as well. Previous quantitative studies have suggested that HIV-positive persons often do not disclose their HIV status to sexual partners and others. Yet few qualitative studies have been done to assess how individuals view and handle these difficult issues of self-disclosure. How do gay men perceive and approach the psychological and ethical dilemmas involved? What decisions are involved in sexual situations, for example, as to whether, when, what, and whom to ask or tell concerning HIV status? This study was designed to shed light on the range of patterns, meanings, and implications of HIV disclosure among gay men.

Several quantitative studies have suggested that HIV-infected individuals often do not disclose their status to others. Perry *et al.* showed that of gay men recently learning they were HIV-positive, 90% who had past sexual partners made no attempt to inform them of the test result (1). Stempel *et al.* showed that after 1 year, a sample of gay men had informed only 56% of their new sexual partners of their status (2). Marks *et al.* found that failure to disclose status occurred in conjunction with unprotected receptive and insertive anal intercourse, and that self-disclosure was less likely as the number of sexual partners increased (3). Moreover, study participants tended to

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1090-7173/99/0600-0039$16.00/1 © 1999 The Gay and Lesbian Medical Association

disclose their positive HIV status when they believed their partners were seropositive, and appeared less likely to disclose to partners thought to be seronegative (3, 4). HIV-positive gay and bisexual men were also more likely to have unprotected insertive anal intercourse with seropositive than seronegative partners (5). Spanish-speaking Latino men have been found to be less likely than English-speaking Latino men or White men to disclose HIV status and sexual orientation to significant others, especially family members (6). Other research among gay men as well as heterosexual men and women has found that those who disclose to all partners are more likely to be women, Caucasian, or Latino rather than African-American, have high spousal support, low support from friends, and a lower number of sexual partners (7).

Difficulties with self-disclosure have been found among both symptomatic as well as asymptomatic men (8) and when disclosures were to family members and others besides sexual partners alone (9, 10). Rejection does not always occur from main partners (11).

Yet little in-depth qualitative data have been analyzed concerning these issues. Qualitative research methods have been successfully used to elucidate how individuals view and approach the meanings and complex interpersonal aspects of illness (12). Qualitative data and narratives of individuals' experiences can also reveal how individuals within a particular social or cultural situation or setting view a phenomenon, thus shedding light on the perspectives of these individuals themselves, as opposed to the viewpoints of researchers (13). Sobo presented qualitative findings examining issues of disclosure among small-town southwesterners, reporting, for example, on one focus group consisting of three women and one gay man (14). Yet norms and practices may vary among gay men, and between small towns and larger urban centers, which have much higher incidences of HIV infection. Gay men also constitute a particular subculture that may shape approaches to self-disclosure.

Goffman describes (15) how individuals learn to conceptualize and manage stigmatized or "spoiled" aspects of their social or personal identities. Some individuals attempt to "conceal" symbols of stigma, and to "pass," while others socialize more fully with similarly stigmatized individuals. How gay men with HIV view and handle decisions concerning disclosure of potentially stigmatizing HIV infection has not been fully studied. Similarly, Parsons describes "the sick role"—a social role characterized by certain exemptions, rights, and obligations, and an impaired capacity to function (12, 16, 17). HIV-positive individuals may not perceive or want to perceive themselves as sick, though others may view them as such, resulting in tension and conflict (18). Green found in a street survey of the general public in Edinburgh, Scotland, more liberal attitudes toward HIV than persons with HIV thought existed. However, people with HIV still experience and fear rejection from potential sexual partners, and the possibility of being a sexual partner with a person with HIV was not examined in this study (19).

In general, social norms dictate that individuals not always divulge medical problems—particularly those involving personal behaviors. Disclosing a disease may mean divulging other aspects of one's life that may potentially be embarrassing or have negative repercussions. This area has been understudied among other diseases, and clearly has additional complications with regard to HIV.

Thus, several gaps remain in the understanding of issues concerning disclosure among gay men. What are the *range* of issues that gay men face—from their own perspectives—concerning disclosure with sexual partners? How do HIV-positive men view and make difficult disclosure decisions? What are the components of HIV disclosure decision-making? What are the specific contents and definitions of disclosures? These issues have critical implications for HIV transmission and prevention. To understand how men view and approach these decisions can help clinicians and researchers develop appropriate interventions to assist men in dealing with these issues, thus furthering efforts to prevent HIV transmission.

