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HEALTH PSYCHOLOGY | RESEARCH ARTICLE

Improving health and coping of gay men who live with HIV: A case study of the “Healthy Relationships” program in Mexico

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Abstract: The object of the study was to analyze the participants response to the issues addressed in the “Healthy Relationships” program applied to a population of HIV-infected gay men in Mexico. This program referred to the obstacles of active coping, mainly (1) revelation of diagnosis to family, friends, and sexual partner and (2) practice of safe sex. Moreover, the goal of the intervention was to gain understanding of the specific needs of participants within the Mexican context in regard to the program’s content, with the ultimate goal of enabling the development of health services that address the specific needs of HIV-infected gay men in Mexico. The findings of the study showed that participants considered themselves to be subject to a double stigma, due to their sexual orientation and emotional state. The study concludes with proposed strategies to develop appropriate health services, such as (a) offer support to patient; (b) recognize their need for emotional companionship; (c) promote safe sex; and, (d) take into account the different degrees of social vulnerability among patients, in an effort to help them deal better with their illness.

Subjects: Social Sciences; Behavioral Sciences; Health and Social Care

Keywords: gay men; HIV; intervention; stigma; discrimination; revealing diagnoses; safe sex

1. Introduction

In 2014, it was estimated that some 180,000 adults were living with HIV in Mexico, with a higher prevalence of men being infected compared to women (ratio 3:1) (National Centre for the Prevention

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PUBLIC INTEREST STATEMENT

Gay men living with HIV in Mexico are subjected to a double stigmatization due to their illness and their sexual orientation. This research overviewed the impact of a public health program that promoted coping abilities and safe sex practices among HIV patients in an urban setting. During the implementation of the program, we were able to identify that patients dealt with feelings of shame and guilt, which as a result made it hard for them to sustain healthy relationships with family and friends. The research proposed strategies that promoted emotional support, recognized their need for companionship, and promoted safe sex practices. Overall, this research suggests that it is important to consider the mental health and social experiences of people living with HIV when developing public healthcare interventions.

and Control of AIDS, 2015, p. 30). Of these men, it was reported that at least 70% had been transmitted with the illness through the epidemiological concept known as “men that have sex with men” (MSM). This category includes gay, transgendered, or bisexual men and those who have sex with men but do not consider themselves homosexuals. Because of this high prevalence, there is an urgent need to construct strategies for primary prevention that will help decrease the number of infections due to sexual transmission through MSM practice. At the same time, however, the health sector must work to develop group and context-specific forms of medical care, designed to respond to the specific needs of this group.

One particularly severe problem that HIV-infected people in Mexico must confront has to do with the stigma and discrimination that are associated with this illness. The sociopolitical situation has changed in comparison with two decades ago, when conservative groups actually supported the violation of the human rights of HIV patients. This improvement is thanks to responses by civil societies and governments that have fostered the construction of institutional mechanisms devised to eradicate discrimination and guarantee universal access to treatment (Diez, 2011; Vela Barba, 2015). Nevertheless, in their daily lives, HIV patients are still victims of stigma and discrimination and still encounter vestiges of inequality. This might force them to either conceal their diagnoses to avoid being discredited in public (Goffman, 1970) or, through revelation of their HIV status, become victims of discriminatory practices in the home, workplace, or community. Other investigations (e.g., Herek & Glunt, 1988; Yi, Sandfort, & Shidlo, 2010) have demonstrated the (double) stigmatization and discrimination that HIV patients encounter. These authors have moreover described the effects that this can have: internalized homophobia (negative attitudes toward one’s own homosexuality and a negative self-image as a gay man) and disengagement coping strategies that orients patients away from their problem (their HIV status). This (among other effects) has often been shown to lead to practicing unsafe sex, and impedes them from revealing their HIV status, which in turn can lead to a situation of isolation and a lack of social support.

Stigma and discrimination are complementary processes. The first phenomenon means a sign or mark. It is often associated with negative attitudes toward people who live with HIV. In the particular case of Mexico’s sociocultural milieu (similar representations have been described in other countries; see: Herek & Glunt, 1988), it appears that a widely shared public opinion relates this illness to death, generates fears of contagion, and links it to moral deviations (Flores-Palacios & De Alba, 2006; Flores-Palacios & Leyva-Flores, 2003). In fact, when a man contracts this infection he is usually relegated to groups that are considered “at risk,” which in the public imagination includes sex workers, addicts who inject drugs, and men who have sex with other men; that is, groups that have been marginalized throughout our history (Aggleton, Parker, & Maluwa, 2003).

