



FIVE BOROUGH AIDS MENTAL HEALTH ALLIANCE

A Quarterly Publication Volume 6 No. 4 Fall 2004

Risk reduction burnout: *Where do we go from here?*

Submitted by: Glenda G. Hasty, M.P.A. and Nadine Ranger, M.S.

After two decades of HIV disease and progress in developing HIV medications that have effectively decreased viral burden and enhanced the quality of life for HIV positive individuals, we have now come to a crossroads. We have witnessed several years of decreasing HIV transmission rates with evidence that prevention messages were heard and practiced, and now are seeing new evidence that suggests

HIV transmission is on the rise again. In this

article, we will highlight some especially vulnerable populations such as men who have sex with men (MSM), injection drug users (IDUs), young people, and heterosexual women of color. Theories abound as to what may be responsible for these increases, but some have posited that risk reduction or prevention burnout is largely responsible.

Prevention burnout can be defined as decay or erosion of previously practiced prevention behaviors. This is likely to occur in groups of people who have had the same prevention message delivered to them over an extended period of time. For example, it is not unreasonable to consider that people long affected by the AIDS epidemic feel that they have heard all there is to hear about prevention and have grown frustrated with prevention behaviors. Over time, they may have become tired of engaging in safer sex behaviors, or they may be reluctant to inform partners of their HIV status and their consequent risks for HIV infections, especially casual partners (HRSA 2003). Evidence of increasing risk behaviors among men who have sex with

(continued on page 6)



**A Letter from the Editor:
Tim Hunt,
LCSW, CASAC**

The Fall 2004 edition of the Five Borough AIDS Mental Health Alliance (FAMHA) newsletter covers the issue of risk reduction burnout or safer sex

burnout that seems to be occurring across populations. In the United States, there are approximately 40,000 people who become infected with HIV every year (Osmond, 2003). While this figure has remained somewhat stable over the last several years, there is concern about a reversal of positive trends in behavior change outcomes that were successful earlier on in the epidemic. This edition of the FAMHA newsletter examines some of the possible reasons for this reversal of positive outcomes associated with

earlier prevention campaigns. There are several subgroups that continue to put themselves at significant risk for contracting HIV. One group that has received a great deal of attention is men who have sex with men. The significant gains made within that subgroup of at-risk individuals seem to have lost steam, and HIV infection is on the rise again. Within this group are men who do not identify as homosexual but who have sex with men

(continued on page 11)



Inside this Issue:

- p 1 Risk reduction burnout:
Where do we go from here?**
- p 1 Letter from the Editor**
- p 2 From the Desk of
Lloyd Sederer, M.D.**
- p 3 Eroticizing safer sex:
A training design to help avoid risk reduction burnout**
- p 4 News You Can Use**
- p 9 Upcoming Events**

5 FIVE BOROUGH AIDS MENTAL HEALTH ALLIANCE

Published by:
Cicatelli Associates Inc.
Five Borough AIDS Mental Health Project
HIV/AIDS Training and
Technical Assistance Project

Barbara Cicatelli
Project Administrator

Theresa Keane, Ph.D.
Managing Editor

Keran Deli
Director of Curriculum and Publications

Tim Hunt, LCSW, CASAC
Editor, Deputy Director
Behavioral Health Division

Luis R. Torres, M.A.
Director of Behavioral Health Division

Banghee Chi
Contributing Photographer

Tom Webster
News You Can Use Contributing Writer

Under contract with the
New York City Department of
Health and Mental Hygiene
Thomas R. Frieden, M.D., MPH
Commissioner

Division of Mental Hygiene
Lloyd Sederer, M.D.
Executive Deputy Commissioner

Office of Adult Services
Peter McGarry, LCSW
Assistant Commissioner

Office of Contract Management
Victoria Pope

Program Consultant
Lisa Bernard

All signed articles published in
this quarterly represent solely
the opinion of the authors.

Cicatelli Associates Inc.
505 Eighth Avenue, Suite 1601
New York, NY 10018
P: (212) 594.7741
F: (212) 629.3321
E: tim@cicatelli.org

www.cicatelli.org

From the Desk of Lloyd I. Sederer, M.D., Executive Deputy Commissioner, Division of Mental Hygiene at the New York City Department of Health and Mental Hygiene, is a regular contributor to the quarterly FAMHA newsletter. For the present issue, FAMHA staffers Tim Hunt, LCSW and Theresa Keane, Ph.D. sat down for a discussion with Dr. Sederer and Andrew Kolodny, M.D. of the Division of Mental Hygiene, as well as, Jan Carl Park, MA/MPA, the Acting Assistant Commissioner for the Department's Bureau of HIV/AIDS and George DeStefano, the Director of the Bureau's Media & Materials program. The discussion centered on the need for risk reduction initiatives and measures to keep in step with the disease of HIV as it changes over time.

Dr. Kolodny: Good afternoon everyone. We at the Division of Mental Hygiene were approached with regard to having a discussion for the FAMHA newsletter around risk reduction burnout. As Dr. Sederer and I thought about it, we felt it would be important to include Jan and George because they are some of the City's foremost experts on this topic.

Mr. Hunt: It is an interesting topic, and it has always been a question - in what way is HIV a mental health issue? Are risk reduction behaviors part of mental health functioning and what role should those of us in mental health have or take a lead in? These are some of the questions we are thinking about at CAI.

Dr. Keane: Well, perhaps we could start by hearing about where are we in the City with respect to risk reduction initiatives. What kinds of risk reduction initiatives are happening and what groups are being targeted?

