Discrimination and Homophobia Fuel the HIV Epidemic in Gay and Bisexual Men

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Over the last 30 years, efforts to prevent new HIV infections among gay and bisexual men have been guided by paradigms that hold individuals responsible for their health behaviors. These approaches, rooted primarily in social-cognitive frameworks (Halkitis, 2010b), have resulted in maintaining new infections in the United States at a steady state for the last decade (Centers for Disease Control and Prevention [CDC], 2011b). In addition, the population of men who have sex with men (MSM) has continued to be the only risk category for which new infections are rising (Hall et al., 2008). In fact, gay, bisexual, and other MSM acquire HIV at rates 44 times greater than other men and 40 times greater than women (CDC, 2011a).

More recently, with the game-changing breakthroughs in the biomedical arena, attention has shifted to these biomedical prevention strategies, which include preexposure prophylaxis (PrEP) for gay, bisexual, and other MSM (Grant et al., 2010) and vaginal microbicides for women (Abdool et al., 2010). In this biomedical approach, the early detection and treatment of HIV have been recommended policy for the last several years (CDC, 2006; Workowski & Berman, 2006) as a way to decrease community viral load. Yet even these medical advances are fraught with their own complications, not least of which are matters of uptake and adherence.

In response to these alarming health disparities among gay and bisexual men, there has been a call to broaden the prevention lens to examine the influence of multiple social and contextual factors influencing health behaviors (Halkitis & Cahill, 2011). The CDC recently delineated the significance of social determinants of health, stating that “while effective interventions that address individual risk factors and behaviors exist, to ensure good health in all communities requires a broader portfolio that looks at social and environmental factors as well” (CDC, 2010, p. 11). Despite clear evidence for the social determinants of HIV transmission and the beneficial effects of structural interventions (Adimora & Auerbach, 2010), there have been limited efforts targeting these social inequalities, which place gay and bisexual men at greater risk for the acquisition of HIV disease.

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Throughout the last 30 years, the HIV epidemic in the United States has adversely affected the lives of gay men. Starting with the earliest cases in the 1980s, this population has borne the brunt of this disease. Close to 500,000 lives have been lost, and to this day, gay, bisexual, and other men having sex with men (MSM) account for 50% of all infections and 50% of recent infections in the United States. In recent years, rates of serconversion have been most pronounced in young African American and Latino men. In effect, since 1981, no less than three generations of gay men have been affected.

Much of the behavioral research conducted during the last 2 decades has focused on the role of individual- or person-level determinants of HIV risk behavior. The direct result has been the development of interventions and programs seeking to effect change on the person level. Yet what has become abundantly clear to those of us working in the field is that these programs fall short by failing to address the structural, systemic, and/or societal factors that place gay men at heightened risk. It is these broader factors that we address in this issue of Psychology & AIDS Exchange.

The overall focus of this issue is on the psychosocial stressors that gay men experience that heighten their vulnerability to HIV. Attention is paid to the role that homophobia plays in fueling the HIV epidemic in all gay men and how this form of discrimination, when compounded by racism and economic inequalities, exacerbates risk states. We examine the extant literature that supports these ideas and consider how a theory of multiple minority stress may guide our understanding going forward. In addition, this issue provides insights for clinicians on how to work with their clients, and we consider implications of research findings for public policy.

We hope that the ideas presented in this issue of Psychology & AIDS Exchange foster a dialogue that allows us to consider and develop programs that move beyond the focus on individual behaviors. We also hope future endeavors will embrace the understanding that structural and policy changes are critical for reducing the rates of HIV transmission among gay men. In this regard, we call for a more holistic approach to HIV prevention that treats gay men as more than sexual beings, as well as an approach to gay men’s health that embraces but is not defined solely by sexual health.

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Of particular relevance to HIV prevention among gay and bisexual men are the social conditions that place us at heightened risk for acquiring HIV as compared to our heterosexual counterparts. In this article, consideration is given to the manner through which discrimination and homophobia, which may have been heightened because of the AIDS epidemic (Halkitis, 1999), perpetuate HIV vulnerabilities for gay and bisexual men. Such health vulnerabilities driven by homophobia are often exacerbated for gay and bisexual men of color, who are often further burdened by the social circumstances of racism and poverty. Since discrimination based on sexual identity is critical to the ideas being put forth, and since the HIV prevention needs of gay and bisexual men differ widely from those of non-gay or bisexual MSM (Halkitis, 2010b), the focus of this issue of the newsletter is on gay and bisexual men, and not MSM in general. This topic will be considered from the theoretical perspective of minority stress theory, with attention to (a) how clinicians can effectively address these social burdens with their clients, (b) the work of AIDS service organizations, and (c) policy in light of the National HIV/AIDS Strategy for the United States (Office of National AIDS Policy, 2010).

**HIV IN THE GAY AND BISEXUAL POPULATION**

In the now historic document, which recently reached its 30th anniversary, the CDC (1981) reported five cases of Pneumocystis carinii pneumonia in young gay men who otherwise should have been healthy. I first became aware of this phenomenon as I sat on the beach reading The New York Times the summer before my freshman year at Columbia University. With bewilderment and fear, I read Robert Altman’s (1981) account of “doctors in New York and California [who] have diagnosed among homosexual men 41 cases of a rare and often rapidly fatal form of cancer.” In the following years, I witnessed the eruption of the disease, which in its early years was given the name GRID (gay-related immunodeficiency disease) because of its omnipresence in the gay population (Shilts, 2007; Weeks & Alcamo, 2010).

Two generations later, GRID has evolved into what we have come to know as HIV/AIDS. However, despite the fact that the disease no longer remains confined solely to gay and bisexual men, the reality is that this segment of the population is the one most affected by this epidemic. In the seminal 1998 American Psychologist article, Walter Batchelor warned that “AIDS still attacks homosexual and bisexual men in great numbers” (p. 854). It is truly alarming that 30 years later, HIV/AIDS continues to be predominantly a gay and bisexual disease in this country (Halkitis, 2010b). This burden becomes abundantly clear when we consider the epidemiological data. Despite the fact that gay and bisexual men constitute approximately 2–4% of the U.S. male population 18–44 years of age, MSM, primarily gay and bisexual men, account for more than 50% of all AIDS cases and all HIV infections and 57% all new HIV infections (CDC, 2011b).

**DISCRIMINATION AND HOMOPHOBIA AS CAUSES OF HIV**

Despite increased visibility, acceptance, and recent sociopolitical advances, gay and bisexual men continue to live in a society that privileges heterosexuality while denigrating non-heterosexual relationships, behaviors, and identities (Herek, Gillis, & Cogan, 2009). As a result, our population continues to face stigma rarely encountered by our heterosexual counterparts. Oppressive social structures and inequalities affecting gay and bisexual men have been implicated in perpetuating not only the HIV epidemic but also rates of anal cancer, Hepatitis B, human papillomavirus (HPV) and lymphogranuloma venereum (LGV) infections, syphilis, gonorrhea, and Hepatitis C (Wolitski & Fenton, 2011).

Despite the fact that gay and bisexual men constitute approximately 2–4% of the U.S. male population 18–44 years of age, MSM, primarily gay and bisexual men, account for more than 50% of all AIDS cases and all HIV infections and 57% all new HIV infections.
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Experiences with oppression and homophobia, which tend to pervade family, school, and community settings, are especially relevant for gay and bisexual young men, who are in the process of establishing their personal identities. Unlike other marginalized groups (e.g., immigrants) who grow up with people like themselves and who receive the support of their families, gay and bisexual youth frequently have more complicated and often abusive family dynamics (D’Augelli, Hershberger, & Pilkington, 1998; Pilkington & D’Augelli, 1995). In a seminal study, Ryan, Huebner, and Sanchez (2009) showed the powerful effects of homophobia perpetrated by family members. These researchers compared lesbian, gay, and bisexual (LGB) young adults who were rejected with those who were supported by their families. Rejected LGB youth were 8.4 times more likely to have tried to commit suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to have risky sex. For young gay and bisexual men, this form of nonacceptance starts in childhood and adolescence within the contexts of families.

The effects of discrimination are likely moderated by numerous factors, including the intensity of the discriminatory experience, the duration over which these experiences occur, as well as the relationship between the victim and the perpetrator(s) (Raymond Chen, Stall, & McFarland, 2011). For example, the lifelong health risks may be even greater if the family victimization takes the form of sexual abuse; Mimiaga et al. (2009) demonstrated that gay and bisexual men with histories of childhood sexual abuse were more likely to report both unprotected anal intercourse, to derive fewer benefits from participation in prevention programs, and to be at an overall greater risk for HIV infection.

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& Goldhammer, 2008; Wolitski, Stall, Valdiserri, 2008). Moreover, experiences with homophobia have been shown to interfere with the ability of gay and bisexual men to establish and maintain long-term same-sex relationships, which protect against HIV acquisition (Diaz, Ayala, Bein, Henne, & Marin, 2001). The experiences of homophobia may exert their effects on sexual risk taking indirectly by exacerbating mental health burden (Halkitis, 2010b; Johnson, Carrico, Chesney, & Morin, 2008).

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Project Desire is an NYU Center for Health, Identity, Behavior and Prevention study that documented the risks and resiliencies of young gay and bisexual men ages 15–29. These images appeared in New York City subway stations.

Graphics courtesy of NYU Center for Health, Identity, Behavior and Prevention Studies.
Recently our research team at the Center for Health Identity, Behavior and Prevention Studies (CHIBPS) at New York University documented the risks and resiliencies of young gay and bisexual men ages 13–29 in a study named Project Desire. Using Gilligan’s (1982) Listening Guide for Psychological Inquiry (see Camic, Rhodes, & Yardley, 2003), we recorded these young men’s fears, hopes, and dreams in relation to emerging adulthood, dating, sex, and HIV. Some spoke very clearly about experiences of homophobia in their lives (Halkitis, Moeller, & Siconolfi, 2010a, 2010b). An 18-year-old Latino who was HIV-negative expressed how he experienced homophobia from his own sister:

The way she talks about gay people it’s, it’s not right. Like she’ll be watching a movie and be like oh my god that . . . faggot.

Similarly, a 25-year-old Black, HIV-positive man described his family’s reaction to his coming out as follows:

I came here [NYC], I never had worked. I went to high school one year here just to get the high school diploma and went to Hofstra University. My scholarship was paid for by my family and I was given a car for my graduation and everything was good and as soon as I told them I was gay . . . all of that was . . . taken back because they think I brought disgrace to the family.

These realities extend to school environments, which, as a microcosm of society, are often filled with victimization and oppression of those who do not present with heterosexual identity (Espelage & Swearer, 2008; Kosciw, Greytak, Diaz, & Bartkiewicz, 2010). In their qualitative study of masculinity, Phoenix, Frosh, and Pattman (2003) found that boys as young as 11 years of age have found it critically important to present themselves as masculine in order to avoid being bullied and labeled as gay. In fact, when it comes to traditional gender expression, boys tend to be watched very closely because of the high value assigned to hegemonic masculinity, which is the most honored way of being a man in our culture (Connell & Messerschmidt, 2005; Pascoe, 2007).

Unfortunately, the cultural perception of gay and bisexual males as less masculine may lead to their assertions of masculinity through engagement in unprotected sexual behaviors (Halkitis, Green, & Wilton, 2004; Harper, 2007). Scientific evidence shows that gay men’s doubts about their masculinity as well as endorsement of masculine characteristics are associated with frequent risky sexual behaviors, which increase exposure to HIV (Connell, 1995; Diaz, 1998).

Life experiences with oppression and homophobia often become internalized and can have detrimental effects on the development of positive sexual identity (Rowen & Malcolm, 2002). Positive attitudes toward one’s sexual identity have been shown to be protective against risky sexual behaviors (Rosario, Hunter, Maguen, Gwadz, & Smith, 2001), while elevated rates of internalized homophobia have been linked to exacerbated sexual risk taking and other health risks.

