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Preventing HIV Among U.S. Women of Color With Severe Mental Illness: Perceptions of Mental Health Care Providers Working in Urban Community Clinics

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Abstract

Given their knowledge of the behavioral issues related to psychiatric illness, mental health care providers are in a unique position to help prevent HIV among women with severe mental illness (SMI). We conducted in-depth interviews with providers at two New York City community clinics. We identified three major, interrelated themes pertaining to HIV prevention among women of color with SMI. Interventions that address the barriers that clinicians face in discussing sex, sexuality, and HIV with patients and train providers in the cultural considerations of cross-cultural mental health care are needed to help prevent HIV among women of color with SMI.

We present findings from in-depth interviews examining mental health care providers' (MHCPs) perceptions of and attitudes toward sex, sexuality, and HIV infection and prevention among US women of color with severe mental illness (SMI) receiving outpatient psychiatric services at community mental health clinics located in an urban, resource-poor setting in New York City. Using the principles of grounded theory, we identified three major, interrelated themes: 1) the dynamics of patient-provider interaction pertaining to sex, sexuality, and HIV; 2) MHCPs' perceptions of their role in HIV prevention; and 3) practical and cultural considerations for HIV prevention interventions among women of color with SMI. We believe that, together, these findings may help inform the design and implementation of HIV prevention interventions for women with SMI of diverse racial/ethnic and cultural backgrounds in the context of outpatient mental health care. We build upon similar work conducted in South Africa and address issues of cross-cultural mental

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health care among women of diverse racial/ethnic, cultural, and immigrant backgrounds, which is relevant to countries with multicultural or multiethnic populations.

Thirty years after the first AIDS cases were diagnosed in the United States (US) (CDC, 2001), the HIV epidemic rages on. At the end of 2006, the year for which the latest HIV prevalence data are available, more than one million US individuals were living with HIV/AIDS, with socially and economically marginalized populations disproportionately represented among their ranks (CDC, 2010). As a group, people with SMI – including major depression, schizophrenia, and bipolar disorder – are at high risk of HIV infection (Blank, Mandell, Aiken, & Hadley, 2002; McKinnon, Cournos, & Herman, 2002; Rosenberg, Goodman, Osher, Swartz, Essock, Butterfield, Constantine, Wolford, & Salyers, 2001). HIV prevalence among adults with SMI ranges from 3 percent to 23 percent, with individuals experiencing homelessness and those diagnosed with substance use disorders displaying the highest prevalence of infection (Cournos & McKinnon, 1997). The National AIDS Strategy for the US, which was released in July 2010, calls for concentrated attention to populations with the highest burden of infection (Office of National AIDS Policy, 2010). Thus, given the White House's goal of "reducing HIV-related health disparities" (Office of National AIDS Policy, 2010), focusing on preventing HIV among people with SMI seems particularly pressing.

The urgent need for HIV prevention in this population is even more apparent globally. Since Acuda and Sebit (1996) found a nearly 24 percent prevalence of HIV among inpatients with mental illness in Zimbabwe, numerous studies from across the globe have underscored the importance and necessity of giving particular attention to HIV prevention among people with SMI (Collins, Holman, Freeman, & Patel, 2006). In sub-Saharan African settings with generalized HIV/AIDS epidemics, the prevalence of HIV among individuals with SMI is elevated (Collins, Berkman, Mestry, & Pillai, 2009; Maling, Todd, Van der Paal, Grosskurth, & Kinyanda, 2011; Singh, Berkman, & Bresnahan, 2009), and women are frequently disproportionately affected (Collins et al., 2009; Maling et al., 2011). Researchers have, in part, attributed women's vulnerability to HIV infection to coercive sexual encounters. For example, in a South African study, MHCPs reported that women with SMI were at elevated risk of rape (Collins, 2001). Similarly, a sample of Ugandan women with SMI described their experiences of rape in the context of psychiatric symptoms, which placed them at great risk of HIV (Lundberg, Johansson, Okello, Allebeck, & Thorson, 2012).

Investigators in the US have identified a range of sexual and substance use behaviors that place women with SMI at particularly elevated risk of HIV infection (Carey, Carey, & Kalichman, 1997; Carey, Carey, Weinhardt, & Gordon, 1997; Carey, Carey, Maisto, Gordon, & Venable, 2001; Dévieux, Malow, Lerner, Dyer, Baptista, Lucenko, & Kalichman, 2007; McKinnon et al., 2002; Meade & Sikkema, 2005; Senn & Carey, 2009) – including unprotected sex (McKinnon et al., 2002; Meade & Sikkema, 2005; Meade & Sikkema, 2007), multiple sexual partners (Carey et al., 1997a; Carey et al., 1997b; Carey et al., 2001; McKinnon et al., 2002; Meade & Sikkema, 2005; Meade & Sikkema, 2007; Otto-Salaj, Heckman, Stevenson, & Kelly, 1998; Randolph, Pinkerton, Somlai, Kelly, McAuliffe, Gibson, Hackl, 2007), trading sex to meet basic needs (Carey et al., 2001; McKinnon et al., 2002; Meade & Sikkema, 2007; Otto-Salaj et al., 1998), inconsistent condom use (Carey et al., 1997a; Carey et al., 1997b; Otto-Salaj et al., 1998; Randolph et al., 2007), a history of injection drug use (Carey et al., 1997a; Carey et al., 2001; Meade & Sikkema, 2005), sharing needles (Carey et al., 2001), sex with partners who use injection drugs (Carey et al., 1997b; Otto-Salaj et al., 1998; Volavka, Convit, Czobor, Douyon, O'Donnell, & Ventura, 1991) or are infected with HIV (Volavka et al., 1991), and sexually transmitted infections (STIs) (Carey et al., 2001; Randolph et al., 2007; Venable, Carey, Carey, & Maisto, 2007).