Mr. DeStefano: Through a combination of federal and city funding, the Department supports an expansive portfolio of HIV prevention programs that focus on risk reduction. The portfolio is designed to address risk across a large spectrum of populations, communities and behaviors. Particularly relevant to this discussion are the "prevention case management" initiatives, which work with people who are having difficulties initiating or sustaining safer sex practices because of particular barriers in their environment. We often find that these barriers are psychosocial in nature. Prevention case management programs, working one-to-one or in small groups, offer skills to overcome challenges to initiating and sustain-

ing safe sex practices by employing risk reduction strategies. Taking our work a bit farther, the Department also funds "prevention modules" or programs that target specific risk behaviors such as injecting drug use, as well "at risk" communities such as men who have sex with men (MSM), women, young people, and incarcerated populations. Several programs are designed to address safe sex challenges faced by people already living with HIV.

Dr. Sederer: Can you describe the modules? What would be the duration of a module and how are some of the modules organized?

Mr. DeStefano: The content of the programs within each module - or, if you will, how community based organizations choose to do their prevention work - can vary, but regardless of the intervention, the Department spells out very clear expectations. For example, with the IDU module, programs address not only drug use and drug use risk, but also sexual risk-taking. For the MSM module, programs are designed to address issues such as homophobia, racism, and societal norms that could be a barrier to safer sex and risk reduction strategies. For women, programs address gender-related issues, particularly women's unequal power in heterosexual relationships. In addition, each contracted agency that provides safe sex/risk reduction interventions were asked to address individual-level barriers such as safe sex burnout or complacency.

Mr. Park: I think that when we talk about safe sex burnout or complacency we must keep in mind a shift in thinking from an era before the success of HIV medications (pre-HAART) to an era of HIV "management" (post-HAART). Here in the U.S., through the 1980s and the first half of the 1990s we experienced the darkest days of the epidemic. During this time, the

pre-HAART era, people with AIDS were visibly very ill, many died. When HAART was introduced, a phenomenon known as "treatment optimism," followed and contributed to a sense of complacency about safe sex. Prior to the advances in HIV treatment, when death was on our doorstep, studies showed that there was a rise in safer sex activities among affected populations. For example, in 1994, in the pre-protease inhibitor days, one study indicated that condom use "every time" during sexual activities was approximately 70% among gay men surveyed; a follow-up study, conducted in 1999, three years after the introduction of protease inhibitors, showed condom usage "every time" dropped to around 50%. I would venture to say that if that study were replicated today the slippage would be even greater. So with the success of powerful, life-extending HIV medications and the resultant thinking among many that HIV is now a "manageable" illness, safe sex practices and risk reduction strategies are far less urgent than they had been in the past. This "take a pill and everything will be fine" mindset combined with a new generation of "risk takers" who never experienced the devastation of the first decades of HIV and AIDS are but one of the challenges facing prevention educators today. We have to repackage condom usage messages to a whole new generation of sexually active adults and teenagers while at the same time refreshing the message for those who have become exhausted by the constant call to practice safe sex. .

Mr. Hunt: So you are saying we need to change the message? If you say 'use a condom, use a condom, use a condom....' after a while that just becomes redundant and ineffective.

Mr. DeStefano: Let me give you an example - the Department funded a public information campaign called "Bring Your Own Condom or -- BYOC". Instead of saying "use a condom every time," there was a tag line on the materials that said "HIV - You Know How To Prevent It" The campaign spoke to people about self-efficacy and its relationship to risk reduction behaviors. Using a fashion photographer, we created a sexy and edgy campaign using young, attractive Latino and African American people to reach our primary target of Black and Latino MSM, and Black and Latina heterosexual women. The one ad I particularly like, one of the MSM posters, showed two men in the rain holding an

umbrella. The umbrella was a symbol of both partners protecting each other. People really liked the subtlety of the message. Aside from subway and bus stop shelter posters, we enhanced the campaign with incentive items like umbrellas, bags and condom packs with the "BYOC" logo. As with many advertising campaigns it is difficult to measure behavior change, but I can tell you that the popularity of those incentive items and materials spoke to the appeal of the message.

Dr. Keane: It seems like younger people are being hit hard in the "new infections" category. What is being done about that? How do we understand the fact that younger people who haven't been around long enough to be burnt out on prevention messages are exposing themselves?

Mr. Park: Yes it is true, the rates of new HIV infections among young gay men, particularly young gay men of color, are far higher than they are in other populations. As someone who is living with HIV it is troubling to me that anyone today would

become infected -- as a gay man witnessing HIV infections in a younger generation of gay men I feel a special sense of responsibility to provide the tools my community needs to stay safe. How do we do that? As I've said before we need to package our prevention messages in a way that appeals to a generation of people whose view of HIV and AIDS is very different from what it was ten years ago. We need to engage young people in crafting relevant messages - vetting them if you will with those to whom they will be aimed. Another approach the Department has taken is working with the Department of Education in its efforts to update the City's sexual health education curriculum including making it current for today's youth. When it comes to sexual health, self-esteem issues go hand-in-hand with a choice of abstinence or sexual activities. This is very much at the intersection of HIV and mental health, and emphasizes that a person's state of mind is an invaluable step towards safe sex behavior and risk reduction strategies.

Additional excerpts from this discussion will be continued in Winter 2004 edition of the FAMHA newsletter.

EROTICIZING SAFER SEX: A TRAINING DESIGN TO HELP AVOID RISK REDUCTION BURNOUT

Submitted by: Bobra Fyne, MSA, CSW

For the past two decades, people with and without disabilities have faced the daunting task of keeping themselves safe from HIV infection. No matter how we look at it, 20 years of hypervigilance has been experienced in various populations as exhausting. For many people, whether faced with cognitive disabilities or not, sex went from being something that was spontaneous, natural and just plain fun to being something that some might describe as planned, rigid and perhaps just plain boring.