This is how a 25-year-old HIV-negative White male participant of Project Desire described his struggles with internalized homophobia:

I grew up in such a heterosexual environment where that was just the norm. So maybe the fact that it [being gay] wasn’t normal. And I’m a very by-the-book person where I feel like, I’m always trying to do right. . . . I was always the child that was given . . . rules to follow, to abide by and . . . I felt like that’s what I would strive for. . . . [Being gay] wasn’t by the book. And it was outside the lines. . . . I’m not completely comfortable with being gay but I’m still so much more comfortable than I was so it’s just a process.

Others nested their experiences of homophobia in relation to organized religion, as demonstrated in the comments of one 28-year-old HIV-negative Black man:

On a Sunday we’d be going to church; my dad would go to church very frequently and I accepted God into my life—Jesus Christ into my life at an early age. But like with a lot of men who have sex with men, especially men who have sex with men of color, it’s like—like the internalized issue—the homophobia with our cultures—the whole issue with being an abomination to God. So that definitely was a brain bender.

Gay and bisexual men experience homophobia throughout the course of their lives. Thus, it is critical that we consider the well-being of gay and bisexual men by using a life course perspective (Institute of Medicine, 2011). Last year at CHIBPS, we enacted a program of study named Project GOLD, which examines the life experiences, risk, and resiliencies of HIV-positive men 50 years of age.
and older (Halkitis, 2010a). Many of the men with whom we have spoken are long-term survivors of the disease, having lived with AIDS for over 20 years. Yet even those older men vividly describe how the experience of homophobia shaped their lives in the past and how it continues to affect their lives. Johnson et al. (2008) demonstrated that among 465 HIV-positive men, internalized homophobia was associated with unprotected receptive anal intercourse with partners who were HIV-negative or of unknown HIV status and was also associated with poorer adherence to antiretroviral therapy. A 51-year-old Latino man, who has been living with HIV for 24 years, described it as follows:

I think that being a gay person, even today we are being kicked around. And it’s hard to accept yourself very well when society seems to be, you know, kicking your ass a lot.

Another, a 53-year-old Black man living with HIV for 21 years, described his experiences in this manner:

Because society will keep telling you that something is wrong with you. And then you would hear very negative things, including even within my family; they’re very homophobic.

THE CONFLUENCE OF HOMOPHOBIA, RACISM, AND ECONOMIC INEQUALITIES

For gay and bisexual men of color, the effects of sexual orientation discrimination on HIV risk may be confounded and exacerbated by other powerful structural factors, including racism, lack of access to economic means, and poverty (Williams, Wyatt, Resell, Peterson, & Asuan-O’Brien, 2004). HIV in the United States has disproportionately affected racial/ethnic minorities and the poor for decades (Brooks, Rotheram-Borus, Bing, Ayala, & Henry, 2003; Karon, Fleming, Steketee, & De Cock, 2001). Thus, the synergistic social conditions of homophobia, racism, and poverty likely explain the even higher incidence of new HIV infections among racial ethnic minorities, particularly Black and Latino gay and bisexual men (CDC, 2011b). In a study of Latino men, Diaz et al. (2001) identified positive relations between risky sexual behaviors and the participants’ experiences of homophobia, racism, and financial instability. Mays, Cochran, and Zamudio (2004) revealed similar findings in a study of gay, bisexual, and other MSM.

Poverty has been identified by the United Nations Population Fund (2003) as a critical factor in the spread and treatment of HIV. For many gay and bisexual men of color, economic inequalities add to the pernicious effects of oppression and homophobia. For example, in a seven-city study of HIV prevalence among young gay and bisexual men, Harawa et al. (2004) found prevalence rates of 16% for Black men, 6.9% for Latinos, and 3.3% for Whites, despite the fact that the White men reported potentially risky sex and drug-using behaviors with greater frequency. In this sample, however, such indicators of socioeconomic status as unemployment and lack of formal education were highly associated with HIV infection, suggesting socioeconomic inequalities suffered by the racial and ethnic minority men.

Perhaps the effects of economic standing on HIV prevalence among gay and bisexual men...
can also be understood in relation to contextual factors, particularly the roles played by residential neighborhoods (e.g., Frye et al., 2006). Certainly person-level variables interact with sociopolitical variables to shape HIV risk-taking behavior among gay men. Yet it is a likely hypothesis that those who have access to and navigate environments where there are high levels of gay presence are also likely to be exposed to HIV prevention messaging through publications and advertisements, as well as through interactions with other gay men in social venues. In addition, living in impoverished neighborhoods may bestow additional burdens on gay and bisexual men. According to Ellen, Mijanovich, and Dillman (2001), the impact of neighborhoods may be manifested through (a) short-term influences on behavior, attitudes, and access to health care, which affect immediate well-being; and (b) long-term effects associated with poor environmental quality and limited resources experienced over numerous years and known as “weathering.”

For those young gay men of color who are socioeconomically disadvantaged, access to gay-related health resources may be more limited because their neighborhoods of residence tend to be outside the exclusive city center, where many gay cultural, health, and social establishments tend to be located (Halkitis, Moeller, & Siconolfi, 2009a, 2009b). In effect, risk may be exacerbated by the fact that these men must negotiate the reality of their sexual identities within residential neighborhoods that reject and stigmatize people with non-heterosexual identities (Mays, Chatters, Cochran, & Mackness, 1998; Mays, Cochran, & Zamudio, 2004). This situation is compounded by the lack of access to other services in poor communities where some African American men reside, increasing their likelihood of HIV seroconversion (Crosby & Grofe, 2001).

The confluence of neighborhood factors, socioeconomic factors, and access to services not only exacerbates HIV risk but also the comorbid conditions of substance use, including injection drug use (Crosby & Grofe, 2001; Shafer et al., 2002), and mental health burden (e.g., Truong & Ma, 2006), which in turn elevate vulnerabilities. Frye et al. (2010) examined the relation between gay neighborhood presence and sexual risk taking of young gay men and found that gay neighborhood presence was positively associated with consistent condom use during anal intercourse. These matters are of particular concern in relation to homeless and unstably housed youth (Marshall et al., 2009), who may reside in a variety of different neighborhood environments including parks and public spaces, vehicles, shelters, and hostels (Daly, 1996).

CONCLUSIONS
Taken together, the extant literature suggests that the perpetuation of the HIV epidemic in gay and bisexual men is not directed solely by person-level behaviors but is influenced by a range of contextual factors, rooted in cultural, historical, and political structures in this country. These findings suggest that HIV prevention efforts must be embedded within a larger framework of gay men’s lives, identities, and health. A holistic approach to the well-being of gay men (Halkitis, 2010b; Safren, Resiner, Herick, Mimiaga, & Stall, 2010) should collectively consider the biomedical, psychological, and social factors that create these health disparities in this segment of the population.

As noted by the Institute of Medicine (2011) and as supported by the ideas presented in this article, an approach to the totality of gay men’s health must consider the role that social structures play in compromising gay men’s health. Specifically, we must combat the homophobia and discrimination that gay and bisexual men face from families, communities, and society at large. We must understand that such oppression not only perpetuates the HIV epidemic but also compromises the overall wellness of gay and bisexual men. In the end, our best hope for eradicating the HIV epidemic in gay and bisexual men will arise from the combined strength of biomedical, social, behavioral, and legislative interventions. Finally, for preventive efforts to be meaningful and effective, such approaches must understand the lives of gay and bisexual men, support us in development of strong and healthy identities, and help us in the creation of strong communities in which we will not only be cared for but also able to take care of ourselves and support each other.

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He is lead editor of two volumes: HIV + Sex: The Psychological and Interpersonal Dynamics of HIV-Seropositive Gay and Bisexual Men’s Relationships (2005) and Barebacking: Psychosocial and Public Health Perspectives (2006). His book Methamphetamine Addiction: Biological Foundations, Psychological Factors, and Social Consequences was published in 2009, and he is currently working on a new manuscript examining the life experiences of gay men who are long-term survivors of HIV/AIDS. Author of over 120 peer-reviewed academic manuscripts, Dr. Halkitis’s research examines how sexual and drug-related risk taking, as well as mental health, are influenced by interpersonal, contextual, developmental, and cultural factors.

Dr. Halkitis’s research has been funded by the National Institutes of Health (NIH), the CDC, the New York City Department of Health and Mental Hygiene, the New York State AIDS Institute, the United Way, the New York Community Trust, and the American Psychological Foundation. He serves on the APA’s Committee on Psychology and AIDS, is a member of the advisory committee on HIV and STD prevention and treatment of the CDC and the Health Services Research Administration, and is a member of the College of Reviewers of the NIH Center for Scientific Review. He is the recipient of numerous awards from both professional and community-based organizations and is an elected fellow of the New York Academy of Medicine, the Society of Behavioral Medicine, and APA. Dr. Halkitis received his PhD in 1995 from the Graduate Center of the City University of New York and is currently completing his MPH degree.

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2012 INSTITUTE OF MEDICINE (IOM) REPORT

**Monitoring HIV Care in the United States: Indicators and Data Systems**


Released: March 15, 2012

Morgan A. Ford and Carol Mason Spicer, Editors; Committee on Review Data Systems for Monitoring HIV Care; Institute of Medicine

In July 2010, the White House Office of National AIDS Policy (ONAP) released its National HIV/AIDS Strategy (NHAS), which includes goals to increase access to care, optimize health outcomes for people with HIV, and reduce HIV-related health disparities. At the same time, the Patient Protection and Affordable Care Act (ACA) is poised to bring millions of uninsured people—including many with HIV—into the health care system when it is implemented in 2014.

**Monitoring HIV Care in the United States** addresses existing gaps in the collection, analysis, and integration of data on the care and treatment experiences of people living with HIV/AIDS (PLWHA). This report identifies critical data and indicators related to continuous HIV care and access to supportive services, assesses the impact of the NHAS and the ACA on improvements in HIV care, and identifies public and private data systems that capture the data needed to estimate these indicators. This report also addresses a series of specific questions related to the collection, analysis, and dissemination of such data.

This is the first of two reports to be prepared by this study. In a forthcoming report, also requested by ONAP, the committee will address the broad question of how to obtain national estimates that characterize the health care of people living with HIV in the United States. The second report will include discussion of challenges and best practices from previous large-scale and nationally representative studies of PLWHA as well as other populations.
The minority stress perspective adds significant insight into the critical application and evaluation of theory regarding the impact of homophobia and correlates of HIV risk among gay and bisexual men and other sexual minorities. Continued understanding of the role that stigma, prejudice, heteronormativity, rejection, and internalized homophobia play in fueling HIV and substance use among gay and bisexual men is also necessary.

Researchers continue to find interest in the uniqueness of stressors related to health outcomes among minority groups (Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008) and whether stressors such as homophobia are associated with greater physical and mental health problems (Williams, Neighbors, & Jackson, 2003). Typically, gay and bisexual men have greater likelihood than the general population (Cochran, Mays, & Sullivan, 2003) for risk-taking behaviors that include polysubstance use (Kalichman & Cain, 2004; Kashubeck-West & Szymanski, 2008) and anonymous sex with multiple partners (Bimbi et al., 2006), and they are at greater risk for sexually transmitted infections (Halkitis, Zade, Shrem, & Marmor, 2004) such as HIV/AIDS (Halkitis, Green, & Carragher, 2006; Halkitis, Green, & Mourguès, 2005). Such risk behaviors may result from a multitude of issues associated with minority stress (Hamilton & Mahalik, 2009; Meyer, Schwartz, & Frost, 2008); individual-level determinants (Crocker, Major, & Steele, 1998; Jerome, Halkitis, & Siconolfi, 2009) of behavior; and social causation associated with homophobia, stigma, and other factors (Link & Phelan, 2006).