Discrimination, in contrast, occurs when such stigmas are acted upon. Generally speaking, it is manifested in rejection, shunning (avoidance), isolation, labeling, unequal treatment, and other forms of violence. Therefore, while stigma is more related to an overall evaluation, discrimination would be its correspondent behavior. Some authors prefer to apply the term discrimination as a function of the severity of the act involved and in relation to international agreements or laws, such as cases of violations of privacy, the obligatory application of HIV tests, firings due to a person’s medical condition, restrictions on mobility, or the absence of a legal framework that prohibits discrimination (Morrison, 2006).

In Mexico, HIV-infected gay men face two interrelated stigmas: one that is associated with their illness and a prior one that refers to their sexual orientation (Parker & Aggleton, 2002). Homosexuality is far from accepted in a social context where the reigning hegemonic masculinities prescribe heterosexuality and sex for the purpose of procreation. Together with the multiplicity of elements involved in constructing the normative male body and its projection in the social space (Prieur, 2008), homophobia emerges as a imposed burden on the moral status of people with HIV, who are forced to live amidst discrimination and rejection at home, at school, at work, and in the community at large, while their illness runs its course (Castro et al., 1998). For these reasons, many gay men opt to

keep their sex life in the shadows, and since sexual activity is clandestine the implementation of preventive measures has proven to be particularly difficult (Nuñez, 2007).

In addition to this, the internalization of these negative attitudes—internalized homophobia—has been shown to lead to disengagement strategies of coping. Active coping (as opposed to disengagement coping) has been defined as “the process of using psychological and behavioral strategies to reduce the potential harm from stressful events” (Folkman, Lazarus, Dunkel-Schetter, DeLongis & Gruen, 1986, quoted in Yi et al., 2010, p. 205). The stressful event in this case is the HIV status and reducing the harm through active coping could be understood as revealing one’s HIV status, seeking social support and medical treatment, and practicing safe sex. In contrast, disengagement coping has been defined as strategies which are oriented away from the problem (HIV infection) (Yi et al., 2010). It has been shown to be related to risky sexual behavior and unwillingness to clarify HIV status which leads to non-diagnosis or a late diagnosis and lack of treatment or later onset of treatment. Moreover, not revealing ones HIV status has been shown to lead to isolation and a lack of a social support system (Yi et al., 2010).

To make matters worse, sex education is still largely restricted in educational spaces due to the conservative forces that operate in Mexico’s sociocultural matrix (Amuchastegui, 2010). This fact reinforces heterosexuality’s hegemonic position and reinforces homophobia and internalized homophobia. Moreover, the lack of sex education and open discussion about HIV can inhibit the personalization of risk by promoting the idea that HIV can only be contracted by “others” who belong to socially marginalized groups. This decreases the use of preventive measures and the possibilities of early detection (Flores-Palacios & De Alba, 2006; Flores-Palacios & Leyva-Flores, 2003).

The internalization of this stigma—in addition to the effect described above—can affect patients’ mental health by causing anxiety, depression and desperation, at the same time as it damages their social relationships because the patient fears infecting others or suffering social rejection if his condition comes to light (Lee, Kochman, & Sikkema, 2002).

Summarizing the processes mentioned above, (double) stigmatization, internalized homophobia, disengagement coping strategies and the risks associated with it can lead HIV-infected gay men to a situation of social vulnerability. This concept refers to the conjuncture of a set of elements in a sociocultural context that increases the risk that patients will suffer some kind of social problem (Stern, 2004). Social problems that have been observed in the case of HIV-infected gay men in Mexico are—among others—: the absence of social support networks, lack of access to the country’s social security system (which offers low-cost health care), scarce opportunities for employment and higher education, and limited access to information, to mention just a few (Flores-Palacios & De Alba, 2006; Flores-Palacios & Leyva-Flores, 2003).

1.1. The “Healthy Relationships” intervention program

“Healthy Relationships” is an intervention designed for use within small groups of people who are living with HIV-AIDS. It was developed by the Medical Center at the University of Southeastern Texas and has been implemented in several centers for disease control and prevention in both the USA and Canada. This program is a product of a research project directed by Seth Kalichman in Atlanta in 1998 (see: Kalichman et al., 2001). The main objective was to reduce participation in high-risk sexual practices by people who are living with HIV.