One of the more difficult tasks of HIV prevention specialists has become not only spreading the message of safer practices but also helping people explore the myriad of ways to make safer sex fun again. The populations of interest in this article are people with mental retardation and other developmental disabilities (MR/DD), as well as those who have developmental disabilities along with co-occurring mental illness. Finding ways of keeping these special populations safer from HIV infection despite their weariness of risk reduction

(continued on page 4)

NEWS YOU CAN USE

WHO IS PRACTICING HIV RISK REDUCTION (SAFER SEX, SAFER INJECTION DRUG USE)?

Anderson et al. (2003) investigated the HIV risk behaviors of adolescents and adults as reported in five nation-wide studies: National Health Interview Survey, National Survey of Family Growth, Youth Risk Behavior Survey, General Social Survey, Pregnancy Risk Assessment Monitoring System. All studies had large numbers of subjects. Each tracked participants' risk behaviors over time, some from as early as 1988 to the present. Anderson and colleagues reported on condom use, dual use of condoms with other contraceptive methods, and HIV testing.

The Centers for Disease Control and Prevention's ([CDC], 2004) most recent HIV/AIDS Special Surveillance Report 5 examined HIV risk behaviors among three high risk populations: MSM recruited at gay bars, IDUs recruited through street outreach or at needle exchange programs (NEPs), and high-risk heterosexual adults (HRHs) recruited at sexually transmitted disease (STD) clinics. This report also surveyed injection equipment sharing as well as sexual behavior in IDUs. This report classified protective behaviors as being practiced "always," "sometimes," or "never." As with Anderson et al. (2003), the CDC report distinguished between risk behavior with regular partners vs. that with non-regular partners.

(continued on page 6)

EROTICIZING SAFER SEX: A TRAINING DESIGN TO

(continued from page 3)

behaviors is an ever evolving challenge as the epidemic continues. Weariness comes not only in the form of hearing the words safer sex over and over and over again, but having to practice safer sex again and again and again and again.

As a young HIV educator in the 1980s, I began speaking with women from a variety of cultures and differing sexual orientations about how they kept the spark in their sex lives while remaining safe from HIV infection. Their ability to have fulfilling sexual experiences delighted them, as I'm sure it did their partners. They were using food coloring to decorate each other's bodies with hand painted lingerie as well as using food coloring to paint pictures on their dental dams and condoms. They were calling their partners' answering machines and leaving luscious, passion-filled messages about what their evening would hold. Their ideas seemed filled with lustful imagination, and it occurred to me that perhaps this is an important ingredient in the fight against safer sex burnout. I remember feeling that I myself was having difficulty tapping into a lustful imagination. So how could I teach people with MR/DD, as well as those who have MR/DD and co-occurring mental illness, about something that I was having difficulty navigating myself?

It was then that I attended a workshop on HIV/AIDS for the transgendered community. There I participated in an exercise that bridged the gap. I have used this exercise for years with people with MR/DD, or with anyone who, like me at times, does not have the energy, the requisite skills, or the opportunity to practice at being creative when it comes to safer sex.

In the spirit of those imaginative, lusty ladies that I spoke with so many years ago, I would like to share with you the Five Senses Exercise.

This is an exercise to be done with a group but can be lots of fun if played by two people.

Using five large sheets of newsprint paper, list one of the senses on each sheet. Separate the larger group into five smaller groups. Each group gets a sheet, with a sense on it. When the facilitators say "GO" each group will have one minute to write down as many erotic, safe, sexy things that have to do specifically with the sense written on their paper. For example if the sense is "taste," they might write "whipped cream," but "stripping" would not belong on their list. Stripping might go on the paper with the sense "sight" written on it. People should be as spontaneous as they can be without editing themselves. The exercise is experienced as more fun and the yield more interesting when one's imagination is not censored. After 60 seconds the facilitator will call time and each group passes their sheet to the group on their left. Participants now have 60 seconds to add to the sheet they've just been passed. After 60 seconds the facilitator will call time and each group passes their sheet to the group on their left. They now have 60 seconds to add to this sheet. Continue until each group has had a chance to add to all of the senses.

These now get posted on the wall, one right next to the other. At random, have a group pick one item from each sense list that they will blend together to make a safe, hot, fun experience.

For example:

<u>Sight</u>	<u>Sound</u>	<u>Smell</u>
Striptease	Music	Perfume
Porn	Whispers	Candles
Lingerie	Squeaky bed	Sweat

HELP AVOID RISK REDUCTION BURNOUT

If the group chooses Striptease, Whispers, Candles, Sweat, Feathers the facilitator (or volunteer) might create an experience such as: You open the door to your home and the first thing you notice is the path of lit candles that leads to the bed. Your partner is there and as you enter the room he/she begins to do a striptease for you. He/she approaches you and you can smell his/her sweat, a scent that always excites you. Your partner begins to undress you and then run a feather boa along your flesh as he/she whispers in your ear what you can expect next.

The group can select another random five choices and the experience continues. As you can see, even with only three items in each category, you can mix and match these for quite an evening filled with fun. Everything is safe. This is not to say that these behaviors replace penetrative sex, although many people who do choose to have non-penetrative sex report not getting bored. However, if there is to be penetration, using a male or female condom may not seem like such a big deal.