One of the most prominent theoretical and explanatory frameworks of sexual minority health risk is the minority stress model. The concept of minority stress stems from several social and psychological theoretical orientations and can be described as a relationship between minority and dominant values and resultant conflict with the social environment experienced by minority group members (Meyer, 1995; Mirowsky & Ross, 1989; Pearl, 1999). Minority stress theory proposes that sexual minority health disparities can be explained in large part by stressors induced by a hostile, homophobic culture, which often results in a lifetime of harassment, maltreatment, discrimination, and victimization (Marshal et al., 2008; Meyer, 2003) and may ultimately impact access to care.

The Meyer (2003) minority stress model—minority stress processes in lesbian, gay, and bisexual populations—is based on factors associated with various stressors and coping mechanisms and their positive or negative impact on mental health outcomes. Significantly, many of the concepts in the model overlap, representing their interdependency (Meyer, 2003; Pearl, 1999). The model describes stress processes, including experiences of prejudice, expectations of rejection, hiding, concealing, internalized homophobia, and ameliorative coping processes (Meyer, 2003). Stressors such as homophobia or sexual stigma that may arise from the environment require an individual to adapt but also cause significant stress, which ultimately affects physical and mental health outcomes (Dohrenwend et al., 1992).

Underlying the concept of minority stress are assumptions that stressors are unique (not experienced by nonstigmatized populations), chronic (related to social and cultural structures), and socially based (social processes, institutions, and structures) (Meyer, 2003). While this theory has been applied to other populations, including women, immigrants, the impoverished, and racial/
those who are HIV-negative live with the possibility of seroconversion, with potential for varied levels of psychological distress that may result in mental health challenges, unprotected anal intercourse, substance use, or sex with multiple partners. Such attitudes and risk behaviors increase exponentially when a member of the gay or bisexual community is also a member of a minority racial/ethnic group. Having multiple minority statuses increases the likelihood of experiencing homophobia, stigma, isolation, and rejection (Diaz, Bein, & Ayala, 2006), along with heightened risk for sexual risk behavior or substance use.

Some studies, however, underscore the fact that individuals with multiple minority identities may actually be better equipped to cope with minority stress factors (Consolacion, Russell, & Sue, 2004) because of a more complex self-concept and varied experiences that have involved adaptation and resilience, among other factors. Other research on ethnic minority gay and bisexual men has shown that they must confront homophobia within their own racial/ethnic community, experience alienation from the larger gay and bisexual community, and simultaneously manage their own internalized homophobia (Diaz, Ayala, Bein, Jenne, & Marin, 2001). Such multileveled stressors can have deleterious repercussions related to sexual risk behavior and increased risk for HIV/AIDS among racial/ethnic gay and bisexual male populations.

Continued research and examination of the effect of homophobia and minority stress factors on the sexual risk behaviors of gay and bisexual men can often be complicated, as the recruitment of subjects for research studies and subsequent behavioral interventions remains limited and challenging because of difficulty accessing the community (Kanouse et al., 2005). Additionally, most research related to gay and bisexual men and their risk behavior patterns typically relies on convenience-based samples, often without heterosexual control groups. This ultimately results in ambiguity about whether gay and bisexual men experience stressors such as prejudice, rejection, and discrimination more frequently than heterosexual men and women (Mays & Cochran, 2001).

Challenges involved in working among this vulnerable population include appropriate and effective interventions (Natale & Moxley, 2009) and theoretical approaches for understanding risk behavior (Halkitis, Palamar, & Mukherjee, 2007). In that regard, gay and bisexual men, along with other sexual minorities, often draw upon personal and community-level coping mechanisms and resources to develop resilience, coping, and hardiness (Meyer, 2003; Ouellette & DiPlacido, 2001). Similarly, individuals who adopt a strong sexual minority identity may be better equipped to manage minority stressors, invalidate stereotypes, and dismiss or address perceived or actual homophobia while affirming a positive self-evaluation (Herek & Garnets, 2007).

Clinical applications such as affirmative-based practice are effective when working with gay and bisexual men and other sexual minorities. Affirmative-based practice focuses on defining coping strategies, affirming a positive self-identity, and increasing the ability to assess the effect of homophobia and stigma on psychological functioning and health risk behavior (Browning, Reynolds, & Dworkin, 1991). In addition, behavioral interventions administered at three levels—individual, group, and community—

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appear to effectively reduce risky sexual behaviors associated with HIV and other sexually transmitted infections (Mustanski, Newcomb, Du Bois, Garcia, & Grov, 2011).

Other promising future directions for practice and interventions with the gay and bisexual community include Internet-based delivery and those approaches that go beyond the individual level to address a more combined approach, including structural, community, and social network factors (Mustanski et al., 2011) as well as those suggested in the recent National HIV/AIDS Strategy for the United States (Office of National AIDS Policy, 2010). The continued assessment of the efficacy of other therapeutic interventions with this population is also necessary, along with the vital role of ongoing training and clinical supervision to increase practitioner sensitivity, knowledge, and competency. Continued study of the implications of minority stress factors for gay and bisexual men may lead researchers, clinicians, and policymakers to better understand cofactors, such as homophobia, and the relationship with sexual risk behavior and increased risk for HIV/AIDS among other resultant factors.

ABOUT THE AUTHOR

Michael P. Dentato, PhD, is a clinical assistant professor at Loyola University Chicago in the School of Social Work. He received his BA and MSW from Fordham University in New York and his PhD in social work from Loyola University Chicago. Research interests include the examination of minority stress factors associated with substance use and sexual risk behavior among gay and bisexual men. In addition to teaching and research, Dr. Dentato is a member of the Council on Sexual Orientation & Gender Expression for the Council on Social Work Education; a faculty research affiliate at the Center for Health, Identity, Behavior and Prevention Studies at New York University’s Steinhardt School of Culture, Education, and Human Development; and program consultant for the Center on Halsted in Chicago. Experience in the arena of HIV/AIDS and LGBT issues include his former role as executive director of Body Positive, New York, and the development of the Alliance for GLBTQ Youth in Miami, an organization providing a continuum of care for sexual minority youth and their families. His latest article, “The Vital Role of Social Workers in Community Partnerships for GLBTQ Youth,” was published in 2010 by the Journal of Social Work With Adolescents.

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Despite 3 decades of advances in HIV testing technologies and medications, HIV continues to burden gay and bisexual men disproportionately, especially within communities of color in the United States. One key structural driver of vulnerability to HIV infection is anti-gay stigma. To counter the detrimental effects of pervasive anti-gay stigma, widespread implementation of innovative and replicable HIV prevention interventions that affirm and cultivate the healthy formation of gay identities is strongly needed. This article outlines current community-based HIV prevention approaches addressing anti-gay stigma being used in the field, often with little or no funding.

**LGBT-AFFIRMING SCHOOL-BASED INTERVENTIONS**

Anti-gay bias is rampant in schools and in urgent need of redress. Several studies show that lesbian, gay, bisexual, and transgender (LGBT) youth experience higher rates of harassment and violence from their peers because of their actual or assumed sexual orientation (Bontempo & D’Augelli, 2002; Espelage, Aragon, Birkett, & Koenig, 2008; Swearer, Turner, Givens, & Pollack, 2008; Rivers, 2004). Many LGBT students feel unsafe at school and report higher rates of social isolation, depression, suicidal ideation, and unprotected sex (Russell, Ryan, Toomey, Diaz, & Sanchez, 2011).

A number of school-based, LGBT-affirming and anti-bullying interventions are emerging across the country. One such program is the Gay Straight Alliance (GSA). GSAs are support groups where LGBT students, those questioning their sexual orientation or gender identity, and their straight friends can gather to discuss issues associated with their sexual orientation or gender identity and foster communication with others (Ginsberg, 1999). Currently, 4,000 GSAs are registered throughout the United States. The spate of suicides that occurred in late 2010 among gay men who were victims of anti-gay harassment and bullying underscores the importance of GSAs. Research shows that these interventions are a key resiliency factor for gay youth; young gay and bisexual men in schools with pro-gay interventions report fewer risky behaviors associated with HIV transmission, including unprotected sex (Goodenow, 2007).

One study in Salt Lake City found that students’ academic performance improved, their sense of belonging to the school community was enhanced, and their school attendance increased if they were involved with the GSA (Lee, 2002). Replicating programs such as these is critical to preventing the development of risk behaviors that increase vulnerability to HIV among young gay and bisexual men and transgender women.

**SOCIAL MARKETING CAMPAIGNS PROMOTING FAMILY ACCEPTANCE OF GAY SONS AND CHALLENGING ANTI-GAY STIGMA**

Family acceptance of LGBT persons is also central to addressing HIV. Research shows that the greater the extent to which one experiences family rejection because of one’s sexuality during adolescence, the poorer the health outcomes for LGBT young adults (Ryan, Huebner, & Sanchez, 2009). In addition to exhibiting higher rates of substance use, depression, and attempted suicide, participants in the study who were rejected by their families were 3.4 times more likely to report having engaged in unprotected sexual intercourse,
compared with peers who reported little to no experiences of family rejection (Ryan et al., 2009).

Gay Men’s Health Crisis (GMHC) has implemented a series of social marketing campaigns that draw on a strength-based intervention model. Strength-based campaigns are effective in changing an individual’s behavior (Detweiler, Bedell, Salovey, Pronin, & Rothman, 1999; Devos-Comby & Salovey, 2002; Rothman, Salovey, Antone, Keough, & Martin, 1993). One 2008 campaign, titled “My Son Is My Life,” models behavior in which a Black father supports his gay son. Informational palm cards and ads in print media and in bus shelters highlight reactions parents can have when they learn their son is gay and illustrate steps they can take to provide support and love. “I know he is gay, and I don’t always understand, but that doesn’t change my love for him,” the image reads.

Another campaign, titled “I Love My Boo,” depicts young Black and Latino men in loving, affectionate embraces in public settings—a portrayal of gay men of color rarely seen in mainstream media. “We’re about trust, respect and commitment,” the image reads. “We’re PROUD of who we are and how we LOVE.” The campaign ran in 1,000 subway trains and 150 subway stations in New York City in 2010 to promote positive, strength-based images of Black and Latino gay men, encourage gay men to aspire to committed, long-term relationships, and counter anti-gay stigma.

A 2008 campaign titled “I know my rights . . . Do you?” focuses on combatting the stigma transgender women experience in public accommodations by explaining a New York City nondiscrimination ordinance passed in 2002 covering gender identity. Palm cards addressed access to health care, homeless shelters, and employment. Research to date on public health issues affecting men who have sex with men (MSM) has largely neglected transgender persons. There are no national data on transgender women and HIV. However, independent studies report that transgender women are among the most vulnerable to HIV infection (Clements-Nolle, Marx, Guzman, & Katz, 2001). Addressing HIV among transgender women requires better surveillance and culturally competent and effective HIV prevention campaigns.

Community Connectedness

Community connectedness has also been proven to protect against HIV infection. Greater community involvement counters the negative effects of anti-gay bias on safer sex practices among gay men by providing social support, enhancing feelings of self-efficacy and positive self-identity, and reinforcing peer norms supporting safer sex practices (Ramirez-Valles, 2002). Greater emphasis on prevention among older adults is also necessary. The Centers for Disease Control and Prevention (CDC) reports that most new infections among White gay and bisexual men occur among those who are 30-49 years of age (CDC, 2008). In 2007, 16% of new HIV infections were among people 50 and older (CDC, 2007).

Evidence suggests that in addition to experiencing anti-gay bias, older gay men also experience issues related to aging and self-esteem. Some older gay men experience aging differently than their heterosexual counterparts, a concept referred to as “accelerated aging” (Rosario, Schrimshaw, Hunter, & Braun, 2006). This experience of feeling older at an earlier age than one’s chronological age presents issues of social isolation for gay men over 40 who are single and equate physical attractiveness with youth. These men may put themselves at risk for HIV by meeting
anonymous partners on the Internet and coupling these experiences with substance use.