The primary goal of the “Healthy Relationships” intervention is to develop the cognitive abilities and coping strategies that will make it easier for patients to reveal their diagnoses to family, friends, and sexual partners. Subsequently, patients become more receptive to the adoption of practices involving safe, protected sex. Developing these capacities has been integrated into a sequential process in which the first step is to help the person become aware of the real situation he is confronting. The next objective is to identify the “triggers” that can lead patients to admit their medical condition and begin practicing protected sex, or the “barriers” that may dissuade them from doing

so. The next stage focuses on problem-solving, which is followed by a process of decision-making. The final phase consists of taking concrete actions.

During this intervention, patients carry out three principal activities. First, a technique called “scales of risk” asks participants to indicate—on a lesser-to-greater scale—the degree of risk that revealing their condition to family, friends, and then sexual partners, would generate. After that, they assess the degree of risk involved in a variety of sexual practices.

In the second activity, subjects watch a series of scenes from films that have been selected according to the characteristics of the population and cultural context in which the intervention takes place. Here, the idea is to encourage participants to practice the cognitive abilities and coping strategies, as the excerpts present situations in which the characters portrayed must decide whether to reveal their diagnoses to family, friends, and sexual partners, and then negotiate safe sex practices. The use of these extracts stimulates group discussion while leading patients to identify themselves with the characters on the screen and thus re-signify the stressful events related to their illness. Also, it gives them the opportunity to practice these abilities through role-play, while the facilitators model the use of such abilities.

Later, they participate in an educational activity focused on the correct use of the condom, where the amount of information on safe sex practices and risks that members display is evaluated, as is their dexterity in the use of the condom itself.

Mexico health authorities decided to undertake the “Healthy Relationships” program and implement it to a Mexican population because they were interested in adding sociocognitive components to the health services that HIV patients received. During implementation of the program, the patients expressed how the sociocultural context of Mexico was limiting their capacity to have active coping strategies. It was, therefore, decided that there would be adaptations of the “Healthy relationships” program as it had originally been designed in the USA. These adaptations became the focal point of our study. We assessed context-specific (i.e., Mexican) experiences with (double) stigma and discrimination and its effect on the way that patients cope with their HIV status and the incompatibilities between their needs and the services provided by the Mexican healthcare system. The original American version does not contemplate contextual factors in the intervention procedure because it is based on Bandura’s Social Cognitive Theory (1989), which considers coping strategies to develop on an individual, cognitive level, without regarding the specific context in which these coping strategies develop.

In the Mexican intervention, which is the focus of this study, we opted for a more contextually oriented theoretical approach focusing on the specific significations of the participants and their “lived experiences” (see: Jodelet, 2001). In line with the theory of social representations, the assumption is made that confronting the reality of the HIV infection happens not just on an individual cognitive level, but depends on the local meanings and symbols related to HIV; the construction of which takes place on the interface of an ecologically situated social process and individual cognitive and emotional mechanism (Wagner, Hayes, & Flores, 2011). In other words, the way in which people come to understand and deal with HIV infection is determined by the contextually dependent system of values, beliefs, and practice (Moscovici, 1973). This system of values is a conglomerate of social representations that not only exist in the minds of the individuals, but also between individuals, in their collective talk and action (Wagner et al., 1999).

In the process of adapting this intervention to the Mexican population, it was decided to add an activity in which participants were encouraged to express themselves about living with HIV. This turned out to be a key factor in establishing a degree of group cohesion. Also, it allowed the men to talk about the difficulties involved in the process of confronting this infection, with the result that they identified aspects that were not contemplated in the original intervention but were of great significance.

It is important to point out that when applied in other cultural contexts this intervention has led participants to significantly reduce unprotected sexual practices and increase condom use (Kalichman et al., 2001). Moreover, reports show that patients evaluated the advantages and disadvantages of revealing their HIV diagnoses to family, friends, and sexual partners, and began to practice what they learned about safe sexual practices (Kalichman et al., 2001).

2. Method

2.1. *The intervention*

In the second semester of 2007, a team of Mexican specialists received training at the Dallas Department of Health Care Sciences STD/HIV Behavioral Intervention Training Center based on a recommendation from the National Centre for the Control and Prevention of AIDS (CENSIDA) and with financial support from Mexico's National Science and Technology Council (CONACyT, for its name in Spanish) and the National Autonomous University of Mexico (UNAM, for its name in Spanish).

In the first trimester of 2008, the project was presented to health service authorities in Mexico and the directors of CAPASITS (Ambulatory Centers for Prevention and Attention for AIDS and Sexually Transmitted Infections), where the objectives and methodology of the program were explained. Following the presentation and after certain adjustments were made to the program—in accordance with the characteristics and suggestions of the target population—users of CAPASITS' services were informed of the intervention and invited to participate.