Despite some lingering taboos around talking about sex, I have found that audiences relish the opportunity to struggle with the language of sex in a group and to play in an open, safe environment. It is, of course, important that the trainers remain open to the wide range of responses and

combinations that a group may generate. The Five Senses Exercise is a useful training exercise for audiences comprised of people with disabilities, people with disabilities and mental illness, or just about anybody who might need some help in the area of eroticizing safer sex. By thinking about safer sex as incorporating something to

stimulate each sense, those of us with less than lustful imaginations can begin to train ourselves to think outside the bed.

Bobra Fyne, LMSW, CSW is the Supervisor of the AIDS Education Program at Young Adult Institute, N.Y.C.



Taste

Chocolate

Champagne

Sweat

Touch

Feathers

Massage

Spanking

NEWS YOU CAN USE

The following are some general findings:

Condom Use:

- Adolescents increased their use of condoms from 46.2% in 1991 to 57.9% in 2001. (Anderson et al., 2003)
- For adults, there were differences between frequency of condom use with regular partners vs. non-regular sexual partners:

Regular Partners:

- Anderson et al. (2003) found that with regular partners, condom use was generally much less frequent than with non-regular partners. There was “no observed increase in condom use overall by adults since the mid-1990s...”
- **High-Risk Heterosexuals (including IDUs):** The CDC reported that 60% HRH men used condoms with their primary partners either “sometimes” (52%) or always (8%). Women used condoms with their primary partners either “sometimes” (50%) or “always” (9%). (CDC, 2004, p. 26)
- **MSMs:** The CDC reported that 74% MSMs used condoms for receptive anal intercourse with their primary partners either “sometimes” (39%) or always (35%). 75% used condoms for insertive anal intercourse with their primary partners, sometimes (38%) or always (37%). (CDC, 2004, p. 21-22)

Non-Regular Partners:

With non-regular partners, Anderson et al. (2003) reported that condom use increased from 52.1% in 1996 to 68.5% in 2001.

(continued on page 8)

Risk reduction burnout: *Where do we go from here?*

(continued from page 1)

men (MSM) underscores the difficulty of sustaining behavior change over a lifetime in any population (CDC, 2001). For example, the CDC report (2001) states that twenty years into the HIV epidemic, many older gay men who had adopted safer sex practices in response to the initial health crisis are finding it difficult to maintain these practices over the course of a lifetime. Another at-risk group are young people. People under the age of 25 may account for as many as 50% of the new cases of HIV infection that occur each year in the United States. Finally, in cases of AIDS, heterosexual transmission increased from 5% of AIDS cases in 1983 to 28% in 2001 (Osmond, 2003).

Evidence of risk reduction burnout comes from epidemiological data. Within the last seven years, sexually transmitted diseases (STDs) and HIV infections have been on the rise. Among the many reports, the CDC's Morbidity and Mortality Weekly Report (2001), revealed a dramatic rise in new infections among men who have sex with men as well as a high increase in STDs rates. In San Francisco, the health department reported that the new infection rate among MSM has jumped from 1.3 percent of those tested in 1997 to 3.7 percent in 1999. Similarly, an increase in syphilis infections among gay and bisexual men in New York and elsewhere indicates that they may be letting their guard down. According to the CDC, this increase in infection rate suggests that men may be abandoning safe sex practices in part because of life extending HAART treatment drugs that are now widely available. It seems clear that earlier efforts to decrease HIV transmission vis-à-vis safer sex practices and other prevention skills are being abandoned and an attitude of complacency may be taking hold.

A number of variables have been posited to explain higher rates of new HIV infections across populations. Studies have shown that the use of drugs and alcohol increase the likelihood of risky sexual behavior that may predispose one to HIV infection. Factors which have been associated with risky behavior in injecting drug users (IDUs) include a lack of knowledge about HIV transmission and prevention, motivational

factors related to HIV prevention, perceptions of low vulnerability to HIV, and lack of requisite behavior skills for engaging in safer injection drug use and sexual practices. Experiencing withdrawal has also been implicated in risky behavior among IDUs (Fisher et al., 1999).

With respect to specific risk factors for IDUs, HIV infection via injection drug use remains one of the highest modes of transmission. This is in spite of the fact that client acceptance rates for syringe/needle exchange programs have been consistently high. For example, in San Francisco it was found that 41% of IDUs surveyed were regular users of needle exchange and 65% had visited it within the past year (Fisher et al., 1999). However, in a study done with Puerto Rican injection drug users, Colon et al. (2001) reported that even though individuals are not sharing needles, they are sharing drug preparation materials. This includes use of a single syringe to mix, divide, and distribute injectable drugs (back loading/frontloading). Hence, while the practice of shared use of syringes decreases with legal access to syringes, drug preparation risk behaviors remain a significant problem.

The literature supports the contention that drug use has also played a role in the sexual lives of some MSM. In recent years, particular drugs (including crystal methamphetamine) have become popular among some MSM. Substantial drug use occurs during gay “circuit parties.” In a survey done in San Francisco with gay and bisexual men, half of the respondents reported having unprotected anal sex during circuit parties (CDC, 2001). A significant association has also been reported between drug use and unsafe sexual activity in men who have sex with men (Ross et al., 2001). Studies done in HIV-positive MSM with a drug history showed that in addition to biological factors (e.g., addiction, etc.) fear of stigma (e.g., rejection, abuse) from sexual or needle sharing partners was a major factor in continuing to practice risky behaviors (Fisher et al., 1999).

The reasons for risk reduction burnout or resistance to safer sex messages may be different in each population and may overlap in some cases. Researchers at Johns Hopkins have posited that because HIV disease, drug use and sexual transmission are interrelated, the social interaction

makes intervention difficult and dependent on an understanding of the driving forces for the risk behaviors (John Hopkins AIDS Service, 2004).