Identifying the need for HIV prevention among older gay men in 2008, the Fenway Institute in Boston piloted a group intervention to reduce HIV sexual risk, depression-related withdrawal, and anxiety-related social avoidance in gay and bisexual men 40 and older. The intervention, titled “40 and Forward,” was a series of 2-hour weekly sessions that brought together groups of gay men, ranging from 49 to 71 years of age and of multiple races, to socialize and discuss topics like safer sex. Men who participated in the intervention reported a significant decrease in depressive symptoms, as well as a significant increase in condom use self-efficacy (Reisner et al., 2010). It is notable that the intervention also helped socially isolated older gay men develop social support networks, a critical resiliency factor against HIV.

INTERNATIONAL EFFORTS

Globally, public health specialists are also recognizing the importance of combatting anti-gay bias to stem the spread of HIV, especially among MSM. The full scope of the global HIV pandemic among MSM is unclear, as most countries fail to gather surveillance data for MSM. However, evidence suggests that the 86 countries which criminalize homosexuality render MSM highly vulnerable to HIV infection because they are forced underground and face multiple barriers to HIV prevention and treatment.

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In 2008, the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) was reauthorized and included language calling for prevention with MSM and research to understand the impact of HIV on MSM. Also in 2008, the former presidents of Zambia and Mozambique, chairing the United Nations’ Economic Commission for Africa, issued a report calling for HIV prevention with MSM and opposing legal discrimination against them. The Global Fund for HIV, Tuberculosis and Malaria is also promoting MSM concerns. In May 2011, the U.S. Office of the Global AIDS Coordinator issued field guidance on MSM (see U.S. President’s Emergency Plan for AIDS Relief, 2011). The guidance gives suggestions for providing HIV prevention to MSM in Africa, the Caribbean, and elsewhere.

CONCLUSION

The alarming number of HIV infections among gay and bisexual men makes it imperative that U.S. and global agencies as well as state and local health departments combat anti-gay bias as a public health threat. School-based initiatives that affirm LGBT youth, social marketing campaigns that challenge family rejection and social isolation, and other gay-affirming interventions should be implemented on a broader scale to challenge anti-gay stigma and promote the health and well-being of gay and bisexual men and transgender women.

ABOUT THE AUTHORS

Sean Cahill, PhD, is the director of health policy research at the Fenway Institute in Boston, MA, where he oversees efforts to adapt Fenway’s LGBT health and HIV/AIDS research data and findings to better advocate for a progressive public health policy. He was the former managing director of public policy, research, and community health at the Gay Men’s Health Crisis in New York City and an adjunct assistant professor of public administration at New York University’s Robert Wagner School of Public Service. His policy priorities have included promoting a national HIV/AIDS strategy, advocating for LGBT elders and HIV-positive elders through the Older Americans Act reauthorization, repealing the HIV entry ban, and preventing HIV among gay and bisexual men in Africa and the Caribbean through the President’s Emergency Plan for AIDS Relief. He serves on the New York City Ryan White Planning Council.

Dr. Cahill directed the National Gay and Lesbian Task Force Policy Institute from 2001 to 2007, where he led research and policy analysis on demographics, poverty/homelessness, family recognition, aging, voting, the anti-gay movement, and other topics. He is the author of two books on LGBT family policy and the forthcoming Lesbian,排版。

Robert Valadéz, MSW, is a policy analyst at the Gay Men’s Health Crisis, the world’s oldest HIV/AIDS service organization. He was a 2009 recipient of the Urvashi Vaid Fellowship of the Policy Institute of the National Gay and Lesbian Task Force. He previously held tenures at the Sexual Health and Rights Project of the Open Society Institute and the Family Services Program of the L.A. Gay & Lesbian Center. He received his master’s degree in social welfare policy from the Columbia University School of Social Work.

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PSYCHOLOGY & AIDS EXCHANGE

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Previous studies have reported that stigma has been a key obstacle for individuals living with HIV/AIDS (Swendeman, Rotheram-Borus, Comulada, Weiss, & Ramos, 2006) and that stigma is a major barrier for HIV prevention (Chesney & Smith, 1999; Wolitski, Pals, Kidder, Courtenay-Quirk, & Holtgrave, 2009). Research has also demonstrated that gay and bisexual men living with HIV/AIDS (GBMLHA) are likely to experience both HIV stigma and gay-related stigma, which may cause significant psychological stress (Chenard, 2007). This “double stigma” may be traced back to the initial label of HIV/AIDS as the “gay cancer” or the “gay-related immune deficiency.” However, such stigma may also be influenced by individuals’ perceptions that gay and bisexual men who contract the disease are to “blame” for their own actions.

For example, a report of the Centers for Disease Control and Prevention (CDC, 2000) found that people who were most knowledgeable and educated about HIV infection were least likely to believe that people with HIV/AIDS “got what they deserved” (p. 1). Some studies have also shown that individuals are more likely to place blame and anger on GBMLHA than they are with other populations with HIV (Herek & Capitano, 1993; Schellenberg & Ben, 1998).

Given the findings that gay, lesbian, and bisexual people with HIV/AIDS are more likely to possess symptoms of depression and engage in risky health behaviors (Lam, Naar-King, & Wright, 2007), it is important for counselors and clinicians to demonstrate cultural competence in working with this population. Furthermore, because there is a dearth of clinical and counseling services for people living with HIV/AIDS (Lam et al., 2007), it is necessary for practitioners to develop strong therapeutic relationships with their clients in order to prevent treatment dropout (Leeman et al., 2010). Finally, because gay-related stigma consciousness, or one’s ability to perceive heterosexist stigma, has been found to be a predictor of depressive symptoms (Lewis, Derlega, Griffin, & Krowinski, 2003), it is imperative that clinicians manage or eliminate such stigma in their counseling relationships in order to provide the most effective and optimal treatment for their clients.

The purpose of this article is to provide clinical and counseling recommendations regarding working most effectively with GBMLHA. Using the multicultural competence tripartite model developed by Sue, Arrendondo, and McDavis (1992), which was later adapted for the APA’s (2003) Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists, we discuss how it is an ethical responsibility of psychologists to attain appropriate knowledge, awareness, and skills in working with all cultural minority groups, including GBMLHA.

It is paramount that when considering the tripartite model for developing cultural competence with this population, clinicians reflect on how their own attitudes and beliefs about gay and bisexual men developed, as well as their own biases or stereotypes about people living with HIV/AIDS. This introspective process begins by thoroughly examining one’s own cultural heritage, including how various aspects of identity (e.g., race, ethnicity, gender, sexual orientation, religion and spirituality, etc.) influence the development of one’s worldview. For example, a clinician with a strong Christian
identity may not recognize her biases about same-sex relationships and may inadvertently display judgmental facial expressions, thus damaging her rapport with a GBMLHA client.

Traditionally, the model posited that people harbor biases toward those who are culturally different than themselves. While this is likely true, especially when considering the biases against gay and bisexual men harbored by heterosexuals, it is also important to emphasize that gay and bisexual individuals living without HIV/AIDS may also have biases against GBMLHA as a byproduct of learned HIV stigma (Courtenay-Quirk, Wolitski, Parsons, & Gómez, 2006) or their own internalized heterosexism (Szymanski, Kashubeck-West, & Meyer, 2008). For instance, a gay male therapist who is HIV-negative may have a bias that his GBMLHA client is sexually promiscuous or a drug abuser, thus placing blame on his client and failing to provide a safe, empowering environment for him. It is expected that culturally aware clinicians should recognize their limitations, which in turn will encourage clinicians to seek out educational experiences to address their shortcomings.

Gaining knowledge is the next component of the tripartite model for developing clinical cultural competence. This knowledge pertains to learning about gay and bisexual men as a unique social group, as well as their risk and protective factors with HIV/AIDS. The clinician must gain knowledge about the unique experiences of gay and bisexual men in general, which may include their developmental process (e.g., sexual orientation identity development and internalized heterosexism) and the social and political issues they face in everyday life (e.g., institutional and interpersonal discrimination).

For example, gay and bisexual men are not a monolithic group but are quite diverse in terms of life experience. A potential microaggression, or subtle form of discrimination, that may occur for an unaware clinician is to provide services based on the assumption that all gay and bisexual men have a common experience or that there is only one way for one to “come out of the closet” (Nadal, Rivera, & Corpus, 2010). Thus, the culturally competent clinician will recognize, through his or her acquisition of knowledge, that gay and bisexual men are diverse among themselves.

Furthermore, culturally competent clinicians will be well-informed about issues involving HIV/AIDS, so that time in the counseling session will be well spent on their clients’ emotional exploration. For example, a GBMLHA client may drop out of therapy because he feels that the majority of the time is spent on educating his counselor about HIV/AIDS instead of talking about his depression, which is what brought him to therapy.

Through developing multicultural skills—the final component of the tripartite model of cultural competence—clinicians may learn that the most effective approaches or techniques in working with GBMLHA parallel the most effective skills in working with any client. Using humanistic techniques like empathy or unconditional positive regard is essential, particularly for clients who have internalized oppression, blame, or guilt as a result of their sexual orientation or HIV status. Existential approaches may be effective in exploring how clients understand their life span and mortality, while cognitive–behavioral techniques may be useful in examining faulty cognitions and unhealthy behaviors. Psychodynamic approaches may be used to reveal unconscious feelings about the client’s sexual orientation or to identify defense mechanisms related to the client’s coping with his HIV status.

Finally, counselors and clinicians must recognize that GBMLHA have other identities that must be accounted for that may influence their everyday lives in numerous ways. People of color, transgender people, persons with disabilities, and individuals of diverse ethnicities, religions, ages, and social classes may uphold an array of social identities that may need to be integrated into the treatment. For instance, an African American GBMLHA client may report experiencing discrimination and how it affects his mental health. In this case, a culturally competent counselor would be cognizant not just of exploring the client’s HIV status or sexual orientation but also of examining the client’s racial identity in order to provide a safe, nonjudgmental space for him. Using techniques that address a client’s intersectional identities may

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He will be completing his predoctoral internship at the University of Pennsylvania. He cohosts a blog—“Microaggressions in Everyday Life”—on Psychology Today’s website. Mr. Rivera has received multiple recognitions for his work, including national honors from the APA and the American College Counseling Association.

ABOUT THE AUTHORS

Kevin L. Nadal, PhD, is an assistant professor of psychology at the John Jay College of Criminal Justice—City University of New York, where he also serves as the deputy director of the forensic mental health counseling program. His research interests focus primarily on multicultural issues in psychology, particularly regarding issues related to race, sexual orientation, and gender. He has published several works specifically on microaggressions toward LGBT people and Filipino American issues in psychology. Dr. Nadal is an executive board member of the Asian American Psychological Association, a national trustee of the Filipino American National Historical Society, a member of the APA Committee of LGBT Concerns, a psychologist-trainer for the New York Police Department, and a fellow of the Robert Wood Johnson Foundation.

David P. Rivera, MS, is a doctoral candidate in counseling psychology at Teachers College, Columbia University. He holds degrees in psychology and counseling from Johns Hopkins University and the University of Wyoming. His research focuses on issues impacting the marginalization and health of people of color and sexual minorities. His research has been published in the Counseling Psychologist, Cultural Diversity and Ethnic Minority Psychology, and the Journal of Counseling & Development. His therapeutic interests include working with college students and people with substance abuse issues. He will be completing his predoctoral internship at the University of Pennsylvania. He cohosts a blog—“Microaggressions in Everyday Life”—on Psychology Today’s website. Mr. Rivera has received multiple recognitions for his work, including national honors from the APA and the American College Counseling Association.

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WHAT IS COPA?