It should be noted that an analysis of the profile of the population was made to assure that all materials used in the sessions were suitable and to select appropriate scenes from different films. To be able to participate in the program, HIV patients could not have been diagnosed with a mental illness or be in the terminal phase of their illness.

The original plan was to hold five, one-hour sessions; however, due to complications such as the distance that patients had to travel from their homes to the health center where research was conducted, the lack of economic resources to pay for transportation, and health problems indirectly related to HIV/AIDS, it was decided to perform the entire intervention on one day in one five-hour session.

Despite these adjustments, the three central areas stipulated in the intervention's Handbook (National Network of Prevention Training Centers, 2004) were respected: (1) revealing their condition to family, friends and (2) sexual partners, and (3) constructing safer sexual relations. Once these areas were covered, it became necessary to extend the session and discuss some emotional aspects of the experience (4).

The number of people in the groups varied from eight to twelve. The research team introduced themselves to the participant group, and the objectives and structure of the session were explained. Then each participant introduced himself, and the rules of confidentiality and respect were explained. Sessions were conducted by two trained moderators, and an observer (a member of the research team) was present to take notes.

2.2. *The study*

2.2.1. *Participants*

Eight HIV-positive homosexual men participated in the program intervention. There was no selection process; they voluntarily registered to the program through an open invitation made by the Secretary of Health. All men were from urban areas and were visiting a primary care clinic specialized in HIV/AIDS. Most participants were single and they aged from 21 to 55. All had jobs, but none were registered in Mexico's Social Security system. Occupations varied: teachers, merchants, employees, etc. In terms of education, most had finished high school or university. All were receiving antiretroviral treatment. Time from diagnosis ranged from 1 to 18 years. Two of the eight

participants in the intervention also participated in a semi-structured interview. In both cases, a member of their social network also took part in the interview because the participant considered the member to play an important role in their ability to cope with the HIV diagnoses. It, therefore, seemed relevant to involve them.

2.3. Procedure

The study was conducted through a qualitative process which included the use of participatory observation, focus groups, and individual interviews as techniques for data collection. An observer (member of the research team) took notes during the program; in particular, significant verbal comments and other significant events were recorded. The notes were transcribed. In addition, two semi-structured interviews were held with two participants and members of their family. The interviewees' participation was voluntary through an open invitation, and there was no selection process. That is why only two interviews were conducted. With the participants' consent, the interviews were recorded. The interviews were transcribed, as well as the transcriptions of the observer's notes. Both served as data for the study. Categories of discussion in the interviews were: (1) receiving the diagnosis, obstacles and facilitating factors to revelation, (2) initiating medical treatment, (3) the influence of stigma and discrimination, and how they cope with this, and (4) their current emotional situation, and how they live and cope with their HIV status in their daily life.

2.4. Technical analysis

Data was analyzed using the NVivo® computer program. This computer program enables the analysis of extensive qualitative data by making the manual ordering, classification and preparation of the data unnecessary. Through the identification and codification of themes, the establishment of relationships among them and the creation of concepts, the program assists in the description of phenomenon and by making adjustments in the development of theories (Trejo, 2009). This analysis was complemented with notes obtained from the observation and conventional interpretation of the meaning of narratives of each participant.

3. Results

Four main categories were found in the expressions of participants, all linked to the principal axes of the intervention: (1) revealing diagnoses to friends and family; (2) revealing one's condition to sexual partners; (3) safe sex; and, (4) other situations that cause stress, including factors that patients felt were relevant to their daily lives, but are not included in the intervention.

3.1. Revealing diagnoses to family and friends

All the participants in the study expressed that there was a significant range of time between knowing about the diagnosis and sharing it with a member of their social network. It was observed that patients found it less stressful to admit their status to networks of close friends than to family members. If revelation was done within the family, the first to find out was usually a sibling, who might then become the patients' main source of support and help him to face up to the reality of the illness. In contrast, revealing their status to other family members often generated more anxiety and stress, especially the father figure, who mainly perceived as the most threatening person in the revelation process.