METHODS

Participants were recruited from a cohort followed longitudinally since 1988 at a major medical center in New York City as part of a research study of HIV-positive and HIV-negative gay men. Data gathered from these men on a variety of psychological and medical variables have been previously reported (20). A self-report questionnaire was developed concerning issues of self-disclosure and was administered in conjunction with a biyearly follow-up appointment that was part of the longitudinal study. All members of the cohort completed the questionnaire between July and December 1993. Participants were asked on the questionnaire if they would be willing to be interviewed in-depth about these

issues, and a portion of those who agreed were interviewed. The researchers randomly selected subjects from among those who on the structured questionnaire indicated that they disclosed, and those who indicated that they did not always disclose to sexual partners. The interviewees' responses on the questionnaire thus reflected the range of responses provided by the larger cohort. The interviewees as a group did not differ from the larger cohort in terms of age, ethnicity, or other sociodemographic characteristics. In all, 26 HIV-positive and 15 HIV-negative men were interviewed in-depth in one-on-one semistructured interviews of 1–2 hr each. All interviews were conducted either by a psychiatrist or a professor of public health who has had extensive training in interviewing techniques. Interviews were audiotaped, transcribed, and evaluated closely to maintain quality. The study had been approved by the hospital Institutional Review Board. Interviews were confidential and participants signed informed-consent forms agreeing to participate, and were paid $15 for their time. In the interviews, participants were asked to describe their experiences with self-disclosure—to whom they have disclosed, how they decided to whom they would or would not disclose, and whom to ask or not ask, what participants said, what reactions participants encountered, what sexual behaviors, if any, these men then engaged in with the people to whom they did or did not disclose, and did or did not ask, and how these participants made and viewed these decisions. Data were content-analyzed, informed by grounded theory, as described by Strauss and Corbin (21). Narratives were analyzed by two independent raters to assess factors that shaped participants' experiences, identifying categories of recurrent themes and issues (22). Coded themes included contexts, contents, reasons, and definitions concerning disclosures and nondisclosures and related behaviors, and expectations concerning these areas.

Data were collected on HIV-negative as well as HIV-positive gay men to find out how expectations and experiences concerning disclosure and truth telling and views of the ethical issues involved varied between the two groups. Though the two groups differ in whether they face potential stigma in self-disclosing, they encounter similar questions of whether to raise the topic of HIV status with sexual partners—whether to ask a partner his status and whether or not to engage in safe or unsafe sex when the issue is or is not raised.

RESULTS

Several sets of issues emerged from the data analysis concerning aspects of disclosure decision making. These areas are presented below.

Views of Disclosure

Most participants—both HIV-infected and HIV-uninfected—saw self-disclosure of HIV status to sexual partners as an important issue, and specifically as a "moral" one. As one HIV-positive man reported, "I'm almost a moral man. I don't always tell, but when I don't, I practice safe sex." Another HIV-infected interviewee said, "I'm a goody two shoes—I always tell my partners I'm positive." Conversely, many men—both HIV-positive and HIV-negative—suggested that not telling and practicing unsafe sex was, "like shooting people with a loaded gun. How could you kill someone like that?" Other men called it, "a serious crime," "like being a murderer." Of note, participants repeatedly raised these moral terms and viewpoints spontaneously on their own, without prompting.

Who Is Told

Most HIV-positive and all HIV-negative men agreed that main partners should be told. Participants explained, "How can you be in a trusting relationship and not tell? In a love relationship, you trust and expect to be trusted because why else be in the relationship—to build a life together?" Closeness led to the sharing of information, and expectations that such information would be shared.

Standards concerning disclosure varied depending on the type of partner, particularly with anonymous partners. As one man said, "On one night stands, people don't talk about HIV." An HIV-positive man explained, "How can I tell you when I don't know you?" HIV-positive men generally thought there was no obligation to tell anonymous partners if safer sex is practiced, but that lying was not acceptable.

Participants felt that social settings affected the "appropriateness" or need to tell, and determined expectations concerning communication between sexual partners. Approaches differed with potential sexual partners, e.g., during dates or at a bar. Ordinarily, men did not disclose at bars, and were sur-

prised when they were asked about their HIV status in these locations. At bars, men generally neither asked about nor discussed HIV status. In other locations, dates often "ended" as soon as a positive HIV status was disclosed. As one man said, "A guy in the gym was hot after me. Finally, we had a date and I told him about my HIV status. I could see a cloud just drop over his face. The date ended right there—which really pissed me off."