Investigators have reported the individual-level determinants of HIV risk behaviors among adults with SMI and shown that psychiatric symptoms (McKinnon et al., 2002; Meade, 2006; Meade & Sikkema, 2005; Meade & Sikkema, 2007) – as well as cognitive (e.g., HIV/AIDS information and knowledge) (Carey et al., 1997b; Gordon, Carey, Carey, Maisto, & Weinhardt, 1999; Meade & Sikkema, 2005; Otto-Salaj et al., 1998), psychological (e.g., motivation for condom use, self-efficacy for HIV prevention, inadequate assessment of HIV risk) (Carey et al., 1997b; Kloos, Gross, Meese, Meade, Doughty, Hawkins, Zimmerman, Snow, & Sikkema, 2005; Meade & Sikkema, 2005; Otto-Salaj et al., 1998), and behavioral (e.g., assertiveness and communication skills) (Gordon et al., 1999; Meade & Sikkema, 2005; Weinhardt, Carey, Carey, & Verdecias, 1998) factors – shape individuals' sexual and substance use behavior. At the interpersonal level, individuals' relationship status (Carey et al., 2001; Collins, von Unger, & Ambrister, 2008; Meade, 2006; Meade & Sikkema, 2005; Meade & Sikkema, 2007; Otto-Salaj et al., 1998), childhood physical and sexual abuse (Dévieux et al., 2007; McKinnon et al., 2002; Meade, Kershaw, Hansen, & Sikkema, 2009; Meade & Sikkema, 2005; Meade & Sikkema, 2007), adult physical and sexual abuse (Meade et al., 2009; Meade & Sikkema, 2005), and coerced sexual activity (Otto-Salaj et al., 1998; Weinhardt, Bickham, & Carey, 1999;) are related to HIV infection risk among people with SMI.

Few investigators have published studies that explicitly focus on the contextual risk factors underlying the HIV risk behaviors of women with SMI. Nonetheless, existing evidence suggests that societal-level determinants play an important role in shaping HIV infection among severely mentally ill women. Social support has a protective effect on the HIV infection risk of women with SMI (Meade & Sikkema, 2007; Randolph et al., 2007) whereas certain domains of social stigma and discrimination are associated with increased sexual risk in this population (Collins et al., 2008a; Collins, Elkington, von Hunger, Sweetland, Wright, & Zybert, 2008). The setting in which people with SMI receive treatment (Wright & Gayman, 2005) and the social environment in which they live – which is often characterized by poverty, unemployment, a lack of access to high-quality health care, inadequate housing, and limited means of transportation – also play a role in determining severely mentally ill individuals' risk of HIV infection (Carey et al., 1997a; McKinnon et al., 2002; Meade & Sikkema, 2005; Senn & Carey, 2009; Weinhart et al., 1998). Together, these findings underscore the importance of undertaking HIV prevention activities with women with SMI at multiple levels (e.g., individual, interpersonal, societal) and in multiple domains (e.g., psychiatric illness, interpersonal skills, abuse, discrimination, economic security) (Coates, Richter, & Caceres, 2008; Meade & Sikkema, 2005). Despite this need, mental health care settings often lack routine HIV risk assessment and comprehensive HIV prevention activities (McKinnon, Wainberg, & Cournos, 2001; Satriano, Rothschild, Steiner, & Oldham, 1999; Solomon, Tennille, Lipsitt, Plumb, Metzger, & Blank, 2007; Walkup, Satriano, Hansell, & Olsson, 1998).

Given their knowledge of the behavioral issues related to psychiatric illness, MHCPs are in a unique position to help prevent HIV infection among women with SMI (McKinnon, Cournos, Herman, Satriano, Silver, & Puello, 1999; McKinnon et al., 2002). However, clinicians may face a number of societal-, institutional-, and individual-level barriers to addressing HIV-related issues with their patients (Collins, 2006; Cort, Attenborough, & Watson 2001; Herman, Kaplan, Satriano, Cournos, & McKinnon, 1994; Higgins, Barker, & Begley, 2008; McKinnon et al., 1999; Satriano et al., 1999; Solomon et al., 2007; Sullivan, Koegel, Kanouse, Cournos, McKinnon, Young, & Bean, 1999; Wright & Martin, 2003). Societal barriers pertain to social norms and attitudes about sexuality in the context of mental illness (Collins, 2006), including those acquired during MHCPs' professional socialization and education (Higgins et al., 2008). Institutional barriers center on the structure of service delivery (Collins, 2006), institutional values and practices related to

sexuality in mental health care clinics (Herman et al., 1994; Higgins et al., 2008;), limited funding for HIV services in mental health settings, and a lack of provider training related to HIV and other sexual health concerns (Herman et al., 1994; Higgins et al., 2008; McKinnon et al., 1999; Satriano et al., 1999; Solomon et al., 2007). At the individual level, providers' attitudes, views, and beliefs pertaining to sex, sexuality, and HIV among persons with mental illness, as well as a lack of knowledge and skills regarding HIV/AIDS, may affect their ability to engage severely mentally ill individuals in HIV prevention (Collins, 2006; Cort et al., 2001; Herman et al., 1994; Solomon et al., 2007). Similarly, MHCPs' personal background (e.g., age, gender, profession, sexual orientation, and amount of experience working with HIV-infected clients and HIV-related issues) may also influence their willingness and ability to address patients' HIV-related needs and concerns (Wright & Martin, 2003).