Examination of some of the possible reasons for the increase of complacency is in order. HIV/AIDS complacency is defined as minimizing, discounting, or discrediting the threat of HIV/AIDS. This is related to the notion of safer behavior fatigue. Behavior fatigue can be defined as decreased vigilance toward maintaining safer sexual and drug-related behaviors (Valdiserri, 2004). As stated above, increased sexual risk taking might be associated with years of exposure to prevention messages and long term efforts to maintain safer sex practices (Wolitski, et al., 2001). After two decades of HIV/AIDS, prevention messages about safer sex have remained essentially the same. Initially, the use of condoms was considered a short-term strategy because people were not living as long as they are today. Longer term strategies and messages have yet to be developed.

Another possible way to understand complacency is that young gay men have not seen the devastation of the disease when there were no or few treatments available, and the older men may be under the influence of 'prevention burnout' or fatigue. For example, Shernoff (2003) described the reasons why a 29 year old client forgoes condom use: "I know intellectually that condomless sex is wrong, but today AIDS simply doesn't seem to be a big deal. I hear my gay uncle who's in his 50s that in the early days of the epidemic, it was common to see prematurely aged gay men in wheelchairs, covered with lesions, or who looked like they'd just come out of Dachau. I've never knowingly seen anyone who was seriously ill with AIDS. This fact contributes to the reason I'm not as afraid of contracting HIV as I should be and am not always careful sexually."

Another subgroup that has gained significant recognition is the "non-gay identified" MSMs who discretely have sex with men but are also in sexual relationships with women. This population of MSMs, sometimes called men on the down low (DL), represents a challenge with respect to prevention messages because they do not identify as gay or bisexual and their female partners are

not aware that they have sex with men. One publication (NASTAD, 2002) put forth a set of recommendations regarding attempts to engage this population. Among them was the need to develop interventions that requires the least amount of self disclosure. In addition, men on the DL need a safe place to disclose and explore their sexual practices. Finally, HIV prevention programs need to include indigenous expertise among 'non-gay' identified MSMs.

Prevention Messages

As stated above, prevention messages are years old. Even when prevention strategies became more abundant and effective, gaps in the messages remained. With the changing trend of the disease, the prevention messages have failed to address those changes within specific at-risk populations and subcultures. For example, choosing receptive versus insertive anal intercourse is being used as a harm reduction strategy in reducing HIV transmission or re-infection among HIV-positive and HIV negative MSMs (Johns Hopkins AIDS Service, 2004). Some people perceive HIV disease as a manageable one because healthcare providers may be giving mixed messages about contracting the disease and treatment options. On the one hand, they are told to reduce the risk of becoming infected with HIV, and on the other hand they are told that if you contract the virus it can be treated effectively (Olufs, 2001). There has also been speculation that pharmaceutical advertisements minimize the negative aspects of HIV infection and HAART with unrealistic portrayals of HIV sero-positive individuals. In addition, the disease has now moved into the chronic disease category because people are living longer and the mortality rate of death from AIDS related illnesses has decreased significantly.

There is increased interest in prevention of the spread of HIV among those who are already HIV+. This should continue to be a priority.

(continued on page 8)



NEWS YOU CAN USE

■ **High-Risk Heterosexuals (including IDUs):** The CDC (2004) reported that 84% HRH men used condoms with their non-primary partners either “sometimes” (52%) or always (32%). 76% of women used condoms with their non-primary partners either “sometimes” (38%) or “always” (38%).

■ **MSMs:** 88% MSMs used condoms for receptive anal intercourse with their other partners either “sometimes” (33%) or always (58%). 91% MSMs used condoms for insertive anal intercourse with their other partners either “sometimes” (34%) or always (57%). (CDC, 2004, p. 21-22)

HIV Testing: (Anderson et al., 2003).

■ “By 2001 a high percentage of US adults reported having been tested at least once, and reproductive-age and pregnant women were tested at a greater rate than other groups” “Persons who were at increased risk for HIV or who believed they had a high or medium chance of becoming infected had a substantially higher rate of testing, as did black respondents and persons below the poverty level.”

■ **High Risk MSMs and IDUs:** 88% reported having “ever been tested” for HIV. 75% had an HIV test in the 12 months before their interview.

■ **High-Risk Heterosexual Adults:** 73% reported having “ever been tested” for HIV. 56% had an HIV test in the 12 months before their interview.

(continued on page 10)

Risk reduction burnout: *Where do we go from here?*

(continued from page 7)

However, interventions for HIV infected individuals require a detailed understanding of the cultural context of HIV today including knowledge about behavioral patterns of the HIV positive individual. The notion that HIV is a manageable disease has created a paradigm shift in people's attitudes and behaviors towards contracting HIV. HIV positive individuals on HAART may over rely on being less infectious due to a lower viral load which may lead to a conclusion that HIV is not life threatening and to the minimization of the need for safer sex and risk reducing practices (Valdeserri, 2004).

In summary, the face of HIV disease has changed. The redundancy in safer sex messages has an impact on the individual's beliefs and attitudes about using risk reduction interventions. Prevention messages must change. A blanket prevention message will not be effective over the long haul. Prevention messages need to be targeted for specific populations at risk. Moreover, the cultural and socio-demographic needs of emerging high-risk groups require messages and interventions that differ from those used two decades ago. Today, a person with AIDS is more likely than ever to be African American, Latino, or female. There is also an increase in new infections in adolescents and young people. As HIV infection increase among adolescents, the idea that prevention messages have lost their impact is evident. Olufs (2001) describes discussions related to safer sex with several young students who stated how tired they were of hearing about HIV. In fact, AIDS has been around longer than they have been alive and the historical context of the disease is not something they identify with.