None of the men, once learning their HIV status, disclosed to past male partners. One bisexual man notified previous female but not male partners, saying, "The duty to notify overrode my fears." The women he contacted turned out to be HIV-negative, but were grateful to him. He did not notify male partners, as he felt that they were more aware of HIV as a potential threat and of the possibility that they might be at risk. Past male partners, as gay men, were—participants assumed—probably already concerned about the possibility of HIV infection and would get tested.

Problems arose concerning disclosure to third parties. For example, one participant described a friend with AIDS who introduced sexual partners to the participant, saying, "Don't tell him I have AIDS." Another participant warned a woman about an infected bisexual friend with whom she was sleeping. The participant commented, "It was like pulling a child out of traffic—she should have a right to decide what to do." Such disclosures raise difficult ethical issues concerning the limits of confidentiality among friends and acquaintances among whom established, explicit rules do not exist concerning such secondary disclosure. As one participant said, "To tell is also a kind of letting go—you don't have control over it anymore, and who knows." Such difficulties frequently arise in families. Participants have told family members, such as siblings, who often have then disclosed to other family members to whom the participant was not yet ready to disclose, causing additional stress.

What Is Told

Disclosures varied in their content and directness and often occurred in code and through indirect hints. Several examples arose through the interviews. For instance, a participant reported, "I leave bottles of AZT around my apartment when I bring someone home, so the issue is 'out there.'" Another man leaves copies of HIV organizations' newsletters and *Poz* magazine around his apartment. One participant tells partners, "Well, my ex-lover died of AIDS," but does not say that he himself is HIV-positive.

One man reported that he tells partners he "doesn't know" his HIV status, but that "it is 98% probable I'm HIV-positive," even though he knows that he is HIV-positive. Yet the definitive label carries added stigma and hence is more difficult to admit. Another man has mentioned his "immune functioning and fluctuating T-cells," but not his HIV-positive status to a casual partner. They have had sex intermittently over 2 years. The study participant assumed that this partner understood the implications—though the two men had never discussed it—and the participant was not sure that this partner in fact knew. One man's mother asked him, "Are you healthy?" meaning HIV-negative. He answered "yes," as he felt healthy, though he is HIV-positive, and knew his mother was asking about his HIV status.

Men also disclose that they, "are HIV-positive," but not that they, "have AIDS," since the fact of illness rather than infection alone—the result of a blood test that may not be accompanied by symptoms—is felt to be more likely to prompt rejection. Denial and minimization of the illness also play roles in some men's lack of full and complete disclosure.

Several participants make assumptions concerning the existence of "unwritten rules." For example, one man explained, "There's an unwritten rule when you see the condoms," that is, that they had to be used. In oral sex, many men feel there's a "rule" not to ejaculate in a partner's mouth. Many men who are passive in oral sex feel such a norm exists, and get angry when it is violated, while other men do not believe such a rule exists at all. Problems arise in that some men expect rules to be followed, though what and whose are not always clear. In short, rules that are not mutually agreed upon in advance are not necessarily operative, though some individuals feel such mores exist nonetheless.

Men also give inaccurate information to sexual partners, making errors of both commission and omission. Several infected men gave no information, while others have claimed they "didn't know" whether they were HIV-positive, "hadn't been tested," "hadn't been tested for a while," or "were negative when they were tested, but that was a while ago."

Infected men find that they not only have to tell, but to educate partners about HIV. Individuals to whom participants disclosed often then asked questions about safer sex, prognosis, and other medical

aspects of the illness. As one participant reported, "I say that I'm positive, and then I'm ready to say what we can and cannot do sexually." Prognostic and other medical information often is even more important when disclosing to others besides sexual partners (e.g., parents) who may have less information about HIV.

When to Tell

Men disclosed at various times. It took time for many participants to accept the diagnosis themselves before being able to disclose it to others. Over time, attitudes toward and ability to tell change. As one man said, "As I grew less ashamed of HIV, I felt more comfortable talking about it." He told one casual partner only after several weeks of having sex, though it was safe. Initially, the partner was angry and upset, but the two men, "worked it through" and continued to have sex. Many wait to tell until having sex, or potentially unsafe sex, not telling at first if they consider the sexual activities engaged in to be safe. Some participants waited as long as several months or even years after receiving a positive test result to begin to tell sexual partners.