To our knowledge, there are no published studies in the US on the influence of culture or ethnicity in provider-patient interactions around sexuality and HIV prevention for women with SMI. We used the principles of grounded theory (Charmaz, 2001; Strauss & Corbin, 1990) to explore urban MHCPs' perceptions of sexuality and HIV risk among women of color with SMI, as well as their attitudes toward discussing HIV prevention in the context of psychiatric treatment. We draw particular attention to providers' views on the role of culture – as it specifically relates to patients' expectations of providers' behavior, the cultural meaning that patients assign to age differences between provider and patient, gender, and religion – in shaping provider-patient interactions and the nature of HIV prevention activities among women of color with SMI living in a resource-poor, urban community in the US.

Methods

Overview of methodological approach

We conducted in-depth interviews with MHCPs in order to inform HIV prevention interventions among women of color with SMI of diverse racial/ethnic and cultural backgrounds receiving treatment in the context of outpatient psychiatric services. The study's specific aims were to: 1) explore MHCPs' perceptions of and attitudes toward sex, sexuality, and HIV among urban women of color with SMI and 2) identify cultural considerations for implementing HIV prevention interventions among women of color with SMI. We chose to interview MHCPs of diverse personal and professional backgrounds in order to obtain rich, detailed information about a range of provider experiences, from their perspectives.

Sample

The research team recruited MHCPs at two community mental health clinics in New York City to participate in the project. In order to be eligible for the study, individuals needed to provide clinical mental health services at one of the sites. Investigators visited both clinics and met with staff members at each one. MHCPs were notified of the study at clinical staff meetings and invited to participate. All participants provided written informed consent at the start of each interview. The study was approved by the Columbia University Medical Center and New York State Psychiatric Institute Institutional Review Boards.

The sample consisted of 12 MHCPs, seven women and five men, and included five psychiatrists, three nurses, two social workers, and two psychologists. The providers ranged in age from 36 to 55, with a mean age of 45. Participants were diverse in terms of self-identified race/ethnicity and first language spoken. Four providers identified as Hispanic or Latino, one as African-American, and seven as white. English was the first language of all

but three providers, two of whom were native Spanish speakers. All MHCPs worked in a predominately Latino, resource-poor community in New York City.

Research Setting

The research setting has been described previously (see Collins et al., 2008a). Research team members conducted the interviews in two New York City community mental health clinics that provide outpatient psychiatric services – including psychotherapy, medication management, and therapeutic and educational group interventions – primarily to people with SMI. Both clinics are located in an impoverished community and primarily serve poor and low-income Latinos, many of whom are immigrants to the US, and African-Americans. A core group of patients with more severe illness attend the clinics' day treatment programs and often spend the majority of the work week at the centers. Patients with illnesses in remission and less severe symptoms attend the clinic less frequently for appointments with physicians, nurses, psychologists, or social workers. Those who had attended the clinics for several years described the clinic staff and other patients as important members of their support system and social networks (Collins et al., 2008a).

Data Collection

Three female interviewers (one African American with a background in psychiatry and public health and two white with training in public health) conducted face-to-face, in-depth interviews with MHCPs using a semi-structured interview guide written in English. The interview guide was initially used in a South African MHCP population in order to identify ways to equip clinicians with skills for conducting HIV prevention interventions among people with SMI (Collins, 2001; Collins, 2006). The single modification that we made to the South African interview guide for the US study was adding a prompt reminding interviewers to ask providers how stigma vis-à-vis severe mental illness affected their patients' lives. All interviews lasted between 30 and 60 minutes and were administered in the providers' work place.

The interviews covered the following broad topical categories: the intersection of culture, sexuality, HIV risk, and mental illness; access to HIV and other sexual and reproductive health services among women with SMI; the place of sexuality and HIV prevention in clinical mental health treatment; and practical and cultural considerations for preventing HIV among women of color with SMI living in a resource-poor, urban community. Interviewers posed questions such as, "What do you know about the kinds of social relationships your female patients have? What about their sexual relationships? How does mental illness affect the kinds of sexual experiences your patients encounter? What are your attitudes toward their sexuality?" Data were collected over the course of two months until theoretical saturation of the aforementioned major topical categories was reached. In this paper, we do not report on sub-topics that were addressed in some but not all of the interviews and were therefore not saturated (e.g., how providers' personal background affects patient-provider interaction). All interviews were audio-recorded, transcribed verbatim, and entered into ATLAS.ti® for analysis.