In August 1990, the Ad Hoc Committee on Psychology and AIDS (COPA) was authorized by the Board of Directors and the Council of Representatives for a 3-year period. Initially, COPA reported to the Board of Directors and was charged with the following responsibilities:

- Provide policy direction and oversight for current APA activities related to AIDS.
- Advise APA staff and establish liaisons with governance groups regarding AIDS issues.
- Formulate new APA initiatives to meet the continually changing challenges posed by the epidemic.

The Council of Representatives reauthorized COPA for an additional 5 years in 1993, 1998, 2004, and 2009. In executive session at its June 2001 meeting, the Board of Directors changed the governance reporting line of COPA from the Board of Directors to the Board for the Advancement of Psychology in the Public Interest (BAPPI).

COPA members serve for 3 years. They are required to attend two face-to-face meetings per year in Washington, DC, and to participate in monthly conference calls. Between meetings, members devote a substantial portion of time to COPA projects, provide consultation to APA Office on AIDS staff, and participate in advocacy activities.

WHAT HAS COPA BEEN DOING?

In the last year, COPA has been active in a variety of initiatives. Some of these activities are summarized here:

- Members of COPA developed a resolution, “Combining Biomedical and Behavioral Approaches to HIV Prevention,” which was placed on the cross-cutting agenda for the Fall 2011 APA consolidated committee meetings. Committees reviewed the draft resolution and provided both written and oral suggestions for modification. Those suggestions were incorporated into a revised draft that was approved by BAPPI, and the Board of Directors recommended that the Council of Representatives adopt it. The resolution was adopted by Council on February 25, 2012 (see pp. 26–29 for more details).
- Perry Halkitis, PhD, the current COPA chair, collaborated with members of the Committee on Lesbian, Gay and Bisexual Concerns to jointly develop this special issue of the Psychology & AIDS Exchange newsletter examining psychosocial and structural factors that predispose gay, bisexual, and other MSM to HIV health disparities. The next issue of the newsletter, organized by Mariana Cherner, PhD, will focus on neuropsychological aspects of HIV/AIDS.
- Members of COPA provided consultation and oversight for three federally funded programs administered through the Office on AIDS: (1) the Cyber Mentor Program, funded by the National Institute of Mental Health (NIMH); (2) the Behavioral and Social Science Volunteer (BSSV) Program, funded by the Centers for Disease Control and Prevention; and (3) the HOPE Program, funded by the Center of Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA).
- Members of COPA collaborated with other APA Public Interest committees to submit to BAPPI two symposia proposals for presentation at the 2012 APA Convention: (a) “Women Under Siege: Disparities and Despair” and (b) “Immigration, Race, & Disparities: Health Care, Education, and Employment.” Members of COPA also organized a conversation hour, sponsored by Division 12, titled “Do Biomedical Interventions Make Behavioral Ones Obsolete?” (see details on p. 37).
- In collaboration with staff of the Public Interest Government Relations (PI-GRO) Office and the Office on AIDS, members articulated advocacy goals. Members also initiated meetings and developed action steps with the leadership of the CDC and the
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Health Resources Services Administration (HRSA) related to the integration of mental health and substance abuse assessment and treatment in HIV/AIDS prevention and care. COPA members provided expert opinions and recommendations for PI-GRO staff to deliver at two consultations with the Department of Health and Human Services regarding implementation of the National AIDS Strategy. Lastly, COPA members provided input and support for the following bills:

- **H.R. 1774: Increasing Access to Voluntary Screening for HIV/AIDS and STIs Act of 2011**—Rep. Alcee Hastings (D-FL). This bill would reduce financial barriers to getting tested and pay for the development and distribution of sex education materials that promote voluntary screenings. It also includes provisions for referrals to medical or mental health services at the time of screening. Finally, the monitoring of HIV/AIDS and STI screening trends, particularly among special populations, will allow for the tracking and evaluation of efforts to increase voluntary screening.

- **H.R. 1880: Status Report on the 30th Anniversary of HIV/AIDS Act**—Rep. Barbara Lee (D-CA). This bill would direct the president to transmit to Congress and make publicly available reports on (a) the status of the implementation of the National HIV/AIDS Strategy and (b) the status of international progress toward achieving universal access to HIV/AIDS treatment for people living with HIV/AIDS.

**H.R. 3053: Repeal HIV Discrimination Act**—Rep. Barbara Lee (D-CA). This bill will outline problems with existing laws, regulations, and policies criminalizing HIV/AIDS transmission, including the threat of stigma and infringement on civil, incompatibility with current knowledge about HIV transmission routes, and potential undermining of efforts to promote voluntary screening. Dr. Marguerita Lightfoot met with Rep. Lee’s staff in Washington, DC, to discuss the pivotal role of psychology in the ongoing domestic and global response to the HIV epidemic and to express APA’s support for the Repeal HIV Act.

**COPA MEMBERS**

Perry N. Halkitis, PhD, MS (COPA Chair), is an associate dean for research and doctoral studies, professor of applied psychology, public health, and medicine, and director of the Center for Health, Identity, Behavior, and Prevention Studies at the Steinhardt School of Culture, Education, and Human Development at New York University. He is also an affiliate of the Center for AIDS Research and the Center for Drug Use and HIV Research, also at NYU. He is internationally recognized for his work examining the intersection of HIV, drug abuse, and mental health and is well known as one of the nation’s leading experts on methamphetamine addiction and HIV behavioral research. He is lead editor of two volumes: *HIV + Sex: The Psychological and Interpersonal Dynamics of HIV Seropositive Gay and Bisexual Men’s Relationships* (APA, 2005) and *Barebacking: Psychosocial and Public Health Perspectives* (Haworth Press, 2006). His book *Methamphetamine Addiction: Biological Foundations, Psychological Factors, and Social Consequences* was published in 2009, and he is currently working on a new manuscript examining the life experiences of gay men who are long-term survivors of HIV/AIDS. Author of over 120 peer-reviewed academic manuscripts, his research has been funded by NIH, the CDC, the New York City Department of Health and Mental Hygiene, the New York State AIDS Institute, the United Way, the New York Community Trust, and the American Psychological Foundation. He serves on the APA’s Committee on Psychology and AIDS, is a member of the advisory committee on HIV and STD prevention and treatment of the CDC and the HRSA, and is a member of the College of Reviewers of the NIH Center for Scientific Review. Dr. Halkitis received his PhD from the Graduate Center of the City University of New York and is currently completing his MPH degree.

Eugene Farber, PhD, ABPP, is an associate professor of psychiatry and behavioral sciences in the Emory University School of Medicine. A clinical psychologist, Dr. Farber serves as director of Mental Health and Substance Abuse Services in the Grady Health System Infectious Disease Program,
which is among the largest HIV/AIDS primary care centers in the United States. The mission of this program is to provide accessible community-based services to underserved individuals who are living with HIV/AIDS. In addition to his administrative and clinical service activities, he is also active in clinical teaching and supervision in the HIV/AIDS mental health arena. Dr. Heckman’s research interests and activities focus primarily on factors that influence psychological adaptation to the multiple challenges of living with HIV/AIDS and clinical outcomes of HIV mental health services provided in community-based primary care settings.

Timothy G. Heckman, PhD, is a professor of geriatric medicine/gerontology and the director of the Center for Telemedicine Research and Interventions at the Ohio University Heritage College of Osteopathic Medicine. Since 1993, he has conceptualized, implemented, and evaluated innovative interventions for persons living with HIV/AIDS. His AIDS mental health intervention research has focused primarily on rural persons and older adults living with HIV/AIDS. Dr. Heckman is particularly interested in the use of teletherapy to deliver mental health support services to geographically and psychologically distant persons living with HIV/AIDS. His AIDS mental health research has been funded by NIH since 1998. Dr. Heckman has served on numerous NIH study sections and as a standing member of the Behavioral and Social Consequences of HIV/AIDS Study Section from 2007 through 2010. He is an editorial board member of AIDS and Behavior and serves as an ad hoc reviewer for numerous journals.

Amanda Houston-Hamilton, DMH, is an associate clinical professor in the Department of Psychiatry at the University of California San Francisco School of Medicine. She is also a practicing psychotherapist with clinical, research, and consulting experience emphasizing the health needs of ethnic and sexual minorities as well as the implementation of behavioral interventions to complex, hard-to-reach populations in underserved community settings. She has been clinical director of Tenderloin Health, serving the multiply diagnosed homeless and marginally housed in San Francisco, and the coordinator of community research at the Center for Health and Community at UCSF. She was a research scientist at the Northern California Cancer Center, where she studied health decision making in low-income African American women, and at Polaris Research and Development, where she conducted one of the first population-based studies on HIV/AIDS knowledge, attitudes, and behaviors in the Black community. She has assisted numerous nonprofit organizations in assessing, implementing, and evaluating the service needs of communities disrupted by HIV/AIDS, trauma, substance use, and violence and has over 25 years of experience training and educating medial providers in client-centered care. She has designed curricula and managed a range of training and technical assistance efforts at the community, state, and national levels on mental health and issues associated with AIDS treatment, prevention, and education. She received her doctorate through a joint doctor of mental health program from the University of California, Berkeley and the University of California, San Francisco.

Velma McBride Murry, PhD, is the Betts Chair in Education and Human Development, a professor of human and organizational development, and director of the Center for Research on Rural Families and Communities at Vanderbilt University’s Peabody College. She is also the co-director of the Community Engagement and Research Core at the Vanderbilt Medical Center. She has conducted research on rural African American parents and youth for over 15 years and brings a perspective on adversity that includes race, ethnicity, and poverty; a strong background in the role that parenting plays in addressing the needs of youth; and extensive experience in designing and implementing randomized control trials. She has served as commissioner of the Georgia Children’s Trust Fund and as a member of the Institute of Medicine’s Board on Children, Youth, and Families and of the Standing Committee on Family Planning. She has also served on the board of directors of the Family Process Institute and as co-director of the African American Mental Health Research Scientist Consortium. The Consortium has mentored over 100 early career African American scholars to increase the number of competitive grant applications African American research scientists submit to NIMH; advanced the overall participation level of African American mental health researchers continued on page 26
in NIMH initiatives and programs; and fostered the development of high-quality individual and collaborative mental health research on racial/ethnic minority populations. She edits articles, serves on the publication committee and editorial boards of several journals, and has published over 125 peer-reviewed articles.

Monica Rivera Mindt, PhD, is an associate professor of psychology at Fordham University and has a joint appointment in the Departments of Neurology and Psychiatry at the Mount Sinai School of Medicine. She received her PhD in clinical psychology, with a concentration in neuropsychology, from the University of Nebraska. She completed her internship within the neuropsychology track at the University of Washington School of Medicine and her postdoctoral training in clinical neuropsychology at the University of California, San Diego. Her research is focused on neuroAIDS, multicultural issues in neuropsychology, and health disparities. She is the principal investigator of an NIMH-funded study investigating the neurocognitive and sociocultural determinants of antiretroviral adherence among HIV-positive Latinos and is co-investigator on two additional NIH-funded studies. Her clinical practice comprises forensic work and pro bono services for disenfranchised communities. She has been a member of APA since 1997 and has served APA via the advisory board for the Presidential Taskforce on Diversity Education Resources and as a grant reviewer for the APA Science Directorate’s Dissertation Research Award. She has also served APA Division 40 since 2001, currently as an elected member-at-large. She is a grant reviewer for NIMH, the National Academy of Neuropsychology, and the Alzheimer’s Association and serves on the editorial board of the Journal of the International Neuropsychological Society and as an ad hoc reviewer for numerous other journals. Dr. Rivera Mindt’s research, teaching, and contributions to the field have been recognized with numerous awards, including the Early Career Award from APA’s Division 40 (Clinical Neuropsychology) in 2011 and the Early Career Service Award from the National Academy of Neuropsychology in 2010.