Many men have not yet disclosed to family and friends, and anticipate waiting until getting "bad" medical results, such as developing *Pneumocystis carinii* pneumonia, or being hospitalized, and then needing the additional social support.

Why Tell?

Reasons for telling varied, depending on who was being told. Thus, with main partners, "closeness" and "trust" were most frequently mentioned. As one man said, "I could not imagine not telling my partners, because lies destroy a relationship." Disclosure also results from the sense that HIV infection is an important part of one's identity—as one man said, "a part of me, of who I am." Particularly with main partners, individuals also tell to receive social support.

Views of self affect disclosure. As one man said, "I tell partners because I'm an open person." Conversely, another man encounters difficulty disclosing and explains, "I'm basically a private person." Such reasons arise when telling family members as well. One man says he informed his family right away—"It was very hard for me, but how could I not tell them? How could I be at all close and not let them know? It's not fair to them and would deprive me of support I get from the relationship." Closeness thus both leads to and results from disclosure. In short, decisions as to whether or not to disclose are based not only on avoidance of stigma, but on the desire for intimacy and support.

Not surprisingly, issues of closeness and trust did not emerge with anonymous partners. Yet the issue nonetheless arose of sexual partners' "right" to know each other's serostatus—so that partners can make informed decisions about what risks to take—and of the "duty" to inform sexual partners. Many HIV-negative men felt that they have a "right to know" and to make a choice as to whether or not to have sex with a person who is HIV-positive. Yet HIV-positive men felt that if they practiced safer sex, the duty to inform lessened.

Men often tell only when asked. As one man who practices safer sex with his main partners but not with his anonymous partners reported, "If people ask me, I will tell them. If they don't ask, I won't volunteer [the information]." He assumes that people who do not ask are engaging in behaviors with which they feel safe. Another man said that with outside partners, he has anal sex, "25–30% of the time, without a condom. If they don't ask, I don't tell. I hate talking about HIV just before or during sex—it kills spontaneity. It's like noticing something hanging from their nose!" Men also tell to avoid feeling guilty afterward. As one man said, "I've always practiced safe sex since finding out my status. I don't want the guilt of finding out it was my fault [if someone seroconverted]."

In close relationships, the psychological costs of keeping the infection a secret also compel men to disclose. "I reach an emotional boiling point," one man said. "How could I not tell?" Another man said that during the 9 months after finding out he was HIV-positive, he told only one person. "It was like a big dirty dark secret," until he began to seek help at Gay Men's Health Crisis and told a second person, a friend in ACT-UP who could direct him to services. A participant who described himself as "a gay man who got married" has told his wife, but few other people, and has "lied" to friends concerning hospitalizations, claiming he has brain cancer. Yet, he reports, "lying eats me up, since I have to dig the hole deeper every time when my friends ask about the cancer. I feel my whole life is a lie." He says that he dissembles because he teaches music and his income depends on tutoring high school and college students pri-

vately. He feels they would treat him differently, and that he would lose business. He also does not want his wife to be seen as "an AIDS widow" after he dies, such that she would encounter problems if she then wanted to date or enter another relationship. He told his family only reluctantly, because they began to suspect something was wrong. When he does tell, it is to, "not be alone with it."

Why Not Tell?

In part, secrecy grows out of earlier experiences of being gay. Men refer to "coming out" as HIV-positive. Yet these two situations differ, too. One man reported that he can't "escape, or laugh it off like I do when I tell people I'm gay." The reactions encountered differ, too. With HIV, "people give me a big hug—which they've never done when I've told them something traumatic—and say, 'I'm sorry' or don't know how to react."

The most common reason to avoid telling is fear of rejection. Yet, in fact, among these men, rejection generally has not occurred even when it was feared. As one participant reported, "I told this gorgeous guy, a 'Greek god,' that I was positive. I was afraid to tell him. But after I did, he said he was positive, too." Many men do not disclose to parents because of the fear the news would "burden" parents, many of whom are elderly and often face serious medical problems themselves.