Conclusions

People with HIV/AIDS are living longer, healthier lives and now have to contend with practicing safer sex practices for a lifetime instead of a short time. After hearing the same prevention messages for more than two decades, infected and uninfected persons may have become inured to prevention messages and are engaging in high-risk behavior. High rates of new HIV infections are due in part to this risk reduction burnout or fatigue. Accordingly, prevention messages directed toward uninfected and HIV-infected individuals need re-examination. Advances in HIV treatment and care due to HAART optimism may be contributing to an

attitude of complacency when it comes to HIV/AIDS prevention. This treatment optimism has given many people a false sense of security regarding the threat of HIV transmission. Alcohol and other drug use, as well as the dynamics of shame and guilt, are important contributing factors to high-risk behavior. To alleviate the effects of risk reduction burnout, prevention messages must reflect changes in the perceptions of the disease and must include renewed prevention efforts for HIV+ individuals, as well as addressing the changing needs within specific at-risk populations and subcultures.

Nadine Ranger, M.S., is Director of Clinical Services, Brooklyn AIDS Task Force. Glenda Hastay, M.P.A., is Director of Education, Brooklyn AIDS Task Force.

REFERENCES

- Centers for Disease Control** (2003) In No Turning Back- Addressing the HIV crisis among MSM. Retrieved November 20, 2004, from <http://www.thebody.com>
- Colon, H. et al.**, (2001). Joint drug purchasers and drug preparation risks among Puerto Rican injection drug users. *AIDS and Behavior*, (5)1, 85-96.
- Fisher, J.D., et al.**, (1999). Dynamics of HIV risk behavior in HIV-infected injection users. *AIDS and Behavior*, (3)1, 41-57.
- HRSA Care Action**, (2003). Prevention is treatment: Prevention with positives in clinical care. Providing HIV/AIDS care in a changing environment.
- John Hopkins AIDS Services** (2004). In Challenges and Barriers to Implementation of HIV Efforts. Retrieved November 20, 2004, from www.hopkins-aids.edu.
- National Alliance of State and Territorial AIDS Directors** (NASTAD). 2003. In *HIV Prevention Bulletin: Focus on MSM Issues*.
- Olufs, C.** (2001). *The Body: Women Alive. Prevention for Positive: What is it?*
- Osmond, D.H.** (2003). Epidemiology of HIV/AIDS in the United States. In *HIVInsite knowledge Base chapter*. Retrieved November 20, 2004 <http://hivinsite.ucsf.edu/InSite>
- Ross, M., Rosser, B., Simon, S. et al.** (2001). Unsafe sexual behavior and internalized homonegativity in men who have sex with men. *AIDS and Behavior*, (5)1, 97-103.
- Shernoff, M.** (2003). Gay men and unsafe sex beyond a knee jerk reaction. *Social Work Today*, (3)17.
- Valdiserri, R.O.** (2004). Mapping the roots of HIV/AIDS complacency: Implications for program and policy development. *AIDS Education and Prevention*, (16)5, 426-439.
- Wolitski, R., Valdiserri, R., Denny, P. & Levine, W.** (2001). Are we headed for a resurgence of the HIV epidemic among men who have sex with men? *American Journal of Public Health*, (91)6, 883-888.

COUNCIL ON SOCIAL WORK
EDUCATION
51ST ANNUAL PROGRAM MEETING

"One World, Many Cultures, New Challenges"

02/26/2005-03/01/2005

New York, NY

Sponsor: Council on Social Work Education
[CSWE] in association with the 3rd National
Gerontological Social Work Conference.

Council on Social Work Education

1725 Duke Street

Suite 500

Alexandria, VA 22314

Contact: 703/683-8080

703/683-8099 fax

Website: info@cswe.org

THE 2005 NATIONAL CONFERENCE
ON AFRICAN-AMERICANS AND AIDS
02/28/05-03/01/05

Philadelphia, PA

Location: The Philadelphia Wyndham

Franklin Plaza Hotel.

Contact: 866-901-6267

Website: www.minority-healthcare.com

This is a Continuing Medical Education and
CEU accredited course that includes all facets
of clinical management of HIV infected African-
Americans, while focusing on the impact the
HIV epidemic has on the African-American
Community at Large. Registration is \$90 and
includes breakfast and lunch each day. CME
and CEU certificates are included.

Speaker Highlights

- Rev. Jesse Jackson
- Phill Wilson (The Black AIDS Institute)
- Beny J. Primm MD
(Chairman, National Minority AIDS Council)
- Jonathan Zenilman MD
(Johns Hopkins University Hospital/STD)
- Celia Maxwell MD
(Howard University/Womens Health)
- Daniel Alvarez, MD
(Drexel University/HIV/AIDS Medicine)

and much more

UPCOMING EVENTS

THE SOCIETY FOR THE SCIENTIFIC
STUDY OF SEXUALITY WESTERN
REGION MEETING

*Unstudied, Understudied & Underserved Sexual
Communities - New Areas for Research,
Education and Therapy*

05/05/2005-05/8/2005

San Francisco, Ca

Hyatt Fisherman's Wharf

Contact: David Fleming (610) 530-2483

P.O. Box 416

Allentown, PA 18105-0416 U.S.A.

e-mail: thesociety@inetmail.att.net

AMERICAN PSYCHOLOGICAL
SOCIETY

17th Annual Convention

05/26/2005-05/29/2005

Los Angeles, California

Contact: The Convention Department

202 783-2077

Keynote Speaker: Steven Pinker,

Harvard University,

author of The Blank Slate

Website: www.psychologicalscience.org/convention/

17TH ANNUAL NATIONAL
CONFERENCE ON SOCIAL WORK
AND HIV/AIDS

05/28/2005-05/31/2005

Chicago, IL

The theme for this year's conference is the
global impact of the epidemic.