Scyatta A. Wallace, PhD, received her PhD in developmental psychology from Fordham University and her BA in psychology from Yale University. She also completed a 2-year postdoctoral research fellowship at the CDC’s Division of HIV/AIDS Prevention. Her research interests include examining contextual and cultural influences associated with HIV risk among Black adolescents and young adults. She is currently an associate professor in the Department of Psychology at St. John’s University and is also principal investigator on a 4-year, CDC-funded study to develop culturally tailored and gender-specific health education materials that promote HIV testing among low-income heterosexual young adult Black men recently released from jail/prison. In addition, she has received funding from NIH and other federal agencies and foundations for her work focused on substance use and sexual risk among Black youth. Dr. Wallace is an NIH Loan Repayment recipient (2006–present). Previous honors include receiving a 3-year summer visiting professorship at the Center for AIDS Prevention Studies at the University of California, San Francisco; being named an NIH Health Disparities Scholar (2002–2004); receiving the first Dalmas A. Taylor Summer Policy Fellowship (2000) awarded by the APA; and receiving a Graduate Research Ethics Education Training fellowship from the National Science Foundation (1998–2001). Dr. Wallace is currently on the editorial board of Applied Developmental Science.
Thirty years after the initial discovery of the virus that causes AIDS, the epidemic continues to spread, both nationally and globally, and it continues to affect millions of individuals across the developmental spectrum (UNAIDS, 2010). Although daunting challenges remain, there have been major advancements in biomedical approaches to reduce HIV transmission during the past 10 years as a result of the increased tolerability and decreased cost of antiretroviral treatment (ART) and vaccines (e.g., Hepatitis B, HPV vaccine), the expanding range of medical options (e.g., male circumcision, microbicides), and the improvement in technological approaches (e.g., female condom). The interest in biomedical approaches has dramatically increased in recent months with the release of findings from the CAPRISA 004 (Karim et al., 2010), the iPrEx (Grant et al., 2010), and the HTPN052 trials (National Institute of Allergy and Infectious Diseases [NIAID], 2011).

South African scientists associated with Caprisa, a Durban-based research center, announced in July 2010 that women who used a vaginal microbicide gel containing an antiretroviral medication widely used to treat AIDS, tenofovir, were 39% less likely overall to contract HIV than those who used a placebo (Weiss, Wasserheit, Barnabas, Hayes, & Abu-Raddad, 2008). Even more impressive, those women who used the gel most regularly reduced their chances of infection 54% (Karim et al., 2010). In November 2010, scientists associated with the iPrEx (Pre-exposure Prophylaxis Initiative) trial reported that the HIV infection rate in HIV-negative gay men who were given a daily dose of Truvada (a pill containing two HIV drugs [tenofovir plus FTC]) was reduced by 44%, compared with men given a placebo (Grant et al., 2010). In May 2011, results released from the HIV Prevention Trials Network (HPTN) 052 study (NIAID, 2011) indicated that initiation of antiretroviral therapy (ART) reduced transmission from HIV-positive men and women to their seronegative sexual partners by 96%.

For many, the results from these three recent studies constitute “game-changing events” suggesting the need to prioritize biomedical over behavioral approaches to HIV prevention. However, close inspection of the results demonstrates that biomedical approaches to HIV prevention are optimized when they are combined with behavioral approaches. Although biomedical approaches to HIV prevention such as “test-link-and-treat strategies” and pre- and postexposure prophylaxis are important tools for HIV prevention, in order to optimize prevention outcomes, they must be combined with evidence-based behavioral strategies including structural interventions that increase access to services, decrease costs, and reduce stigma and discrimination to ensure broad-scale implementation (Morin et al., 2011).

The debate over the value of biomedical versus behavioral approaches to HIV prevention has substantial implications for funding decisions about behavioral approaches to HIV prevention and care. In order to promote the value of behavioral approaches to HIV/AIDS and to advocate for ongoing support of both biomedical and behavioral approaches to HIV/AIDS, the Committee on Psychology and AIDS developed the following resolution, which became official APA policy when it was adopted by the Council of Representatives on February 25, 2012.

Resolution on Combination Biomedical and Behavioral Approaches to Optimize HIV Prevention

WHEREAS recent findings from the CAPRISA 004 trials (Karim et al., 2010) (women receiving tenofovir gel were 39% less likely to contract HIV than those receiving placebo), the Pre-exposure Prophylaxis Initiative (iPrEx) trials (Grant et al., 2010) (HIV-negative gay men given Truvada had 44% lower infection rates than men given placebo), and the HPTN 052 trials (NIAID, 2011) (HIV-positive individuals initiating ART decreased transmission rates to sexual partners by 96%) clearly establish the importance of biomedical approaches to HIV prevention, they do not justify decreased focus or funding for behavioral prevention strategies; and,

WHEREAS these recent biomedical studies represent significant breakthroughs, combination

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combined Biomedical and Behavioral Approaches to Optimize HIV Prevention

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approaches to prevention of HIV and other sexually transmitted infections (STIs) that comprise both biomedical and psychosocial components work best for optimizing health outcomes (Coates, Richter, & Caceres, 2008; Piot, Bartos, Larson, Zewdie, & Mane, 2008); and,

WHEREAS the success of biomedical interventions is dependent on behavioral factors affecting medication adherence and treatment uptake (i.e., treatment acceptability and use) (Weiss et al. 2008); and,

WHEREAS the efficacy of the CAPRISA, iPrEx, and HTPN 052 studies were optimized by behavioral approaches (Grant et al., 2010; Karim et al., 2010; NIAID, 2011); and,

WHEREAS women in the CAPRISA study who accessed the adherence counseling program and used the gel most regularly had an HIV infection rate that was 54% lower than controls while those with low adherence had an HIV infection rate that was only 28% lower than controls (Karim et al., 2010); and,

WHEREAS treatment adherence played a central role in the iPrEx study as evidenced by the fact that 91% of the men assigned to the treatment group who later tested positive for HIV had no detectable levels of Truvada in their bloodstream (Grant et al., 2010); and,

WHEREAS behavioral approaches played a central role in the HTPN 052 study (NIAID, 2011), in which all participants were given HIV care that included safe sex counseling; and, WHEREAS biomedical interventions for HIV and other STIs without combined behavioral approaches have shown suboptimal medication adherence and treatment uptake (e.g., 80% of women do not receive medication to prevent HIV parent-to-child transmission [Temmerman, Quaghebeur, Mwanyumba, & Mandalya, 2003]; 80% of uncircumcised Zambian males have expressed no interest in considering circumcision as an HIV risk-reduction option [based on 2009 qualitative study in Zambia; S. Weiss, personal communication, March 3, 2011]; only 27% of drug users in need of the Hepatitis B vaccine completed the required three-dose regimen [McGregor, Marks, Hayward, Bell, & Slack, 2003]; and only 28.2% of young women at a clinic who were offered the human papillomavirus vaccine accepted, and of those who accepted, only 55.7% completed all three required doses [Moore, Crosby, Yungu, & Chamigo, 2010]); and,

WHEREAS medication adherence and treatment uptake of biomedical interventions can be addressed by behavioral interventions that enhance knowledge and build skills while incorporating attention to factors such as age, socioeconomic status, religious beliefs, chronic or acute health conditions and disability, developmental understanding, cognitive impairment, race, immigration history and status, language, gender, gender identity, sexual orientation, family context, culture, stigma, mental health, substance abuse, attitudes, prior knowledge, etc. (Liebowitz, Byrnes Parker, & Rotheram-Borus, 2011; Underhill, Operario, Skeer, Mimiaga, & Mayer, 2011); and,

WHEREAS policy and recommendations have yet to be established as to whether biomedical interventions for HIV prevention will be viewed as life-long or as short-term solutions for high-risk individuals (Paltiel et al., 2009); and,

WHEREAS successful behavioral engagement in biomedical prevention models may be out of reach for certain populations (e.g., human trafficking victims, sex workers, people living in poverty, children, etc.) necessitating the development of concurrent models that can be accessed by multiple at-risk populations (Bowleg, Neilands, & Choi, 2008); and,

WHEREAS there is insufficient behavioral research to assess the potential for unintended consequences and unanticipated ethical issues in everyday clinical use of HIV biomedical interventions (e.g., individuals might engage in more risky behavior; individuals may not use biomedical agents as prescribed; there may be health disparities in access to biomedical interventions; there may be as yet undefined, long-term, negative health implications and side effects from an exclusive reliance on biomedical interventions; etc.);

THEREFORE behavioral research is needed to optimize medication adherence and treatment uptake, to document real-world decision-making processes associated with biomedical interventions, and to better understand the possible unintended and/or undesired consequences of biomedical interventions; and,

THEREFORE HIV/STI prevention research teams of the future must bridge biomedical...
and behavioral approaches and develop new combination approaches that consider biological, cognitive, attitudinal, affective, behavioral, gender, familial, developmental, cultural, educational, social, racial, linguistic, socioeconomic, religious, and environmental factors (Fisher, Smith, & Lenz, 2010; National Institutes of Health, 2011); and,

THEREFORE funding should be increased for HIV prevention research that incorporates mental health, substance abuse, behavior change, and adherence strategies to optimize the health outcomes of biomedical strategies with special attention paid to the development of combination prevention interventions that can be accessed by multiple at-risk populations; and,

THEREFORE Congress, the executive branch, state and local governments, and nongovernmental organizations should promote public policies that increase support for multidisciplinary, interdisciplinary and transdisciplinary training, practice, and research; and

THEREFORE psychology should continue to be mobilized to conduct research on strategies for improving health outcomes based on behavioral optimization of biomedical approaches to HIV/STI prevention and to continue basic and applied research to identify and disseminate effective universal and selective prevention strategies.

REFERENCES


ADVANCING THE NATIONAL HIV/AIDS STRATEGY IN METROPOLITAN WASHINGTON: SCIENCE-PRACTICE PARTNERSHIPS CONFERENCE

April 20, 2012
Howard University, Blackburn Auditorium
Washington, DC

The conference is sponsored by the American Psychological Association; the Georgetown University School of Nursing and Health; Howard University; and the Office of Behavioral and Social Sciences Research (OBSSR), NIH.

HIV prevention and care providers, people living with HIV/AIDS, researchers, local and federal health officials, community-based and faith-based organizations, HIV advocates, and others will come together to share their challenges and successes in HIV prevention and care and set a path for future collaboration. The goals of the conference are to:

- identify and develop practical ways that providers can stay informed about HIV research relevant to their work;
- identify and develop mechanisms for providers to communicate critical issues for HIV researchers to address;
- identify and develop mechanisms to assist providers to adopt best practices associated with the implementation of HIV/AIDS prevention priorities established by the National HIV/AIDS Strategy (NHAS) and CDC’s High Impact HIV Prevention approach; and
- develop research initiatives to create evidence-based prevention programs to prevent HIV transmission and to implement high-impact prevention.

The co-sponsors represent the DC Health Department, faith-based communities, academic institutions, and important community-based organizations representing at-risk and infected individuals.

The conference will include morning plenary sessions and afternoon breakout groups. Morning sessions, which will focus on how the adoption of the NHAS and high-impact prevention strategies will impact the local prevention and treatment community; how the District of Columbia is responding to the new NHAS and guidance from the CDC; and how syndemic issues in the District (such as poverty, mental health, sexual health, isolation, drug abuse, housing, environment, access to care, therapy, etc.) impact prevention and treatment efforts.