Rationalizations arise for not telling. As one man said, "I decided I would not have sex with my current partner until I told him. But then I allowed myself to be seduced by him—though I still hadn't said anything. It took a month [for me to tell him]. It was very hard. I was afraid of rejection and of his anger. But we had been safe. I did practice oral sex without a condom, but at that point, I didn't think oral sex was a risk. Still, he was very uneasy when I told him." But they have since stayed together. In short, the participant rationalizes having sex without disclosure because he "was seduced" and thus—he feels—not fully responsible. The decision not to tell, but to continue to practice unsafe sex also becomes rationalized. "I don't know if it's fully conscious or subconscious, but I block it out, like it's a delicate issue. It's going to raise a lot of problems, so I'd rather not deal with it right now. I can't say that I was promiscuous—I was not having sex 20 times a day." He sees the fact that he was not having sex 20 times a day as adding support to his decision not to disclose.

Yet even when asked, not all men disclose. One man has told only four people—one of whom was his physician. When other friends asked this participant about his HIV status, he said that he was not tested or was negative. He provides several reasons, offered by other participants as well:

> I just don't want to be perceived as different. And maybe I'm superstitious, but talking about it may do something, maybe make me become sick sooner. I think there's some kind of superstition working there. I'm not a superstitious person, but somewhere I'm thinking that if you tell people this, does that mean you're also telling yourself that you have AIDS? Why should I put myself in a position where I think of myself as a sick person, when I'm not? I mean a sick person is incapacitated in some way, and I don't right now see myself that way. You have to live a normal life as much as you can, so telling people about the disease means you're letting the disease, the virus encroach on your life even more. That is less of a normal life and more of being an invalid, or someone to be pitied or shunned. There is also some kind of denial working there. On some level, maybe I'll never become sick. Now I'm not saying this is true. But you play tricks on yourself so you can just survive, get through the day. To admit to friends would mean that I'd have to admit it to myself.

Thus, magical thinking—that talking about it may jeopardize health—and denial play roles here. He later also rationalizes that he often did not tell because he was asked in "inappropriate situations," for instance, at a party when others were present. In short, the desires to feel normal, uncontaminated, and desirable often serve as important reasons for nondisclosure as well.

Disclosure and Sexual Behavior

Many men adopt the position, "I don't tell, but practice safe sex." Indeed, as one man said, condoms are "a substitute for talking." Another man reported, "If they use a rubber, then it's as if I told them." But several problems arise concerning these attitudes.

First, definitions of safe sex vary. What some men consider safe, others do not. In particular, a "gray zone" exists around oral sex. Among those men who believe that oral sex is safe, precum rarely arises as a possible source of infection. As one man said, "I had a 2 week affair and told the person after we'd been having sex—though only doing what I felt was safe—that I was positive. My partner freaked out because I had put my penis in his mouth—which I felt was safe since I hadn't ejaculated. He said, 'If

I knew you were positive, I never would have let you put your penis in my mouth.' I assumed people would do what they feel comfortable with, if I haven't told them my status. I don't think there's any reasonable risk—no greater risk than walking across the fucking street." Yet clearly, the two men had different senses of what they felt safe with. As another participant reported, "Safe sex is only relatively safe." Yet men establish positions of what they feel is and is not safe. As another man said, "Everyone is safe in his own mind." Notions of relative risk are thus difficult to accept. Many men behave differently with a sexual partner known to be HIV-positive versus one whose status is unknown, though the risk of exposure may be the same (e.g., if the partner had never been tested or was negative when last tested and has since seroconverted).

Another problem with not telling, but using condoms is that they can break. Several men believe that they in fact became infected in this manner. Yet HIV-positive men generally felt that condom breakage is a possibility that HIV-negative men implicitly accept when using condoms. As one HIV-positive man said, "Knowing they can break is the risk you take. You sort of go with the flow." The question thus arises as to how much responsibility one's sexual partners have toward each other. As one man reported, "I let a friend go down on me, without me coming. That's his decision . . . sex makes people do dumb things." If a casual or anonymous, as opposed to main, partner engages in risky behavior, HIV-positive men generally did not feel compelled to dissuade him. As one man said, "I've gotten crabs and other STDs from those who lied to me. But it's like crossing the street." In short, in 'playing the field,' one accepts a certain amount of risk. Men also engaged in mutual risk-taking, legitimizing each partner taking risks.

When advocating the use of condoms, HIV-positive men generally spoke of protecting others from infection. Fewer discussed protecting themselves from reinfection. Yet the latter may be an area of potential concern, given the possibility of multiple viral strains and resistance developing to medications such as antiretrovirals.