Data Analysis

We analyzed the interview data using a modified grounded theory approach (Charmaz, 2001; Strauss & Corbin, 1990), such that given our targeted goal of identifying practical and cultural considerations for HIV prevention interventions among women of color with SMI, we focused on identifying major themes pertaining to this objective as opposed to developing an overarching theory of HIV prevention in this population. In line with the principles of grounded theory, we employed open, axial, and selective coding, accompanied by memo writing, to identify concepts and categories – which were then grouped into

themes during discussions among research team members (Charmaz, 2001). We organized the data in a set of tables to assist with the constant comparison of categories and themes across different participants based on their age, gender, race/ethnicity, and profession (Huberman & Miles, 2002). We subjected the data to this constant comparative approach not only as a method of analysis, but also to increase the internal validity of the study results (Charmaz, 2001). In order to increase the internal validity of our findings, we also engaged in critical peer review, identified alternative interpretations of the data during study team discussions, and actively sought disconfirming evidence in the interviews (Maxwell, 2005). Using this process, we arrived at conclusions about how providers negotiate the discussion of sexuality and HIV prevention, in relation to culture, in the context of outpatient psychiatric services. We explore three major, interrelated themes: 1) the dynamics of patient-provider interaction pertaining to sex, sexuality, and HIV; 2) MHCPs' perceptions of their role in HIV prevention; and 3) practical and cultural considerations for HIV prevention interventions among women of color with SMI.

Results

The dynamics of patient-provider interaction pertaining to sex, sexuality, and HIV

Walking the tight rope: Managing patient sexual behavior—Several clinicians agreed that managing patient sexual behavior inside the clinic was part of their responsibility as MHCPs. This activity required that providers assess the psychiatric status of the women receiving services, hear and understand their social needs, and take into consideration the dynamics of the clinic as a community where many social interactions occurred. During one-on-one interactions with patients, providers first sought to discern what kinds of sexual behavior signaled decompensation. A social worker explained:

You can't stop someone from wanting companionship, that's a normal, human reaction, it's a healthy one. So, if you see it in someone and if it's not poor judgment or impulsivity – distinguish between them – if it's the healthy response to want a companion, then you work with the person on it. You work with the patient and let them make their own decision and be there for them. . . . But you do try to distinguish between symptoms and normal, adult behavior – psychiatric symptoms and adult behavior. That's the most you could do.

An extension of this responsibility included teaching lower functioning patients how to set sexual boundaries and to care for themselves. Outside of individual sessions, providers kept an eye on patients' sexual behavior in order to prevent them from being distracted from the goals and purpose of treatment, as well as disrupting other patients in the clinic.

At the same time, the clinic was a significant venue for socializing among patients. In the context of having limited possibilities for partners due to their mental illness, potential partners in the clinic setting eliminated some of the complexities of disclosing mental illness. One provider, a psychiatrist, noted that “many a romance has been brokered in the clinic.” She continued:

So we really have to keep tabs on them, but at the same time, respecting their rights to...do what they want. You know, not monitor, but...you could get a substance abusing bipolar male who comes in who's very street-wise, and then there's a bevy of...naive, schizophrenic young women who this guy might start preying on and, you know, his agenda is probably very different than the [female] patients' agenda. So in a protective way, we have to look out for them. So we would probably take such a guy and talk with him about the fact this is not a place to pick up women and it's not something we encourage patients to do.

MHCPs reported utilizing various formal and informal strategies to manage patient sexual activity. Psychiatric medications that controlled symptoms of illness were expected to prevent patients from engaging in “hypersexual” (and potentially dangerous) behaviors. MHCPs indicated that the clinic milieu itself also served as an intervention of sorts. A nurse explained that by creating a sense of family in the clinic, providers established norms, expectations, and boundaries for patient behavior, including sex. She elaborated:

This is their home. I think a lot of people think of this place as a home. And the staff does too, because most of the staff [has been] here, as I have been, for many years. This is my home away from home. So...our director resents it when something happens, you know, that he has to say...you know, ‘This is your home. This is our community. We want to keep it clean. We need your help.’

This message was also conveyed to clinical trainees. One nurse explained: “And I say, ‘... And why do you think [the patients] would come back every single day?’ Well, every single day they come back because they know they’re safe here.” Other providers reported that their ability to regulate patients’ sexual behavior in the clinic was limited. They described experiencing tension between “supervising” patients’ sexuality in the clinical setting and respecting their autonomy. One provider remarked, “...as long as they’re psychiatrically stable..., it’s often a gray zone.”

Although sexual relationships between patients were discouraged in the clinic, they were not addressed by a formal policy but rather on a case-by-case basis, often with the aim of protecting female patients from others perceived to be “sexual predators.” However, providers reported that a “no-touching policy” was in place to limit patients’ physical and sexual contact with one another. One clinician raised the concern that MHCPs’ ability to enforce such a policy may be limited by patients’ cultural background. Although affectionate behavior was culturally sanctioned among the majority Latina patients, providers worked in a setting where these behaviors could be sexualized, and they felt responsible for providing a safe environment. One psychiatrist noted that in order to reconcile the policy with patients’ cultural mores, the staff permitted some forms of touching and intimate physical contact (e.g., hugging) to occur.

Although providers described “supervising” patients’ sexuality *inside* the clinic through formal and informal mechanisms, they reported being unable to do so *outside* of the clinical setting, where sexual activity that placed patients at risk for HIV was most likely to occur. A social worker pointed out: “Whatever they do outside of the clinic, that’s their business. We don’t get involved in that.” However, he further added that providers were genuinely concerned about their patients’ health and well-being.