Afternoon breakout sessions will address approaches to (a) identifying those who are at highest risk and who are unaware of their HIV status; (b) identifying and testing those who are unaware of their HIV status; (c) getting those who test positive linked to and engaged in care; (d) getting those who test positive to adhere consistently to their treatment regimens and be retained in regular care over time; (e) providing evidence-based prevention counseling/interventions; and (f) handling cross-jurisdictional prevention and treatment issues in metropolitan Washington, DC.
The BSSV Program

Translating HIV Prevention Science into Culturally Relevant Practice

The Behavioral and Social Science Volunteer (BSSV) Program continues to provide online training support to our volunteers to further equip them to provide capacity-building assistance (CBA) to community-based organizations (CBOs) across the United States and U.S. territories. During the past several months, we have been developing and delivering these core trainings as well as creating new tools and resources for use by our BSSVs, other CBA providers funded by the CDC, and, of course, our key audience—CBOs.

Profile of BSSVs

Our BSSV team is made up of 296 dynamic and professional volunteers. Together they represent a diverse professional background of behavioral and social science disciplines and education levels. The majority of our BSSVs hold a doctorate (73%) or master’s degree (19%). We currently have BSSVs in 43 states and territories, including Guam and Puerto Rico. The majority of our BSSV’s are female (68%).

Recent BSSV Trainings

There have been five CBA-specific evidence-based intervention trainings developed and offered to BSSVs. These include Choosing Life: Empowerment, Actions, Results (CLEAR); Community Promise, Healthy Relationships; Many Men, Many Voices (3MV); and Sisters Informing Sisters on Topics About AIDS (SISTA). The intent of these trainings is to acquaint BSSVs with the overall core elements and operating principles; provide an overview of the intervention; and provide a review of adaptation issues, program monitoring and evaluation tools and resources, and the facilitation process. These trainings are available online 24/7 and can be accessed by BSSVs at their convenience.

Integration of Mental Health, Substance Abuse, and HIV Prevention

We are pleased to announce that the Integration of Mental Health, Substance Abuse, and HIV Prevention resource page is now available online. It is our hope that these resources will be helpful to those seeking a comprehensive and integrated approach to care and prevention. A presentation is available to assist CBOs in exploring how to effectively integrate care into their service organization. CBOs who are interested in receiving capacity-building assistance support in this area should contact Sharon Asonganyi, CBA Coordinator, at (202) 336-6164.

We pride ourselves on building trust and mutual respect with the communities with which we work.

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ADAPTATION TOOL FOR MANY MEN MANY VOICES (3MV)

The BSSV program recently developed an adaptation tool for Many Men Many Voices (3MV): A Collaborative Toolkit for Capacity Building Assistance Providers and Community-Based Organizations, which was submitted to the CDC for review and consideration. This tool was developed for use by BSSVs and other CBA providers in their data collection efforts as they assist CBOs in adapting the evidence-based intervention Many Men Many Voices (3MV) to reach targeted participants. The tool was designed to complement several existing tools and resources that have been developed by fellow CBA providers such as the Center for Health and Behavioral Training in Rochester, NY; the California Prevention Training Center; and the AIDS Project Los Angeles.

NATIONAL HIV PREVENTION CONFERENCE: BSSV ROUNDTABLE DISCUSSIONS

The BSSV Program was recently selected to present two roundtable discussions at the upcoming National HIV Prevention Conference scheduled for August 14–17, 2012, in Atlanta, GA: “Integrating Mental Health, Substance Abuse, and HIV Prevention” and “Making LINKS: Lessons From Implementing and Navigating Key Steps From Selecting to Adapting an EBI.”

HOW TO REQUEST CBA SUPPORT

For more information or to access the services of the BSSV Program, please contact Edna Davis-Brown, BSSV Program Director, at (202) 336-6176, or Sharon Asonganyi, CBA Coordinator, at (202) 336-6164.

2012 APA CONVENTION SYMPOSIUM

IMMIGRATION, RACE, & DISPARITIES: HEALTH CARE, EDUCATION, EMPLOYMENT

Co-sponsored by CEMA, CSES, CDIP, CLBGTC, CYF, COPA and CWP

As demographics in our country change rapidly, it is a critical time for psychology to engage in research, practice, education, and policy that can help promote the psychological well-being of immigrant communities. This panel will focus on the ways in which immigrant-origin individuals (first and second generation) experience and cope with racism and disparities across three different contexts: health care, education, and employment. Each presenter will focus on one of these contexts and highlight the ways in which racial/ethnic/linguistic/cultural and other social identities (e.g., sexual orientation, social class) shape and are shaped through the immigration process. They will speak on a particular context (health care, education, employment) as it relates to specific immigrant communities (e.g., Asian American, Arab American). The discussants will provide comments on the presentations, with a special focus on the issue of policy as relevant to health care, education, and employment.

This symposium will be chaired by Pratyusha Tummala-Narra, PhD. Presenters include Kevin L. Nadal, PhD; Germine Awad, PhD; Guillermo Prado, PhD; and Carola Suárez-Orozco, PhD.
The Cyber Mentors Program is an innovative research mentoring program preparing promising researchers who have not yet received R01-level funding to develop successful independent careers in HIV/AIDS research. The Cyber Mentors Program uses a national cadre of senior HIV/AIDS researchers as volunteer mentors and matches them with a national sample of promising HIV/AIDS research mentees. The program assists mentees in developing their capacity for a successful career in HIV/AIDS research; refining their technical knowledge; strengthening the skills required to design and implement high-quality research; and developing skills to write and submit a successful NIH grant.

To achieve program goals, Cyber Mentors uses state-of-the-art distance-learning technologies to prepare mentees to submit a high-quality NIH grant application, facilitate professional relationships with senior HIV/AIDS scientists, and support their research and mentoring efforts. Mentors assist mentees by reviewing drafts and providing feedback, discussing or assisting with data analysis, assisting with revisions, coauthoring, and providing encouragement and support.

Monthly webinars cover various research, methodology, and administrative topics relevant to research careers. Some webinar discussion topics have included the development of preliminary studies; the construction of successful proposal budgets; the use of power analysis, effect size, and sampling; and HIV research ethics. During small group discussions, mentees apply concepts learned during webinars in the development of their own proposals and receive feedback on specific sections of their applications from a variety of program mentors and HIV/AIDS experts.

Mentees also have the opportunity to participate in full-scale mock reviews in which their grant applications are reviewed and scored by senior HIV/AIDS researchers. Reviewers provide written feedback to mentees, with an emphasis placed on recommendations for improvement. Mentees revise their applications in response to the mock review feedback before submitting finalized proposals to funding agencies. Of the applications submitted to NIH, 69% were discussed and received a priority score, 41% were successfully funded, and an additional three grants are awaiting a funding decision.

To further prepare mentees for proposal submissions, the program conducts an annual workshop in conjunction with the APA convention. Last year’s workshop took place in...
Washington, DC. It provided attendees an opportunity to participate in simulated mock review sessions of their colleagues' draft proposals and network with one another. It also allowed mentees the opportunity to attend the APA Convention.

To find out more about the Cyber Mentors Program, contact Cherie Mitchell, the Cyber Mentors Program coordinator. You may also see the Cyber Mentors web page for additional information.

The International AIDS Conference is the premier gathering for those working in the field of HIV, as well as policymakers, persons living with HIV, and other individuals committed to ending the pandemic. It will be an important opportunity for researchers from around the world to share the latest scientific advances in the field, learn from one another's expertise, and develop strategies for advancing all facets to treat and prevent HIV/AIDS.

The return of the biennial International AIDS Conference to the United States since 1990 represents a significant victory for public health and human rights. The selection of Washington, DC, as the site for the 19th International AIDS Conference (AIDS 2012) is also significant as it is home to key players in the global response to AIDS, including the Office of the U.S. Global AIDS Coordinator, which directs PEPFAR—the President’s Emergency Plan for AIDS Relief; the National Institutes of Health; and the World Bank.

The AIDS 2012 program will present new scientific knowledge and offer many opportunities for structured dialogue on the major issues facing the global response to HIV. A variety of session types—from abstract-driven presentations to symposia, bridging sessions, and plenary sessions—will meet the needs of various participants.

Other related activities, including the Global Village, satellite meetings, exhibitions, and affiliated independent events, will contribute to an exceptional opportunity for professional development and networking.

The 2012 International AIDS Conference is expected to convene more than 25,000 delegates from nearly 200 countries, including more than 2,500 journalists.

The conference will be held from July 22 to 27, 2012, at the Walter E. Washington Convention Center.

For more information on AIDS 2012, visit www.aids2012.org or call (202) 442-8391.
In June, the world observed the 30th anniversary of the first report in the United States of five gay men diagnosed with Pneumocystis carinii pneumonia, or PCP. What puzzled doctors was that PCP is an infectious disease usually found in people undergoing chemotherapy for cancer treatment and others living with identified impaired immune systems. Although the first cases were clustered in Los Angeles, 26 new cases were identified the following month in San Francisco and New York. Although the initial demographic was primarily gay men, the profile quickly grew to include heterosexuals, hemophiliacs, and injection drug users. Some younger professionals in our field have always lived in a world with this pandemic, while others remember the confusing original reports of a “new form of cancer.”

According to the most recent data from the CDC, more than 1.7 million people in the United States are estimated to have been infected with HIV, including more than 583,000 who have died. Annual HIV incidence is between 56,000 to 58,000 new infections a year, down from its peak of more than 150,000 in the 1980s (CDC, 2010; Hall Ruiguang, & Rhodes, 2009).

Although HIV medical treatment has drastically evolved over the last 30 years and HIV has moved toward a chronic and controlled disease in the United States, the way we address the mental health needs of those affected and infected by HIV has never been more important.

The APA Office on AIDS was established early in the epidemic to educate psychologists and society about the unique roles psychology can play in the fight against the pandemic. The office provides information, training, and technical assistance on a wide range of HIV/AIDS-related topics. One of the early training programs established in the Office on AIDS was the HIV Office for Psychology Education (HOPE) Program.

HOPE observed its 20th anniversary this past October. Originally funded in 1991 by a 3-year contract with the Center for Mental Health Services (CMHS), the HOPE Program endeavors to enhance psychologists’ ability to competently and compassionately respond to people infected and affected by HIV. Using a train-the-trainer model, the HOPE Program has trained and certified more than 480 HOPE Program volunteer trainers to deliver interactive workshops for mental health providers. These trainers have in turn provided HOPE curriculum training in their communities to more than 29,000 mental health professionals since its establishment.

Today, the HOPE Program boasts more than 110 volunteer trainers who reside in 31 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. HOPE trainers use flexible topical modules to create individualized training events. Trainers conduct an extensive training needs assessment with staff at a training site. From this assessment, the trainer designs a unique didactic and interactive training with facilitated discussions and skills-building exercises to meet the needs of the audience. Training events are developed using either the HOPE Program Training Resource Package or the Ethical Issues & HIV/AIDS Curriculum.
The HOPE Program is funded by a 5-year contract (No. 280-09-0290) with the CMHS of the Substance Abuse and Mental Health Services Administration (SAMHSA). The APA Office on AIDS administers the HOPE Program.

HOPE TRAINERS MEET THE NEEDS OF ALL MENTAL HEALTH PROFESSIONALS

HOPE trainers are uniquely positioned to adapt content to reach the needs of attendees and provide HIV and mental health training to your staff or students. Social workers, psychiatrists, medical doctors, nurses, school counselors, and graduate students are just a few of the professionals that appear on HOPE training attendee rosters.

To locate a HOPE trainer in your area, please contact David DeVito, Director, HOPE Program, (202)-216-7603.

ONLINE CONTINUING EDUCATION COURSES LAUNCHED

The HOPE Program is proud to announce the release of two new online APA continuing education (CE) courses: Drug Use and HIV Disease and Traumatic Stress Among Individuals Living With HIV/AIDS.

The workshops were developed by the HOPE Program through funding from CMHS of SAMHSA (Contract Number 280-04-0121).