Participants generally thought deep kissing was safe, though a few HIV-negative men were anxious about it and said they would not kiss a known HIV-positive man. For example, an HIV-negative former priest said, "It's foolish to kiss under today's circumstances—all that death." On the other hand, as another man said, "I kissed even before that was shown to be low risk, because I wouldn't not kiss. It's worth the risk." In short, concerning sexual behaviors, men balance desire against fear, knowledge, and perceived possibilities of danger.

HIV-positive men often practice a policy of "Don't Ask, Don't Tell"—of everyone protecting themselves—and thus of *caveat emptor,* or letting the buyer beware. Yet many HIV-positive and HIV-negative men also felt that though people should protect themselves, infected individuals have responsibility, too. As one man said, "Buyers should beware, but sellers should be punished for selling bad goods." Moreover, HIV-negative men easily assume that their partners, if not disclosing, are HIV-negative. Still others feel "it's a two way street." HIV-positive men generally assume that others are informed about HIV—now, after more than 15 years of the epidemic—especially in bars, and that people know to protect themselves. As one man said, "There is a need for defensive driving"—for assuming that one may be endangered by others' actions. In sexual situations, however, often occurring under the influence of alcohol or drugs, intellectual concepts of responsibility and caution prove less compelling. As one man said, "When I want to get off, that's what comes first." Episodes of unsafe sex "sort of happen," i.e., are not fully under conscious control. In short, decisions around self-disclosure involve balancing competing values and desires (e.g., being "moral" versus "getting off") and opinions vary as to the degree to which responsibility should be shared.

Alcohol and drugs often make it easier not to disclose—to forget about HIV almost altogether. Substances are also sought in order to escape from such concerns. For example, one participant reported a friend who uses cocaine to facilitate having unsafe sex and not disclosing his HIV status. The drugs play an integral role in the experience, abetting the friend in feeling less responsible for his behavior. In having unprotected sex and not disclosing, HIV-positive men participate in a fantasy of "being normal" and HIV-negative men participate in a fantasy of living in a "normal" world in which sex is not potentially lethal.

Assessing Disclosures

Both HIV-positive and HIV-negative men discussed their assessments of others' disclosures, not always believing others' claims of seronegativity. For example, one man who has dissimulated because he did not want to scare people away and feel worse

about himself said, "I don't believe it when people say they are uninfected, because 98% of gay men must be infected, the way they act." Yet men also make individual assessments. A 56-year-old Caucasian man from the South said he let a man "fuck me without a condom recently because the man said he was negative and was a Southern gentleman from my same social class, and wouldn't lie." A former schoolteacher said he discloses to casual and main partners and trusts what they say because "I pick those I feel I can trust." He draws on his "experience of being a school teacher for many years and seeing hundreds of kids," which he feels makes him a good judge of character. The former priest said he had a few unsafe encounters of oral sex with one person, but trusted the man's claim of being HIV-negative because "I think there was enough integrity." Others evaluate the health status of partners by "observation." The point is not whether such assessments are right or wrong, but that individuals are making them.

Reactions to Disclosures

Many who are not disclosed to have gotten angry when finding out afterward that a partner was infected. Several men believe they were lied to, of whom a few remain incensed. But most do not. For example, one man said, "I cannot feel angry, because by that time [when he was informed] the dirty deed was done. He didn't feel I could handle the information. He then ended the relationship and went on a mission, having sex with lots of people."

Many have also gotten angry when asked their HIV status, or when they disclose and are then rejected as a result. The reasons for the rejection are often claimed to be other than because of HIV. For example, one man said, "The worst experience was with a guy I dated last summer. We met over the phone-sex lines, spoke for a month beforehand, and got along great. We finally got together and had two dates. He was nuts about me. On the third date I told him I was positive. We had a few more dates and then he broke it off, citing all these reasons: that I was too critical and negative. We had these long discussions about my problems. Being rejected hurt me a lot. It took me a year to figure out that he was crazy about me till he knew I was positive."

Other Attitudes Toward Telling

The fact of rejection has led some HIV-positive gay men not to date at all, and others to date only known HIV-positive men (e.g., met through their HIV support groups) such that "HIV status is then not at all an issue."