Yet, as case managers, some providers’ professional involvement necessarily extended beyond the clinic walls. Social workers and nurses provided patients with assistance regarding legal issues, food, shelter, transportation, financial concerns, family issues, and crisis management. A psychologist and a nurse both reported conducting home visits with some of their female patients. Others described being familiar with various aspects of their female patients’ sexual lives outside of the clinic – including condom use, HIV risk, intimate partner violence, and number of sexual partners.

No time for the “extras:” Discussing sexual issues in the midst of clinical treatment priorities—Providers were responsible for exploring a range of sexual topics, from childhood and current sexual abuse to sexual behaviors that could place patients at risk for HIV. Several factors influenced whether and, if so, how providers discussed sex and HIV with female patients, including disciplinary training, treatment priorities, comfort addressing sexual issues, and attitudes toward sexuality among women with SMI. The extent to which

providers explored patients' sexual relationships and their context, as well as their level of intervention in patients' lives outside of the clinic, varied by provider discipline. In contrast to the psychiatrists in our sample, the social workers, nurses, and psychologists displayed a considerably greater level of knowledge of and involvement in their female patients' lives outside of the clinic. An exception to this noted pattern was a psychiatrist who appeared to be particularly informed about her patients' social and sexual lives. This clinician attributed her comfort discussing sexual issues with both male and female patients to professional experience and young age.

Differences in disciplinary training translated into differences in treatment priorities and affected how providers discussed sexuality. A psychiatrist explained: "In a sense, it goes back to my training that you don't introduce issues, period, beyond the salient issues, the nitty gritty issues of treating the mental illness." However, the provider also noted that he would be more likely to discuss sexuality issues in the context of treatment if the patient's health was in jeopardy. He elaborated: "Now, any issue is open for discussion. In other words, if a woman shares with me that she has a boyfriend who has been trying to have sex with her and doesn't want to use a condom, I discuss that with her, absolutely." Given the limitations of the individual clinical encounter, this clinician viewed educational group sessions as the best alternative for discussing sex with patients.

Treatment priorities and approaches changed according to the severity of patients' mental illness. A number of the providers mentioned that neither sex nor HIV was a prominent topic of discussion with women with more severe mental illness. Participants reported that, with this population, treatment focused on "the basics" – namely symptom management, basic social functioning, and essential social and economic needs such as financial concerns, family issues, housing, employment, food, and social support. In general, the clinicians reported that the more severe the mental illness, the less of a priority sex and sexuality became during one-on-one treatment sessions.

Providers' own comfort, as well as their perceptions of patients' expectations, influenced the likelihood that they discussed sex- and HIV-related concerns with patients. A social worker explained:

Patients don't disclose sexual issues, often you have to ask... We don't always ask and sometimes it's not always the appropriate time and later on we forget to ask. And, it might be our own issue not the patient, but you need to know... whether the patient is going to be at risk in the future or not or to understand why they have this particular behavior now... I think sometimes because... it's defined as such a personal issue, you don't discuss it. You go to a medical doctor, you talk about medicine. You go to a psychiatrist, you talk about psychiatry. Sexuality, maybe you talk to your priest or you talk to your mother. This is a heavily Latino, African-American population, and those are very conservative ethnic groups. So you don't talk about sexuality unless you know someone very well, unless you trust them and you see a very clear significance.

Overall, providers reported feeling more comfortable addressing sexual issues with female patients when the focus was on medical issues of important clinical significance (e.g., symptom management, medication, contraception, pregnancy, and HIV) in contrast to more relational concerns. A notable exception was a provider who not only asked patients about their sexuality when she was concerned about their health, but also as part of a "general assessment" of their overall well-being, which included questions about whether their sexual relationships were consensual and pleasurable.

Similarly, a nurse also noted that providers' views and attitudes toward mentally ill individuals' sexuality might make them reluctant to discuss sexual issues with patients. She explained that pervasive social norms and perceptions – which include “no one really want[ing] to know” about mentally ill individuals' sexual activities, a public need to protect women with SMI from sexual abuse and pregnancy, and the notion that severely mentally ill women do not have active sexual lives – in turn shape whether or not clinicians raise sexuality issues in conversations with patients, as well as how providers address these topics in the clinical setting. A psychiatrist observed that MHCPs often perceive individuals with severe mental illness as “kids” who do not have “very good judgment” and noted that “...it doesn't fit that they'd be sexual.” This provider also pointed out that, when patients are manic, MHCPs “think the absolute reverse. If they're manic, well, that's a person going out there and having a lot of sex.”

Balancing the personal and the professional: Maintaining clear patient-provider boundaries while talking about sex—Psychiatrists, social workers, nurses, and psychologists alike expressed the need to maintain clear professional boundaries with patients when discussing sexual issues. They argued that otherwise, they ran the risk of offending them and making them feel uncomfortable. For example, a nurse noted: “I don't want to be too intrusive because they don't want you to get too involved, too intrusive. So you have to respect that too. You can't do too much probing.” She further explained that she “wait[s] for them to bring it up” out of fear of “crossing the line,” which was a view shared by many of the other providers. One clinician believed that female patients might not wish to discuss sexual issues explicitly, but that relationships – both friendships and romantic relationships – were probably of greater interest to them.