Reasons that participants mention for avoiding or delaying the revelation of a HIV diagnosis were the fear of the discrimination that HIV patients often experience (first quote), and the anxiety caused by confessing one's sexual orientation to family members (second quote). This is especially difficult in a sociocultural milieu where hegemonic models of masculinity promote heterosexuality, and as a result, revelations of homosexuality cause family members great anxiety:

I think that, if he hasn't felt discrimination from other people, it's because they don't know, and the people who do know, people in the family and at CAPASITS, well they're folks who love and support us. But outside of them, other people ... no way, because people out there who find out that someone is ill, well ... many of them might give support, but many others tend to reject [you]. (A, mother of patient D)

[...] we all cried a lot, it was a real shock for us, first finding out that he was gay. I don't know, it was really traumatic for us, because we said "hey we've got two kids and we're going to have grandchildren, we have two daughters and we're going to have grandkids" ... so it was a real blow, then we learned of this (the HIV diagnosis), imagine, in a family like this, so established, so macho, it was a real shock, a very strong blow. (A, mother of patient D)

The information gathered thus shows that this revelation is usually made to a person with whom the patient has ties of trust and intimacy. It was found moreover that informing members of the extended family is normally avoided, though this produces a situation in which some relatives are aware of the diagnosis, while others are not. Generally speaking, the process of revealing one's diagnosis is gradual and selective, but two members of this group had been living with HIV for five years and had not informed anyone about it.

3.2. Revealing diagnoses to sexual partners

Participants identified both facilitating elements and obstacles to reveal their diagnoses to sexual partners. Of the elements facilitating revelation, some were of a situational nature, like the place (or milieu) where they met a potential partner. They moreover said it was important that they were in control of their emotional state; that they were "calm" and "cool." They said that a key factor in achieving this emotional control was to avoid substances like alcohol and drugs. Nonetheless, from the participants' point of view, most of the elements that make it easier to reveal their condition to sexual partners were more closely related to the type of relationship established with the other person. This means that the duration of their relationship and the bonds of trust that exist make them feel more secure about discussing their condition. This is related to their expectation of receiving support and a positive attitude from the partner, not rejection or violence.

With regard to obstacles to revealing one's condition to sexual partners, subjects mentioned several elements or factors of a more personal nature. One of these was a lack of determination, characterized by ambivalence or fear of the consequences of admitting their infection. These barriers lead men to conceal their serological status when they were not sure how a partner might react. Alcohol consumption and drug use are two other factors that delay revelation, because in such altered states of consciousness men may think that it is not an appropriate time to speak about such a sensitive, personal issue. Finally, they alluded to a person's emotional state before the act of revelation, because speaking while anxious, depressed, or angry can adversely affect how the news is communicated.

Men in relationships that are in the formative stage may be hesitant to reveal their condition for fear of causing a breakup. One participant mentioned the fear of his partner's reaction as another obstacle to revelation. This reaction was expected to consist of fear of also being stigmatized, being infected, having to care for someone who is going to be more and more dependent upon them and a fear of committing to an ill person:

One of these days I'm going to have to tell him, and well, if I lose him or if he doesn't want to stay with me, it's his decision, right? It won't hurt me one way or the other. Okay, I might be a bit sad because I'm not going to be with him anymore, but, hmmm, the world isn't going to come to an end because of that. I'd understand him completely, I mean, I'd put myself in his shoes, think back a bit, [and ask myself] if I had a partner with HIV and, well, you know, if I loved him, I think I'd support him, but if I didn't really love him, then I'd leave him; there's no point being with a person and suffering with him if you don't really love him. (J, patient)

Some participants identified "living a double life" as another barrier. In the sociocultural context of Mexico, this alludes to men who present themselves publicly as heterosexuals, who may be married and even have children, but who at the same time have clandestine or secret sexual relations with other men. This situation does not necessarily mean that they identify themselves as bisexual. Indeed, in this milieu where the hegemonic masculinity promotes heterosexuality and certain forms of male behavior manifested, for example, in tone of voice, posture, physical appearance, apparel,

recreational activities, forms of seduction, and the role adopted during sexual acts, men can have relations with other men without considering themselves homosexuals. Instead, they use popular categories like “macho” or “normal” (Nuñez, 2007). Thus, men who live such “double lives” may resist revealing their condition for fear that their sexual practices or hidden lifestyle might come to light and that such knowledge could ruin the relationship.

3.3. Safe sex

The aforementioned scales of risk allowed participants to identify several safe sex practices and acts that entailed no risk of infection, and to differentiate them from other, high-risk activities, such as anal intercourse without a condom. However, during the group discussion, researchers found that participants had a reasonable amount of information on the proper use of condoms, felt secure that they were able to use them correctly and, in fact, had integrated their use into their sexual practices.

Considering the sufficient level of safe sex knowledge, it is important to point out that prevention entails assessing not only the rational components of the decision-making process, but also the affective components involved that can lead people to choose *not* to use condoms. That is, sexual education should not be about obsessive prescriptions or controlling sexuality, it should be about reaching an ethical posture that must be promoted in the interests of both own health and that of others, and should focus on other factors that patients indicate as influencing their decision to use or not to use a condom (e.g., alcohol and drug use).

