

Enhancing Cultural and Contextual Intervention Strategies to Reduce HIV/AIDS Among African Americans

I describe 4 protective strategies that African Americans employ that may challenge current HIV prevention efforts: (1) an adaptive duality that protects identity, (2) personal control influenced by external factors, (3) long-established indirect communication patterns, and (4) a mistrust of “outsiders.” I propose the Sexual Health Model as a conceptual framework for HIV prevention interventions because it incorporates established adaptive coping strategies into new HIV-related protective skills. The Sexual Health Model promotes interconnectedness, sexual ownership, and body awareness, 3 concepts that represent the context of the African American historical and cultural experience and that enhance rather than contradict future prevention efforts. (*Am J Public Health*. 2009;99:1941–1945. doi: 10.2105/AJPH.2008.152181)

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AS THE UNITED STATES

enters the third decade of the AIDS epidemic, the rates of new HIV/AIDS cases among African Americans continue to increase compared with those of other ethnic groups.¹ Consequently, the Centers for Disease Control and Prevention has proposed a heightened national response to the HIV/AIDS crisis for African Americans.² Community advocates, including the National Black Leadership Commission on AIDS and the National Medical Association, have called for a state of emergency³ to address disparities in infection rates.

Among the population as a whole, evidence-based interventions have achieved some success in reducing HIV-related risks and infection rates.^{4–6} Although biomedical and behavioral issues related to the transmission of HIV/AIDS have been well-addressed in these interventions,^{7,8} some of the related key culture-bound protective strategies and their historical roots are not routinely included in HIV preventions targeted for African Americans.^{2,3,9}

In the following section, I give 4 assumptions derived from HIV intervention research^{4–6} regarding how and by whom HIV prevention messages should be conveyed to those at risk and how decisions are made about behavior change. For each of these 4 assumptions, I describe a culture-bound protective strategy used by African Americans that contradicts it: (1) an adaptive duality that protects identity, (2) patterns of personal control developed in

response to external factors such as oppression and gender-based socialization, (3) long-established indirect communication patterns, and (4) a mistrust of “outsiders” that limits acceptance of HIV prevention and care.

Finally, I propose the Sexual Health Model—a conceptual framework that addresses these adaptive coping strategies and promotes African Americans’ protective skills. I discuss new methods to aid implementation of this model in future interventions, making HIV prevention research more historically and culturally congruent.

HISTORICAL EFFECTS OF SHARED TRAUMA

African Americans are a heterogeneous group bound by historical experiences that have resulted in several cultural strengths, such as survival skills, that transcend risks for HIV/AIDS transmission.¹⁰ They have a roughly 350-year history of acute and chronic oppression from which they have experienced unmeasured and undiagnosed physical and sexual trauma, depression, anxiety, and posttraumatic stress disorder much like the lasting effects of terror.^{11–13} Mental illness and psychological distress, once thought to be signs of weakness, were ignored, treated with folk remedies, or kept secret even from family members.^{14–16} When identified, mental health problems among African Americans were more likely to be misdiagnosed and improperly treated.¹⁷

Today, while many focus on the lasting effects of this traumatic history, protective strategies that helped African Americans to survive slavery and oppression are also documented by historical and personal accounts.^{18–20} They continue to be passed through generations and used as buffers when perceived threats to survival or equal opportunities are in question.²¹

Strong family ties, a positive group identity, and extensive kinship networks became the foundation, guided by spiritual and cultural values, from which communities and families honed adaptive skills to overcome barriers to equal access and achievement.^{18,22} The knowledge of how and when to use these coping strategies in the face of oppression often measured an individual’s connection with his or her history and people and tested the will to survive. Some of these strategies—along with the assumptions that they contradict—follow.

An Adaptive Duality

Among the population as a whole, most evidence-based interventions have assumed that the numbers of partners and incidents of unprotected sex are more important than the context of sexual behaviors (when, where, and with whom) and reasons for engaging in those behaviors (why).^{23–25} For some African Americans, their reasons for exposure to risks of HIV transmission are related to their attempts to conform to gender- and culture-bound behaviors.^{26–28}

An adaptive duality, or “role flexing,”^{29,30} is a coping strategy whereby African American speech, behavior, and dress frequently shift and change dynamics to appear acceptable to the group with whom they are interacting. Historically, in the presence of the oppressors, it was not uncommon for African Americans to display verbal patterns, submissive behaviors, and an identity required by authority figures. These characteristics were distinct from other coping strategies, were sanctioned by African American culture, and guided their own culturally sanctioned personal relationships, family ties, and cultural beliefs.³¹