A number of MHCPs mentioned being wary of offending patients of certain cultural backgrounds by raising sexual issues during clinical encounters. For example, a social worker noted: “Depending on the group you're dealing with, it might not be perceived as appropriate for them to talk to you about it.” She further explained: “It's my belief that a Hispanic female is not likely to tell you that she's not having sex with her husband unless she has a very comfortable trusting relationship with you and, even then, she might not.”

Other clinicians reported being reluctant to bring up sexual issues with patients with certain psychiatric profiles out of fear that doing so might elicit negative, unwanted reactions from them. A psychiatrist noted that she constantly has to negotiate boundaries between what sexuality-related concerns are acceptable to discuss with patients in an attempt to not stir up negative emotions in patients who may be “extremely delusional around sex.”

“I should be somebody to tell them about it:” Mental health care providers' role in preventing HIV among women of color with SMI

Several providers reported that their female patients were at high risk of HIV infection due to a range of social (e.g., lack of social support, exposure to sexual abuse), economic (e.g., poverty, financial dependency on male sexual partners), psychological (e.g., low self-esteem, loneliness), and cultural (e.g., gender norms, religious beliefs) factors. Many of the participants reported that patients in the clinic had access to HIV education; one psychiatrist believed that the female patients in his clinic also received psycho-education around family planning and STIs. One provider summarized her views related to female patients' HIV risk and access to HIV prevention services as follows:

I am sensitive to the idea that women are becoming more and more at risk [of] HIV, and I think we've made a clinic-wide effort to educate people about that – including trying to educate women, minority women who make up ninety percent of the [patient] population.

A number of clinicians remarked that providing patients with information and education around HIV was part of their responsibility as providers. A social worker commented, “Because I feel I am part of their lifeline, and I feel that I have the information that’s going to protect them in the long run then, I should be somebody to tell them about it and how to protect themselves.” Similarly, a psychiatrist felt that one of her roles was to “clear up the ignorance or lack of knowledge that some patients may have around the specifics of HIV infection.” Another provider, however, questioned her ability to change patients’ views about sex. Instead, she viewed herself as a non-judgmental source of alternate or additional information or as a “second opinion” on sex, sexuality, and HIV.

Cultural considerations for HIV prevention among women of color with SMI

Providers identified several cultural factors that impact women’s HIV risk; one-on-one, patient-provider discussions about sex, sexuality, and HIV; and the dynamics and content of group HIV education: (1) the culturally-informed meaning that patients assign to age differences between provider and patient, (2) gender roles and norms, and (3) religion.

Participants explained that the cultural meaning that patients attribute to age shapes their willingness to discuss sexual issues with a given provider. A Latina social worker explained that, given her younger age, the older Latina patients with whom she works were cautious about giving her their trust and respect. She noted that in order to bypass this cultural age barrier, she established herself as an expert with valuable knowledge to share, which in turn allowed patients to feel more comfortable revealing aspects of their personal lives with her.

This provider also explained that culturally-informed gender norms affect the manner in which some of her male patients perceive discussions about sexuality – namely, as a sexual advance from her. In order to avoid such misconceptions, she presented conversations about sex, sexuality, and HIV as a professional exchange meant to provide the patient with important health information. Another social worker noted how gender norms shape female patients’ views on sex and sexuality, as well as their comfort level talking to providers about sexual issues. He explained that among his predominately Latina patient caseload, sex was perceived as a taboo topic that women should not discuss or inquire about. In contrast, a psychiatrist described her female patients as being very comfortable having “frank” and “straightforward” discussions about sex, which they discussed in concrete, “physical” terms.

Providers also highlighted how gender roles and norms affect women’s HIV risk by undermining their decision-making power in sexual relationships with male partners, especially in relation to condom use. For example, a social worker explained that women who ask their partners to use a condom during sex may be accused of “seeing another man,” which could in turn lead to violence. A psychologist also noted:

...Women carrying condoms [are] considered...loose, and...it's not a desirable way [for] a woman to present [her]self. Also, because of the level of abuse in these relationships, we assume a lot of these women find it very hard to assert themselves. Also, a fair number of women are dependent on men for financial things, you know, maybe they're living with a man, and if they weren't living with that man who's being abusive, they wouldn't have anywhere to live. So, it's just been my impression that a lot of our women don't feel they have very much power in the relationships they're in, and it would have to come from the man to use a condom. Not...from the woman, who, especially if she were to suddenly introduce the idea, might be viewed as you know, having sex with other men.

Additionally, providers identified religion – namely, Catholicism – as an important cultural factor that shapes their female patients’ views on sex and condom use. Providers explained that their predominately Catholic, Latina caseload perceived condoms as unacceptable.

Patients' religious beliefs also shaped what providers believed was appropriate to discuss during a clinical encounter. A nurse observed:

If they're Catholic, it's against their religion to, you know. And, if it's against their religion, I don't even go there. That's their faith. And whatever their faith is, I'm not going to push my faith on anyone so I'm not going to try. If they say "I'm a Catholic," and we don't believe in that...that's as far as I can go with it.