Several men knew of people who as a result of potential rejection did not disclose accurately, and then practiced unsafe sex. For example, one participant reported that such an individual had been in his HIV support group. The group criticized the individual as a result of such behavior. The man then stopped coming to the sessions. Other men engaging in such behavior also fled when confronted. Those study participants who had not disclosed and then practiced unsafe sex had difficulty talking about such situations in study interviews. These men generally had not reflected much about the issue, and spoke tangentially when asked about it, or minimized such occurrences.

CONCLUSIONS

The range of issues found concerning disclosure reveals much about how gay men view and communicate about HIV, yet also raises several concerns. Specifically, the absence of clear and direct disclosure may result in situations in which unsafe sex is more likely to occur. Individuals may feel they are "safe" when a partner has not disclosed, since they assume that such a partner must thus be uninfected. In fact, other studies have suggested as well that individuals decide how "safe" to be depending on their understanding of their partner's status (23). Men also vary in whether they think they are or will be told the truth by sexual partners.

In addition, self-disclosures, even when reported as such by men to their clinicians or to researchers, may be indirect, ambiguous, or in "coded" language or gestures (e.g., saying one's ex-lover died of AIDS, or leaving bottles of HIV medications around) that may or may not be correctly interpreted. Gay men have had prior experience communicating in code when coming out, gauging whether other men are gay, and when 'cruising,' assessing whether other men may be interested in sexual encounters. Such interactions involve subtle verbal and nonverbal cues. Gay men thus have experience and skills in expressing themselves in and interpreting codes. With regard to HIV, such indirect communication allows HIV-positive individuals to avoid the difficulty and possible rejection of disclosing per se, while enabling them to feel that "at least the issue is out there."

Thus far, research on self-disclosure of HIV sta-

tus has relied on participants' self-reports of acts of disclosure, without examining what exactly was disclosed or how. Given that *definitions* of self-disclosure were found here to vary—such that what one person considers to be disclosure, another person might not (e.g., as a result of coded communication)—self-reports of disclosure may not be valid. Participants may report that self-disclosure occurred when they only dropped hints that may not be correctly interpreted, and thus might not actually constitute disclosure—that is, the communication of information. Prior studies have not assessed how partners knew each others' status—whether such information was explicitly communicated or merely suspected. For example, it has been found that HIV-positive men do not disclose to most of their seronegative partners (5), yet claim to know these partners' HIV status. These findings suggest that mutual disclosure did not occur. Consequently, the information participants provide in studies concerning their partners' serostatus may not be accurate.

Clinicians also need to be aware of these issues—the specific aspects of disclosure concerning which HIV-positive and HIV-negative gay men face dilemmas. Clinicians need to recognize that patients who say they are disclosing to sexual partners may not be doing so explicitly in ways that are thus accurately interpreted. Consequently, HIV-negative men may unknowingly be putting themselves at risk for HIV. In addition, partners who say they are HIV-negative may have been so at the time of their last test, which may have been more than 6 months previously. Such partners may have gotten infected since and thus may be HIV-positive now, even though they are not lying.

Clinicians can ask questions to ascertain the full extent of communication about HIV engaged in by their sexually active patients—specifically, what sexual activities are patients engaging in, and if not safe, what, if anything, have partners said exactly to each other concerning their respective HIV test results? Are patients making assumptions about partners' HIV statuses and engaging in unsafe activities as a result?

The position that many gay men adopt of not disclosing to partners, but practicing "safer sex" raises significant public health concerns, given variations found as well in definitions of "safer sex." Though arguments have been made in the gay community and elsewhere that not disclosing is acceptable, as safer sex can be practiced, this approach is problematic, as partners may have different definitions of what is or is not safe. Moreover, the fact that condoms can break led some men to question whether partners thus have a right to know each other's status in any case. This issue rose among HIV-negative men, though most HIV-positive men did not feel partners had such a right. HIV-negative men also expected that they would be told an HIV-positive partners' status if the two men were engaged in unsafe sex, while HIV-positive men did not expect this to be the case.

This study thus sheds light on the parameters, conflicts, and vagueness inherent in the notion of "sexual ethics." What are the ethics governing the bedroom or other sexual encounters? These are rarely discussed, yet clearly require more attention and research. For instance, decisions not to disclose may be difficult to alter as they become rationalized and not a source of ethical conflict in individuals' minds. Research is needed to ascertain how gay men view and balance risks and responsibilities toward each other in sexual situations, and what factors shape these attitudes. What do gay men feel is acceptable to disclose or conceal in sexual situations, and how do HIV status or other issues affect these views?