As another example, couples in stable, long-term relationships marked by trust and intimacy may prefer not to use condoms despite the risk of infection, or partners may reject the condom because they feel it is a barrier in both sensorial and affective terms.

Some men said they participated in emerging practices like “barebacking,” which involve several forms of risk, including drug use, multiple sexual partners, and sexual acts without a condom. Participants mentioned a lack of self-respect and not valuing life as reasons for engaging in unsafe sex practices despite their knowledge of safe sex:

If you don't value your own life, if you don't love yourself or have self-esteem, then what's the use of taking treatment? What for?... all this information, what good is CAPASITS, right? What good is the attention you get? Because the medicine can't do it alone, you know, and the information isn't just going to fall into your hands and [even if it did] you wouldn't understand it; so if you're not motivated, if you don't have love and self-esteem, it's not going to help you decide, and say this will help me [or] this won't. So I think it's more about love of yourself. (D, patient)

Another problem that came to the fore was the influence that the HIV diagnosis has on the (enjoyment of) their sex life, especially because of issues like the fear of infecting a sexual partner and the anxiety brought on by the fear of contagion, which results in excessive precautions and adopting meticulous measures to prevent contagion. Though condom use was a common practice in the lives of these subjects, the fear of infecting someone else prevented them from enjoying sex as they had before. In addition, the need to conceal their condition can result in emotional detachment in the couple or prevent them from developing greater intimacy. As these factors clearly show, it is important to understand that the sex life of men who learn of their HIV condition can be truncated by the fear of infecting others, the effects of the social repercussions of the stigma associated with HIV, and the consequences that revealing this condition can generate.

Emotional support has been found to be very important in helping patients and couples adapt to the long-term effects of HIV infections, to maintain their sex life, to introduce techniques for safe sex, and to prevent them from being channeled toward compulsive sexual behaviors that put them at risk:

I see it like this, whether I was with him or not I'd have to take the same precautions, because you never know what the person you're going to have sexual relations with is like; I mean, I need to take the same precautions. For example, a friend might say, "hey, aren't you stressed out? he's, he's so meticulous, so ..." "no, because that's how it's got to be for everybody", I just have my precautions, a few more now, and that's it, nothing really changes, nothing changes, we're just aware that he's sick. (M, partner of patient D)

Lastly, because some participants said that having to use a condom in each sexual encounter, among other necessary precautions, bothers them severely, it is important to reflect on how messages on prevention and condom use are presented. For example, instead of portraying the use of condoms as a simple mechanical procedure, the act of putting it on can be eroticized if couples are willing to re-signify its use and integrate it as an additional sensual experience, and not just a means of sexual control. Of course, it is also important that they learn other safe sex techniques that can give pleasure without restricting sexual activity exclusively to the genital area.

3.4. Other situations that generate stress

Finally, at the end of the session, subjects spoke of specific concerns that were not foreseen in the original "Healthy Relationships" program. Some of their doubts revolved around their sexual practices, such as distinguishing between violent and non-violent acts, and between what is normal and what is abnormal. These kinds of issues must be discussed because they illustrate the persistence of the stigma associated with a person's sexual orientation and show how non-hegemonic sexual practices are still considered abnormal, not to be discussed, and pushed into the clandestine territory.

Moreover, participants expressed being worried about a lack of economic resources available to help them deal with their illness, especially in regard to shortage of well-remunerated jobs.

Another common concern among subjects was the stability of their affective relationships, especially the absence of someone with whom they could establish bonds of intimacy and closeness, and who may be counted on as a companion as their condition evolves.

4. Discussion

This study was conducted in the context of a process designed to adapt the "Healthy Relationships" intervention to a Mexican population, specifically in the framework of a pilot study with a group of gay men from urban backgrounds who were receiving treatment at a specialized HIV-AIDS clinic.

Simultaneously with the application of the intervention, in which the activities employed group discussions that deal specifically with topics like revealing diagnoses to family, friends and partners, and safe sex, an attempt was made to analyze the discourse of participants in order to understand their perspective on these themes and their relation to their health.

The objective was to gain insight into the experiences that HIV patients in this specific context have with the issues addressed in the program. Through this, we hoped to develop an understanding of the factors influencing the (active and disengaging) coping abilities of HIV patients in Mexico and other topics that are important to patients in this context, specifically regarding with their ability to deal with their illness. Overall, the findings of this study promote tailoring the program and the standard practices of healthcare services to the needs of this population.