In addition to gender and religion, some providers identified US sexual norms and living in an urban environment as determinants of women's perceptions of and attitudes toward sex, sexuality, and HIV. For example, a nurse intimated that Latina women's decisions to remain primarily identified with Latino versus US cultural notions of empowerment, could lead to clarity for some and confusion for others. Speaking of those who espoused US cultural mores, he explained:

The girls who are very Americanized get half the message but don't know the whole message. They know that they're empowered and they can be what they want to be, but they don't know exactly what they want to be or how to be it. They say, 'I can do what I want, this is my body.' But, they don't really know what they're talking. They don't really know how to protect it.

One provider emphasized that, in working with patients of diverse ethnic and cultural backgrounds, providers should strive to "be very sensitive to" and "work within" patients' culture and be careful not to impose their own cultural views during patient-provider discussions. Another clinician also warned against making assumptions or overgeneralizations about patients based on their cultural background. She highlighted the importance of recognizing the individual variation that exists within ethnic and cultural groups. When asked about the role of culture in shaping women's HIV risk, she remarked:

I think culture has a powerful impact on sexuality, but...there are so many different cultures, and there are so many different ways to grow up within a culture...If I'm working with someone, I ask them specifically...what's true about their culture and what's true about them vis-à-vis their culture.

Finally, several participants emphasized that, although culture shaped female patients' sexual views and HIV risk, socioeconomic factors – especially, education and financial resources – were just as, if not more, important than cultural background in shaping women's decision-making power in sexual relationships (including in relation to condom use) and access to HIV prevention services.

Discussion

The purpose of this qualitative research study was to elucidate MHCPs' perceptions of the sexuality, sexual behavior, and HIV risk and prevention needs of women of color with SMI living in a resource-poor, urban community in order to inform HIV prevention interventions among women with SMI of diverse racial/ethnic and cultural backgrounds. We identified three major, interrelated themes: 1) the dynamics of patient-provider interaction pertaining to sex, sexuality, and HIV; 2) MHCPs' perceptions of their role in HIV prevention; and 3) practical and cultural considerations for HIV prevention interventions among women of color with SMI. We found that providers' views on sex and sexuality among women with SMI – which ranged from women with SMI needing protection from "sexual predators" to being "hypersexual" – were shaped by their disciplinary training, professional experience, and role in the clinic. In their interactions with female patients, providers encountered a range of issues that limited their ability to address and discuss sexual issues in the clinical setting. Many participants experienced tension between wanting to protect women with SMI from sexual risk while respecting their autonomy and expressed concern about discussing

sexual issues in the midst of competing treatment priorities. Several providers also highlighted their efforts to maintain clear professional boundaries and navigate cultural issues – such as patients’ expectations of providers’ behavior, the cultural meaning that patients assigned to age differences between provider and patient, gender roles and norms, and religious beliefs – in their discussions of sex, sexuality, and HIV with women of color with SMI (who were predominately Latina but also included African-American women).

The individual-, institutional-, and societal-level barriers to HIV prevention among women with SMI that we identified in our study are similar to those discussed in the extant literature. While the majority of previous studies on MHCPs’ role in HIV prevention focus on the lack of provider training on HIV-related issues (Herman et al., 1994; McKinnon et al., 2002; Solomon et al. 2007), some have identified other institutional barriers that providers in our study also reported, including broader social and institutional attitudes that lead to avoidance or marginalization of discussions of sex and sexuality with individuals with mental illness (Collins, 2006; Herman et al., 1994) and the division of labor pertaining to HIV prevention among case managers, physicians, and nurses (Solomon et al., 2007). Similarly to our study findings, other researchers have observed that, at the individual level, MHCPs’ personal views and attitudes, including seeing sexuality and HIV as secondary issues in the context of psychiatric treatment priorities, restricted the likelihood that providers would address HIV-related issues during clinical encounters (Wright & Martin, 2003).

In a 2006 study, Collins addressed the role of culture in shaping patient-provider communication around sex, sexuality, and HIV in post-Apartheid South Africa. She specifically noted how racial/ethnic and cultural dynamics between white mental health clinicians and black patients in psychiatric settings shaped the discussion of HIV prevention activities such as condom use and affected providers’ willingness to initiate conversations about sex (Collins, 2006). Through this study, we add to this evidence by providing insight into how culture shapes not only patient-provider interaction around HIV-related concerns but also the delivery of HIV prevention interventions in two mental health clinics in a resource-poor, urban US community. To our knowledge, this is the first paper in which the authors explore the influence of culture on HIV prevention for women of color in mental health care settings in conjunction with the other individual-, institutional-, and societal-level factors addressed in previous studies. Further, given their focus on HIV prevention among women with SMI of diverse racial/ethnic, cultural, and immigrant backgrounds, our findings are relevant to HIV prevention in the context of mental health care systems in which multicultural or multiethnic populations are treated and multicultural or multiethnic staff deliver services.