Contact: For more information on submitting
an abstract contact Dr. Vincent J. Lynch,
Conference Chair, @ lynchv@bc.edu or
(617) 552-4038.

Deadline Abstracts is December 17, 2004

ASSOCIATION OF BLACK
PSYCHOLOGISTS

The 37th ABPsi Annual International Convention

08/9/2005-08/14/2005

Miami Beach, FL

Location: The Eden Roc,

Renaissance Resort & Spa

Website: www.abpsi.org/

AMERICAN PSYCHOLOGICAL
ASSOCIATION

113th Annual Convention

08/18/2005-08/21/2005

Washington, DC

Contact: 202-336-6020

convention@apa.org

Website: www.apa.org/convention05/

PSYCH EVENTS

www.umdj.edu/psyevnts/eventloc.NY.html

Psychwatch.com

Mental Health Conference Listings

www.psychwatch.com/conference_page.htm

Netlib Conference Database List

http://www.netlib.org/confdb/conf_list.html

NEWS YOU CAN USE

Injection Drug Risk Behavior: (Anderson et al., 2003)

■ **Needle Sharing:**

- 67% reported never sharing needles
- 31% reported sharing needles.

■ **Needle Precautions:** 67% reported using bleach either:

- Sometimes: 48%
- Always: 19%

WHAT ARE PEOPLE WITH HIV/AIDS DOING?

Weinhardt et al. (2004) reported on interviews of **3,723 people with HIV infection**. The participants were 1,918 men who have sex with men (MSM), 978 women, and 827 heterosexual men. The researchers asked the participants about their HIV-related sexual and drug taking behavior. They asked about frequency of unsafe sex, of unsafe sex with an HIV-negative partner, needle sharing behavior, and disclosure of HIV status to their partners. The primary findings follow:

Unsafe Sex:

- **Any Unsafe Sex:** During the 3 months before the interview:
- **MSM:** 44.7% said that they had engaged in unprotected anal intercourse;
- **Women:** 36.5%, said that they had engaged in unprotected anal or vaginal intercourse;
- **Heterosexual men:** 34% said that they had engaged in unprotected anal or vaginal intercourse.
- **IDUs:** 52% reported having engaged in unprotected anal or vaginal intercourse.

Unsafe Sex with HIV-Negative Partner:

- **MSM:** 15.6% engaged in unprotected vaginal or anal intercourse with partners who were HIV-negative or whose serostatus was unknown
- **Women:** 19% engaged in unprotected vaginal or anal intercourse with partners who were HIV-negative or whose serostatus was unknown
- **Heterosexual Men:** 13.1% engaged in unprotected vaginal or anal intercourse with partners who were HIV-negative or whose serostatus was unknown.
- **IDUs:** 18.7% engaged in unprotected vaginal or anal intercourse with partners who were HIV-negative or whose serostatus was unknown

Needle Sharing:

- Between 15.4% and 19.1% of IDUs reported having shared their needles with someone else in the 3 months prior to the interview..

Disclosure of HIV-Positive Status to Sexual Partner:

Weinhardt et al. (2004) reported that "Overall, the majority of participants reported disclosing their serostatus to all their sexual partners (Table 4)." The research team measured "disclosure" by "the most unambiguous measure of disclosure: directly telling the partner." Below is a breakdown of the disclosure behavior of the various groups:

■ **MSMs:**

- Disclosed Status to all partners: 53.5%
- Disclosed status to HIV-Positive Partners: 57.9%
- Disclosed Status to HIV-Negative and Unknown Partners: 47.7%

■ **Women:**

- Disclosed Status to all partners: 68.1%

- Disclosed status to HIV-Positive Partners: 62%
 - Disclosed Status to HIV-Negative and Unknown Partners: 68.6%
- #### ■ **Heterosexual Men:**
- Disclosed Status to all partners: 61.5%
 - Disclosed status to HIV-Positive Partners: 58.4%
 - Disclosed Status to HIV-Negative and Unknown Partners: 62.9%

According to the authors, these results may actually underestimate the frequency of disclosure of HIV-positive status. The authors commented that there were other ways of indicating that the sexual partners of the subjects knew the subjects' HIV status that were not scored as "disclosure." For example, some met their partners at HIV-positive support groups. Given their use of "directly telling the partner" as the measure of disclosure, the researchers state that "these disclosure rates are likely conservative, because additional partners were undoubtedly aware of the participant's HIV status through the other means described."

REFERENCES

- Anderson, J.E., Santelli, J., & Mugalla, C.** (2004). Changes in HIV-related preventive behavior in the US population. *Journal of Acquired Immune Deficiency Syndrome*, 34(2).
- Centers for Disease Control.** (2004). 2004 National STD Prevention Conference: *Summaries of highlighted research*. Retrieved November 21, 2004, from www.cdc.gov/std/2004STDConf/mediarelease/researchsummaries.htm
- Centers for Disease Control and Prevention.** (2002). HIV Testing Survey.
- U.S. Department of Health and Human Services.** (2004). *HIV/AIDS Special Surveillance Report 5*. Atlanta, GA.
- Weinhardt, L., Kelly, J., Brondino, M., Rotheram-Borus, M., Kirshenbaum, S., et al.** (2004) HIV transmission risk behavior among men and women living with HIV in 4 cities in the United States. *Journal of Acquired Immune Deficiency Syndrome*, 36(5):1057-1066.