In addition, HIV, though in some ways serving as a special case, illustrates the dilemmas and complexities that can be involved in divulging a medical diagnosis to others—the multifacetedness of questions as to whether, what, how, when, and to whom to disclose.

These data have a few limitations. First, the sample size was limited. Yet it was appropriate for an in-depth qualitative study designed to elucidate the range of issues experienced by a particular group, in this case of gay men. Future research can assess these issues further among larger samples as well. Second, the sample had been longitudinally followed for 6 years. The cohort, as it consists of men who did not drop out, might thus be more conscientious and hence less likely to behave in ways that might be seen as potentially questionable ethically. Thus, the degree to which this sample engaged in potentially risky behavior such as disclosing inaccurately and not always practicing safer sex might be less than among some other groups of gay men. Yet it is of note that this sample reported these behaviors as often as they did. The frequency of these behaviors in this sample might thus be considered to represent a floor or lower estimate of how often they occur within the gay community as a whole. Third, the data are qualitative, which can capture and reveal, in ways that quantitative data cannot, the meanings, conflicts, experiences, and categories involved in disclosure that are important to

understand in designing appropriate and effective interventions. In short, despite potential limitations, this research illuminates the types of problems faced in HIV disclosure and in devising appropriate public health campaigns and interventions aimed at HIV prevention.

This study also suggests areas in need of future research—for example, on how often HIV status is inaccurately or unclearly disclosed, and what other rationalizations for not disclosing arise and how these might be addressed most effectively through interventions aimed at prevention.

The findings suggest that sexually active gay men would benefit from help in learning to deal with issues of self-disclosure—particularly for infected men in disclosing serostatus, and for uninfected men in asking about HIV status. The study also has specific implications for helping HIV-positive men with the disclosure process. For example, it is important not only to tell, but to educate—to be ready to provide information about safer sex and prognoses. It is also useful to anticipate whom a person told may then tell—to think in advance that someone who is told may want to disclose the information to others—and to discuss this possibility when disclosing.

Appropriate public health and intervention messages also need to be developed. On one hand, safer sex should be encouraged, regardless of partners' claims of seronegativity. Yet this message raises a critical public health dilemma. To tell individuals that they should, in effect, be responsible for protecting themselves may lead some HIV-positive people to minimize their concern for protecting others. Such a message thus runs the risk of supporting infected individuals in not accurately disclosing, and of even discouraging self-disclosure. Hence, a more appropriate message is a dual one, encouraging both self-disclosure for HIV-positive men and self-protection regardless of HIV status—advocating accurate disclosure to decrease the possibility of unsafe sex and further viral transmission occurring, but admitting the possibility that such disclosure does not always occur, and thus informing sexual partners that they should not always believe what they are told. In short, public health campaigns and clinicians in discussions with HIV-negative patients need to disseminate prevention messages that individuals should not assume that they will either be disclosed to accurately, or protected against exposure to the virus by their sexual partners. Prevention efforts may be most effective by recognizing that HIV-positive and HIV-negative men face different, though overlapping sets of issues. These messages thus need to be tailored appropriately. Prevention messages might also be most effective by encouraging "staying uninfected" rather than "having safer sex."

On ethical grounds, Bayer, Signorile, and others (24–26) have also recently argued that self-disclosure of HIV serostatus should play an increased role in HIV-prevention efforts, in addition to focusing on self-protection. Such disclosure in certain relationships, particularly with main partners, can also potentially increase social support for the HIV-positive individual.

In sum, these findings suggest that issues concerning making and interpreting disclosures need to be raised and explored further by clinicians, public health campaigns, pre- and posttest counselors, and researchers in order to prevent as much as possible the further spread of HIV among gay men and others, both HIV-infected and not.

ACKNOWLEDGMENTS

I would like to thank Dr. Ronald Bayer, who helped conduct some of the interviews that are part of this study, and Dr. Mervyn Susser, Dr. Robert Kertzner, Shu-Hsing Lin, Dr. Renée Fox, Nancy Lange, Jesse Clark, and Sabia Ali.

This work was supported by grants from The Aaron Diamond Foundation, and the NIMH through Grant P50-MH 43520 to the HIV Center for Clinical and Behavioral Studies, and K08-MH01420-01.

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