In light of our study results, interventions that tackle the individual- and institutional-level barriers that MHCPs face in addressing sexual issues and HIV prevention in the context of psychiatric outpatient services seem particularly warranted. First, in order to ensure that all MHCPs, regardless of their professional background and experience, have the tools they need to discuss sex, sexuality, and HIV with patients, mental health facilities should provide clinicians with training on sexuality and HIV. In a survey of New York State outpatient mental health care program directors, 84 percent of participants reported unmet needs for staff training in HIV/AIDS service provision (McKinnon et al., 1999). In a similar study, Satriano and colleagues (1999) found that some staff members had been trained to provide pre- and post-HIV test counseling in less than half (45 percent) of the sites. Of note, researchers showed that mental health professionals’ lack of training in these areas hindered HIV prevention efforts in the clinic (Herman et al., 1994), whereas training staff in HIV-related issues significantly increased providers’ likelihood of conducting routine HIV risk assessments (McKinnon et al., 1999). Our findings underscore the need to not only train

MHCPs in the clinical, socioeconomic, and cultural dimensions of sex and sexuality, but also empower them to implement comprehensive HIV prevention services in their work setting.

Second, in order to ensure that MHCPs feel comfortable discussing sexual topics with patients of diverse cultural backgrounds, training should seek to build providers' skills in a range of cultural competence areas, including the role of age, gender, and religion in shaping patient-provider communication and interaction. Providing clinicians with cultural competence training will increase the likelihood that patients receive equitable access to appropriate, high-quality care that meets their needs (Betancourt, Green, Carrillo, Ananeh-Firemping, 2003; Saha, Arbelaez, & Cooper, 2003). Training sessions should also focus on exploring MHCPs' perceptions of and attitudes toward sexuality and HIV risk among women with SMI, as they can undermine effective HIV prevention in this population (Cort et al., 2001; Herman et al., 1994; Higgins et al., 2008). Such training may help providers better understand how their views and beliefs pertaining to sexuality among severely mentally ill women affect both their willingness to and the manner in which they address sexual health issues with female patients.

Third, the discussion of sex, sexuality, and HIV during patient-provider clinical encounters should be normalized such that it becomes a routine part of patients' treatment. For instance, incorporating the discussion of sexual health issues into patients' general health assessment would help address a number of the barriers to discussing sexuality that participants identified, including whether the patient or provider should raise the issue. Taking institutional measures to create both time and space to address HIV-related concerns in the clinical setting, as was described by several participants, can help ensure that HIV becomes one of "the basics" that MHCPs and patients discuss during treatment sessions. At the same time, MHCPs should be updated on advances in combination HIV prevention interventions so that conversations about HIV risk are paired with the evidence-based recommendations.

While models for cultural competence in health care settings tend to focus on the patient-provider relationship, researchers and practitioners stress that cultural competence should address organizational and structural barriers at multiple levels of the health care system (Betancourt et al., 2003). Many of the participants emphasized that the women in their caseload faced considerable institutional barriers to accessing sexual and reproductive health care, as well as other physical health services. Respondents also underscored women's need for a range of social services in the areas of food, housing, child care, and transportation. Thus, an important component of an intervention geared toward improving MHCPs' ability to prevent HIV among women of color with SMI living in a resource-poor, urban community would be to ensure communication with clinicians who provide sexual, reproductive, and other physical health services, as well as social services, such that female patients can better access the resources that they need (Sullivan et al., 1999).

Our study findings should be interpreted in light of some limitations. First, the data presented pertain to the views and experiences of a small number of providers in two community mental health clinics located in a predominately Latino and African-American, resource-poor urban setting. However, our intention was to inform HIV prevention interventions for women of color with SMI receiving outpatient psychiatric care at the clinics included in the study. Additionally, we strived to collect data from providers with a range of perspectives and experiences by recruiting clinicians of various personal (i.e., race/ethnicity, gender, age) and professional (i.e., psychiatrists, nurses, psychologists, social workers) backgrounds who occupied different positions in the clinical setting. Thus, through our study findings, we provide insight into the role that various MHCPs play in preventing HIV among women with SMI and highlight opportunities for further integrating HIV

prevention services into the mental health care settings included in the study and, possibly, other community mental health clinics that have similar resources and organizational structures and serve comparable patient populations. Second, while our analytic strategy relied on the principles of grounded theory, the practice-oriented nature of our specific aims and interview guide questions led us to identify three major themes pertaining to the design and implementation of HIV prevention interventions among women of color with SMI, rather than develop an overarching theory that relies on abstract concepts, as suggested by a traditional grounded theory approach to qualitative data analysis (Strauss & Corbin, 1990).

Multidisciplinary teams in mental health treatment settings coordinate resources to help meet patients' psychiatric, social, and economic needs. This same model could provide a division of labor for multifaceted HIV prevention interventions in which providers serving as case managers address the economic and social factors that increase the risk of HIV infection among poor and low-income black and Latina women. For example, clinicians could ensure that women have housing and access to entitlements that will allow them to maintain financial independence, which may in turn reduce women with SMI's likelihood of exchanging sex for goods and their risk of sexual assault (Teplin, McClelland, Abram, & Weiner, 2005), both of which have important implications for HIV prevention in this population. Psychiatrists and nurses can liaise with HIV care providers while also developing their own expertise on protocols for pre- and post-exposure prophylaxis, should such interventions be needed. Peers in the clinic can be prepared to deliver evidence-based behavior change interventions, as part of ongoing group HIV prevention programs. Most important, in the face of a relentless HIV/AIDS epidemic that disproportionately affects women of color, HIV prevention must be aggressively addressed in mental health care settings despite the challenges of cross-cultural care, the pervasive discomfort (on the part of patients and providers) with addressing certain aspects of sexuality, and the disciplinary and institutional barriers to doing so.

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