Drug Use and HIV Disease offers state-of-the-science research and clinical wisdom that is highly relevant to both practitioners and researchers interested in the field of mental health, substance abuse, and HIV/AIDS. This 2.5-hour, online CE course is presented by Perry N. Halkitis, PhD, MS, professor of applied psychology, public health, and medicine, director of the Center for Health, Identity, Behavior and Prevention Studies, and associate dean at New York University.

COURSE DESCRIPTION

In this introductory/intermediate workshop, participants will explore the relationships between mental health, substance abuse, and HIV/AIDS. Topics covered include (a) the effects of mental health and substance abuse disorders on sexual risk taking; (b) the ways in which illicit drug use and mental health issues affect engagement and retention in HIV care; and (c) evidence-based approaches to the treatment of people with HIV/AIDS who struggle with co-occurring disorders. Case study vignettes are used to highlight evidence-based treatment approaches applicable to clinical practice.

LEARNING OBJECTIVES

1. Learn why and how mental health and substance abuse problems place people at greater risk for HIV infection.

2. Understand how the combined burdens of substance abuse, mental health, and HIV affect the lives of HIV-positive individuals.

3. Discover how a theory of syndemics informs practice for delivering holistic care to drug-using HIV-positive individuals.

4. Identify effective interventions for addressing the interplay of substance abuse, mental health burden, and sexual risk taking in both HIV+ and HIV- populations.

Participants will receive 2.5 APA CE credits upon successful completion of the course.

Perry N. Halkitis, PhD, MS, is internationally recognized for his work examining the intersection between HIV, drug abuse, and mental health and is well known as one of the nation’s leading experts on methamphetamine addiction and HIV behavioral research.

Traumatic Stress Among Individuals Living With HIV/AIDS offers treatment strategies based on evidence-based research and clinical practice that is highly relevant to practitioners interested in the field of trauma and HIV/AIDS. This CE workshop is presented by Cheryl Gore-Felton, PhD, professor and associate chair for faculty development and academic affairs, Department of Psychiatry and...
Behavioral Sciences, Stanford University School of Medicine.

**COURSE DESCRIPTION**

In this introductory/intermediate workshop, participants will explore the relationship between trauma and HIV/AIDS. Topics covered include (a) the effects of trauma on sexual risk taking; (b) the ways in which trauma affects HIV disease management, and (c) evidence-based approaches to integrating trauma treatment among people with HIV/AIDS who report psychological distress. Case vignettes are used to highlight interpersonal and contextual factors that influence evidence-based treatment approaches applicable to clinical practice.

**LEARNING OBJECTIVES**

1. Learn why and how trauma experiences, particularly those in childhood, place people at greater risk for HIV infection.

2. Understand how the combined burden of trauma-related symptoms and HIV affect the lives of HIV-positive individuals.

3. Identify effective intervention strategies for addressing the co-occurrence of trauma-related symptoms, HIV disease management, and sexual risk taking among HIV-positive populations.

Participants will receive 2.5 APA CEs upon successful completion of the course.

Cheryl Gore-Felton, PhD, is a licensed psychologist who is nationally and internationally recognized for her work examining the intersection between HIV and trauma and is well known as one of the nation’s leading experts on the sequelae of trauma and HIV behavior research. She has authored or coauthored over 100 peer-reviewed articles and book chapters, and she serves on the editorial boards of *Health Psychology* and the *Journal of Behavioral Medicine*. Her research focuses on the development of clinical interventions to reduce traumatic stress symptoms and enhance health-related behaviors.

Although the HOPE Program has made an impact in the treatment and impact of mental health in the course of 2 decades, there is much more that remains to be done. Let us know how we may help you address the needs of your practice and community. For more information about the program, visit [http://www.apa.org/pi/aids/programs/hope/index.aspx](http://www.apa.org/pi/aids/programs/hope/index.aspx).

**REFERENCES**


This session will evaluate research developments in combination biomedical and behavioral interventions in HIV, cardiovascular, and cancer research that improve health outcomes and address the complementary contribution of combination biomedical and behavioral research to prevention of disease and its consequences. Strategies to encourage such research and practice will be reviewed. Effective models to ensure better training of professionals to conduct combination biomedical and behavioral research will be discussed.

Participants: Perry N. Halkitis, PhD, MS, New York University; Willo Pequegnat, PhD, National Institute of Mental Health; and Neil Schneiderman, PhD, University of Miami
In 2010, the United States struck a major blow against HIV-related stigma by officially lifting the HIV entry ban that restricted non-U.S. citizens with HIV from entering the country. The policy was deemed to be outdated and discriminatory and to stigmatize people living with HIV, the majority of whom are gay men in the United States. The public health community, HIV advocates, and people living with HIV hailed the action as a significant step forward in the international and domestic fights against the stigma of HIV. Once the HIV-entry ban was lifted, the way was paved for locating the 2012 International AIDS Conference in Washington DC, the first time the conference has been held in the U.S. in more than 20 years (see p. 34 for details). Both actions brought awareness to the stigmatizing effects public law and policy can have on people living with HIV/AIDS.

The U.S. federal government has long regarded gay-related and HIV-related stigma as sociocultural forces that ought to be considered in the design and implementation of HIV prevention programs. The Centers for Disease Control and Prevention (CDC) provides funds to state and local health departments and nongovernmental organizations for public information and HIV/AIDS awareness-raising activities. These activities are meant to educate the public at large about HIV/AIDS and also to counter negative connotations society attributes to HIV-positive gay men. However, the impact that these and other federally funded programs have on reducing societal stigma toward gay men is unclear. Renewed attention to the domestic epidemic and the resurgence of HIV among gay men combine to create an environment for renewed consideration of public policy approaches that can advance positive change in this area.

Efforts are now under way to better understand how gay-related stigma and homophobia are related to HIV transmission and HIV-related health outcomes and to determine the best public policies to respond to these challenges. For example, the third goal of the National HIV/AIDS Strategy (NHAS; White House Office of National AIDS Policy, 2011)—to reduce HIV-related health disparities and health inequalities—addresses stigma. The NHAS recognizes that HIV status is often related to stigma and discrimination in employment, housing, and access to health care and to public accommodations. Systemic discrimination can impede the desire and ability of persons living with HIV to get tested, seek care and treatment, and effectively manage their HIV disease.

NHAS calls for the vigorous enforcement of the Americans With Disabilities Act, the Fair Housing Act, and the Rehabilitation Act. Enhanced enforcement of these three laws will combat discrimination by creating an environment in which HIV/AIDS testing and treatment are not socially punished. In addition, the NHAS suggests that older laws directed specifically at HIV/AIDS-positive individuals (such as those linked to consensual sexual behavior, spitting, and biting) be reconsidered. These laws are based on outdated information and support inaccurate conceptions surrounding HIV/AIDS that can discourage individuals from seeking testing and treatment.

The CDC also recognizes the importance of addressing stigma and discrimination in HIV prevention and strategies to reduce health inequities across several disease conditions.
2010 White Paper on Social Determinants of Health, the CDC outlined a plan for reducing health disparities related to HIV, STDs, TB, and viral hepatitis. The CDC identified “social environment” (which includes discrimination) as one of the five main determinants of population health and therefore as one of the foci of their activities. The white paper only includes one priority specifically related to reducing stigma and discrimination toward HIV-positive individuals. This priority aims to generate both culturally and linguistically relevant information that addresses factors which create or reinforce stigma and discrimination of persons with HIV/AIDS, sexually transmitted infections, tuberculosis, and hepatitis.

Both of the aforementioned documents acknowledge the impact of stigma and discrimination in HIV prevention, but neither lays out a far-reaching path. They exemplify the lack of specificity in the federal response to gay-related stigma, which may be due to limitations in the research on and evidence-base regarding the health needs of gay men. A recent Institute of Medicine (2011) report concluded that there is a lack of research surrounding the health needs of the lesbian, gay, bisexual, and transgender (LGBT) community and recommended the implementation of a research agenda to assist the National Institutes of Health (NIH) in enhancing its research efforts in LGBT health.

Laws and policies at the state level are also relevant. The National Alliance of State and Territorial AIDS Directors (NASTAD, 2011) recently called for the repeal of HIV-specific criminal statutes because such state-level laws foster and sustain stigma and discrimination against individuals living with HIV/AIDS. According to NASTAD, 34 states and 2 U.S. territories explicitly criminalize HIV exposure through sex, shared needles, or in some states, exposure to “bodily fluids” that can include saliva. These laws may impede individuals from learning their HIV status and from disclosing their HIV status to sexual and/or needle-sharing partners. The NHAS encourages state legislatures to review punitive HIV-specific criminal laws to ensure that they are consistent with current knowledge about HIV transmission and grounded in sound public health principles.

Current plans that may potentially reduce gay-related stigma are vague and incomplete. Researchers agree that more information is needed to better define how stigma impacts HIV transmission among gay men and how it impacts their ability to access culturally competent care and treatment. The NHAS creates an opportunity for reassessment of all domestic HIV/AIDS prevention and care programs with respect to their contribution to meeting the strategy’s goals and realignment of some domestic HIV/AIDS spending. Strategies that may potentially deserve new and/or enhanced funding include community mobilization strategies that encourage positive attitudes toward sexual orientation and gender identity; interventions that encourage disclosure of gay identity and HIV status; and development, adaptation, and implementation of community-level and structural interventions to address gay-related stigma.

Several action steps can be taken to address the barriers of gay-related stigma and discrimination in HIV prevention:

- Invest in research to develop and test the effectiveness of interventions designed to address HIV-related disparities attributable to stigma, homophobia, and discrimination. NIH and CDC should include such studies in their research portfolios.
- Rapidly evaluate and scale up program initiatives with evidence of effectiveness aimed at addressing gay-related stigma. Such programs would include U.S. Department of Health and Human Services (HHS) public information campaigns, awareness-raising activities, community mobilization strategies, and capacity-building initiatives. Evaluation findings should be disseminated to policymakers and diverse stakeholder groups and should be used to modify, tailor, expand, or eliminate programs based on evaluation findings.
- Fully implement NHAS action steps that respond to gay-related stigma. Action steps in the NHAS are to engage communities to affirm and support people living with HIV; promote leadership of people living with HIV; promote public health approaches to HIV prevention and care on the state level, including revisiting HIV-specific criminal statutes; and strengthen enforcement of federal anti-discrimination laws. Each of these is a good first step. Government alone cannot carry the burden of fully addressing the complexity of these issues. Foundations, corporate donors, and other philanthropic groups should work with the public sector across all levels of government to set realistic goals and timelines for ending
discrimination, stigma, and homophobia. The test will be implementation. Fortunately the NHAS commits rigorous evaluation reporting requirements, which will allow stakeholders to closely monitor and assess progress.

• Support enactment of the the REPEAL HIV Discrimination Act (H.R.3053), introduced by Rep. Barbara Lee (D-CA) during the 112th session of Congress. This bill calls for a review of existing federal and state laws and regulations related to the criminalization of HIV/AIDS transmission, the results of which would be presented to Congress along with recommendations for amending current laws. There is growing empirical evidence that unduly punitive laws undermine efforts to prevent HIV transmission. Criminalizing behaviors that cause HIV transmission produces negative consequences, including increased stigmatization and discrimination and the avoidance of voluntary testing. The review and reform of current HIV criminalization statutes detailed in H.R.3053 will help to reduce the HIV/AIDS-related stigma that undermines health initiatives focused on screening, prevention, and treatment. Recent developments in international HIV policy can inform domestic responses to gay related stigma.

This issue of Psychology & AIDS Exchange shows psychology’s contributions to understanding how gay-related stigma contributes to disproportionate rates of HIV transmission among gay men. As such, it reminds us of the importance of understanding the national HIV/AIDS policymaking process across all levels of government—including the White House, HHS, other cabinet-level agencies, as well as state and local public health agencies—and the benefit of meaningful involvement of governmental organizations and advocacy groups in HIV policymaking processes.

REFERENCES