A Letter from the Editor

(continued from page 1)

while continuing to have sex with women. This subgroup presents serious challenges for those who are attempting to reach them with prevention messages.

Another group who remains at high-risk are young people. Of the 40,000 cases of new HIV infection that occurs every year in the U.S., as many as 50% of these infections may be among young people under the age of 25, and as many as 25% may be among people under the age of 22 (CDC, 1998). A noteworthy study reported by the CDC in 2001 showed that approximately one in seven young gay men (15%) are infected each year and that the new infection rate for all urban gay young men was as high as it was at the peak of the epidemic in the 1980s. In the year 2000, 59% of reported HIV infections among adolescent males aged 13-19 and 53% of reported HIV infections among men aged 20-24 were attributed to male-to-male sexual contact. These statistics are alarming because of the longevity of the multiple burdens that come with HIV as it has transitioned into a chronic condition. Finally, HIV infection contracted through heterosexual sex continues to pose a problem for program developers and policy makers. Cases of AIDS attributed to heterosexual transmission increased from 5% of cases in 1983 to 28% of cases in 2001 (Osmond, 2003).

The lead article in the current FAMHA newsletter examines the problem with prevention messages as they are evolving and what variables are making an impact on behaviors that are associated with HIV infection across at-risk populations. It was contributed by Nadine Ranger and Glenda Hasty of the Brooklyn AIDS Task Force. Bobra Fyne, our colleague at YAI, has written an article outlining a training design to help consumers maintain safer sex practices while keeping sex exciting and spontaneous. The design is useful for populations with or without cognitive deficits. We are also pleased to include a conversation with representatives from the Department of Health and Mental Hygiene, Drs. Lloyd Sederer and Andrew Kododny in the Mental Hygiene division with Jan Carl Park and George DeStefano from the HIV Policy and Prevention Bureau. The conversation focuses on defining the factors that can lead to Risk Reduction Fatigue, Burnout or Complacency, populations at risk and initiatives to help specific populations develop and maintain healthier choices while reducing relapse into riskier behaviors. We learn of several collaborative projects within DOHMH which draw upon expertise within the divisions. This interview will be presented in this issue and the next.

The FAMHA newsletter is a quarterly publication which seeks to provide education and information on topics in mental health for providers who

serve people with HIV/AIDS (PWHAs). It is funded by the New York City Department of Health and Mental Hygiene. In our next issue, we will focus on the topic of long term survival with HIV/AIDS. We hope you will enjoy reading the Fall 2004 edition of the FAMHA newsletter. We welcome any feedback or suggestions on how we can make the newsletter more useful for you. Please send correspondence to tim@cicatelli.org.

Sincerely,



Correction: The article "Mental Retardation and Mental Illness: A Dual Diagnosis Often Overlooked" on page 3 of the Summer 2004 issue inadvertently mentioned the authors incorrectly. The authors are: Luis R. Torres, MA, PhD Candidate and Bobra Fyne, MSA, CSW. For use as a reference, the correct citation is:

Torres, L. R. & Fyne, B. (2004, Summer). Mental Retardation and Mental Illness: A Dual Diagnosis Often Overlooked. In Five Borough AIDS Mental Health Alliance, A Quarterly Publication. Volume 6, Number 3 (Summer 2004). New York: Cicatelli Associates Inc.

5

THE FIVE BOROUGH AIDS MENTAL HEALTH ALLIANCE (FAMHA) is an educational project managed by Cicatelli Associates Inc. (CAI) and funded by the New York City Department of Health and Mental Hygiene. The project's mission is to provide training and technical assistance on subjects related to HIV/AIDS mental health including such topics as assessment and treatment of co-occurring mental health and substance use problems. A wide array of training and technical assistance programs is available for agencies providing services to people living with HIV/AIDS. Readers may request programs by completing the application for training form on the back cover of the newsletter and returning it to CAI. **For further information, please contact behavioralhealth@cicatelli.org.**



5 FAMHA Service Needs Assessment

To request a FAMHA program for your agency/organization, complete the following needs assessment and submit it by mail or fax to:

Cicatelli Associates Inc. • 505 Eighth Avenue, Suite 1601 • New York, NY 10018
phone: (212) 594-7741 • fax: (212) 629-3321 • e-mail: tim@cicatelli.org

Name _____

Agency/Organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ E-mail _____

Desired Training Day(s)/Time(s) _____ Anticipated Audience Size _____

Attending Disciplines

(check all that apply)

- Clergy
- Counseling
- Marriage/Family Therapy
- Medicine
- Nursing
- Psychiatry
- Psychology
- Social Work
- Case Management
- Other (please identify):

Desired Training Format

(check all that apply)

- Grand Rounds
- Interactive Small Group
- Lecture

Desired Training Topic

(check all that apply)

- Treatment Update/Adherence Issues
- Harm Reduction Strategies
- Management for Active Substance Abusers

- Case Management for HIV-Infected Clients
- Issues Relevant to Culturally Competent Service Delivery
- Family-Focused Mental Health Services
- HIV Pre/Post-Test Counseling
- Building HIV Support Groups
- Stress Management
- Boundaries and Countertransference
- Suicide Assessment and Prevention

Technical Assistance:

Face-to-Face Skill Building/ Consultation with Agencies

(check all that apply)

- Making Referrals
- Cultural Diversity
- Behavior Change Models
- Human Resource Development
- Infrastructure Building
- Managed Care
- Implementation of Risk Reduction Groups in MICA Programming

- Special Needs Plans
- Condom Procurement for Clients on Medicaid
- Stress Reduction (Support Group Facilitation)
- Case Conference