4.1. (Double) Stigma, discrimination, and revelation

The study allowed us to demonstrate—as a first obstacle to coping—the persistence of the stigma related to HIV. Many men expressed their fear of being stigmatized not only because of their HIV status, but also because of their sexual orientation. The double stigma that HIV patients experience and that has been described in other parts of the world and as early as in the 1980s (Herek & Glunt, 1988) has been reaffirmed in this study for the current Mexican context.

Considering the facilitating elements and obstacles to revelation mentioned by participants, preventive measures alone do not lead men to reveal their status; they only provide tools to help him do so once he feels that he is capable and that it is the right time and/or necessary to do so.

The current study affirms that in the Mexican urban context the stigmatization that patients experience manifests itself within the revelation strategies, a finding that has been reported in earlier studies as well (Flores-Palacios & De Alba, 2006; Flores-Palacios & Leyva-Flores, 2003; Goffman, 1970). That is, revelation to family member, friends, and sexual partners, which are considered active coping strategies because they can lead to the construction of networks of social support, is influenced by the degree of (double) stigmatization and discrimination that patients expect when they reveal their HIV status.

The urgency of these issues is shown by this study's finding that often a significant amount of time elapses between the diagnosis and the patients' revelation, and that moreover some participants had not revealed to anyone in five years. This has implications such as not receiving medical treatment and impeding the process of constructing networks of social support.

4.2. Family dynamics “chosen family” and support systems

Particularly interesting was the finding that in the Mexican situation, revelation was least often done to the father, most often to a sibling, and often to only part of the family. This indicates that in the Mexican context the influence of the selective revelation on the family dynamics is an issue to be taken into account. This issue becomes especially important considering the lack of social services in Mexico and many patients' lack of economic resources, a concern that was specifically mentioned by our participants.

The participant mentioned that the lack of economic resources was an obstacle for their ability to cope with their illness now and in the future. The concerns voiced by participants focused not only on the present, such as their inability to meet the expenses involved in obtaining treatment for their illness, and being able to count on stable, valuable sources of emotional support to help them confront their reality, but also on the future: they wonder if they will have the economic and personal resources required to endure the disease as the course of the infection advances and opportunistic infections inevitably begin to appear.

Considering the lack of social services and economic resources in Mexico, the family plays a fundamental role in patients' lives as a source of economic and emotional support. Therefore, we consider this to be an issue that should be taken into account in accessing the social vulnerability of patients and the specific support that they need.

Adding to the current study's finding that HIV patients often reveal their condition to their family members gradually, or only to some family members and the effect this might have on family dynamics, healthcare services could help by accompanying patients through the process of revelation and encouraging greater involvement from family members who are willing to become part of the sick person's social support network.

Even though health services should be open to family members and family dynamics, this study has also shown that friends and companions—what in other contexts has been called the “chosen family”¹—may often provide patients with a basis of support. Due to their crucial role, those individuals should be welcomed by health authorities as part of social support networks, instead of being pushed aside on ideological grounds because they are not “family,” as often occurs in Mexico's family-oriented culture.

Another important point to ponder is the role of the patient's *partner* during visits to the health sector, not only because of the fundamental role that he plays in caring for the patient and maintaining his emotional stability, but also because of the disruptive effects that a diagnosis of HIV can

have on the partner's sex life. The partner must accompany the patient as he deals with the anxiety and worries caused by the fear of contagion and help him regain a full, healthy sex life. Including the condom as a safe sex practice to protect both of them is a vitally important step, whether the companion is there for the long-term or not.

It appeared moreover that after receiving a diagnosis of HIV patients often feel alone and abandoned, and experience extreme emotional upset (e.g., anxiety, depression) brought on by the difficulty of revealing the condition to others, and consequently by having to face up to the illness without emotional and instrumental support. Shontz (1975) has reported these emotional consequences and the relevance of a network of support for several cases of chronic illnesses, including AIDS. Emotional upset and the lack of support can increase the risk of affective or behavioral disorders, so it is essential that patients stay in touch with their support networks after informing them of their condition. When this fails, other sources of support, like non-governmental organizations and support groups can also accompany these men through the process of accepting their diagnoses, especially in cases where a person denies his illness or shows no desire to reach out to the health sector to obtain treatment for it.

4.3. Revealing to sexual partners and safe sex practices

On the topic of informing sexual partners, the act of admitting their condition tends to occur in the context of long-term relationships where bonds of intimacy and trust have developed. It is there that men expect to find reactions of a supportive nature. In contrast, casual, short-lived relationships where patients feel insecure about the strength of affective bonds do not lend themselves to revelations. Moreover, the use of alcohol and drugs, the situation in which the sexual encounter takes place, and the emotional (in)stability (anxiety, depression) of the patient were mentioned as important influences on the decision to reveal.

Thus, it appears that the optimal time to make a decision about sharing the diagnosis comes when a man has come to terms with his diagnosis, does not suffer an anxious and depressed episode, is in an intimate relationship and not under the influence of alcohol and drugs.

Considering that patients find it difficult to reveal to casual sexual partners, prevention efforts should focus on convincing patients in such casual situations to practice safe sex in order to prevent both reinfections and contagion. Of course, this task is much easier when a man has accepted his diagnosis, has achieved emotional stability, and is aware of the effects of alcohol and drugs in this situation. Only then can he really promise to take care of himself and adopt an ethical posture of not harming others.

As for the question of prolonged condom use, gay men must devise strategies to eroticize its use and explore other safe sex practices that can complement their sexual activity.

Therefore, we must also continue to work with society in general to fight homophobia and improve the precarious situation of sex education in Mexico. Among our participants, some seemed to have internalized homophobia. Patients indicated that this lack of self-respect and appreciation of life can lead to unsafe sex practice or compulsive sexual behaviors. Moreover, patients expressed finding it difficult to differentiate between normal/non-violent and abnormal/violent sexual behavior. This is likely due to the lack of open discussion of (homosexual) sexual behavior and the tendency to label them as abnormal and perverse.

Generally, it was found that *awareness* served as a basic requisite for achieving safe sex practices. In the first place, awareness and acceptance of the situation the patients were in, and secondly, awareness of the factors that influence their decision-making in sexual encounters (i.e., the decision to have safe sex or not).

5. Conclusion

In conclusion, double stigmatization, internalized homophobia, alcohol and drug use, and psychological problems such as depression and anxiety were found to be obstacles to coping (revealing one's HIV status to family, friend, and sexual partner and practicing safe sex). These findings confirm finding in earlier studies in other parts of the world (Herek & Glunt, 1988; Yi et al., 2010).

In addition, specific obstacles to coping in the Mexican context that came to the fore in this study include: (1) a lack of economic resources, (2) a lack of access to social services, (3) the strength of the heterosexual hegemony and the unwillingness to reveal status to the father and the practice of a double life that were associated with this hegemony, (4) the dependency on family for financial and emotional support on the one hand, and the gradual revelation to family members—and its potential influences on family dynamics—on the other hand, and (5) the importance of being able to count on the emotional, affective and/or economic support of a family, be it a biological or a chosen family.

It is important to emphasize strongly that several of the additional concerns voiced by participants must be addressed, primarily those of an economic nature and especially in the advanced stages of the disease. Thus, health services must identify the degree of social vulnerability of patients and come to understand how their social position limits their ability to come to grips with the disease and then develop new kinds of psychosocial interventions that patients need to help them cope with their medical condition.

These context-specific findings illustrate that the implementation of the “Healthy Relationships” program in the Mexican context must be accompanied by an understanding of participants’ social contexts and other dimensions of their experience, most importantly the influence of emotional and psychological distress and the influence of their specific individual and psychological histories that influence the way in which they approach the intervention and their illness.

This type of intervention aims to gain insight into the social representations that determine patient's signification of their situation in a specific context. Moreover, it aims to enable a process of re-signification in which destructive social representations are changed into systems of representation that convert themselves in the social capital which allows for new, more constructive behaviours toward their HIV illness.

Despite what was gained through the study's collective focus, it also implied a limitation in that we found that patients found it difficult to talk openly about their sexual orientation and HIV status during the intervention (as in their daily life). Often out of fear of being stigmatized and because it confronts them with their mortality

However, the collective character of the intervention also had another positive effect in introducing participants to other patient they could identify with and giving them the sensation that they are not facing the illness alone.

The integrated vision of this intervention will allow us to construct more effective strategies that will help patients take better care of themselves and others, and deal with another public health problem, the one related to adherence to treatment in cases of chronic diseases.

Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent

Informed consent was obtained from all individual participants included in the study.

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Competing Interests

The authors declare no competing interest.

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Note

1. The concept of chosen family refers to a situation in which intimate, affective, and emotional relationships are formed with non-family member which come to replace relationships in the nuclear (biological) family. Often because the latter are problematic and do not offer sufficient emotional affective and/or economical support. The replacement of nuclear (biological) family by a chosen family occurs most often in marginalized, socially vulnerable group such as homosexuals, prostitutes, and homeless children.

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