An example of role flexing is the masculinity adopted by African American males—often characterized by the swagger in their walk, physical agility and posturing, being “tough,” and having sexual confidence with women—which is encouraged in early childhood and throughout life.^{32–34} Men are also expected to provide for, protect, and nurture immediate and extended family members, especially in the absence of other men.^{32,33}

When men have sex with men, however, an adaptive duality is often required in order to conform with culture-bound role expectations of heterosexuality and family responsibilities versus the roles assumed in sexual relationships with men. The contradictions in these roles may subsequently cause African American men to increase their HIV-related risk behaviors with both male and female partners.³⁵

Issues related to this adaptive duality have been overlooked and should be incorporated into HIV interventions²⁹ to ensure that men who do not disclose their dual sexual experiences learn how to

minimize HIV-related risks. African American women also need to better identify and use HIV-related protective skills to counter adaptive dualities of partners and not overlook contradictions in sexual identity and sexual practices even when men satisfy cultural and family responsibilities.

External Factors that Influence Personal Control

Current HIV interventions are based on theoretical assumptions about individuals making their own decisions about sex. The assumption is that with increased self-efficacy, their risky behaviors will diminish.^{36–38}

From a historical perspective, when African Americans made individual decisions and demonstrated self-efficacy at the expense of others, the consequences were often negative for the decision maker.¹⁸ Self-efficacy is influenced by many external factors. Among African Americans, the ability to exert personal control has been limited by economic and educational marginalization^{39,40} as well as religious, gender, and cultural norms that reinforce deference to perceived authority figures and valuing others before oneself.

For example, a demographically controlled study of 900 African American, Latina, and White women in Los Angeles County assessed the consequences of gender-based decisions about condom use. Although African American women were significantly more likely than were Latina and White women to make condom-related decisions independent of their partners,⁴¹ they usually decided not to use condoms at all. Decisions about condoms were influenced by beliefs that they could increase their chances of establishing a long-term relationship if they avoided

“unfeminine” direct confrontations about HIV testing and condom use.^{41,42} Further, these women were mostly single and marginally employed.

African American women’s concerns about relationship stability are also heightened by US census estimates that for every 100 single African American women, there are 70 single African American men, excluding those in prison or group homes (e.g., for foster care or recovery from substance abuse).⁴³ The impact of these issues on long-term condom use cannot be overlooked.

Skills to exert protective self-control among African American women might be more effectively reinforced if both partners were involved in HIV intervention programs that also focus on safer sex practices and their consequences to relationships, regardless of marital status.⁴⁴

Indirect Communication Patterns

Traditionally, it has been assumed that HIV prevention requires clear, assertive skills for self-protection, verbal communication between partners to minimize risky practices, and condom use.^{45–47} Among African Americans, however, patterns of indirect communication were established because direct interactions were prohibited during slavery. As a result, African Americans created elaborate codes of communication through music and nonverbal body language, many of which are contemporized and in use today.¹⁸

Hecht et al.⁴⁸ examined differences in eye contact, body movement, the concept of time, and vocal behavior between African Americans and European Americans in social situations. African

Americans generally preferred more indirect forms of communication. When it comes to sex, communicating directly and disclosing sensitive sexual information may also contradict African American cultural and religious values about modesty promoted by families, social networks, and religious communities.¹⁴ Learning skills to communicate directly before and during sexual activities needs to be distinguished from less direct nonsexual interactions that should be influenced by the culturally and socially condoned styles of communication.

Mistrust of Outsiders

Some investigators have assumed that individuals should be willing to adopt HIV prevention strategies when taught by knowledgeable providers who want to deliver the information.^{49–51} However, both the messenger and the message need to be acceptable to populations with heightened HIV risks. African Americans’ mistrust of people different from themselves is well-established. The outcomes of clinical trials such as the Tuskegee study, in which treatment of syphilis was intentionally withheld from African American study participants, have contributed to this mistrust.^{52–54}

“Healthy paranoia”—or suspicion of the intent of unknown persons until they demonstrate their honesty and trustworthiness—has grown out of a history of medical mistreatment and health care disparities. It is one of the most commonly used protective coping strategies that promotes disbelief and mistrust.⁵⁵ For example, Parsons et al. reported that more than 40 percent of 1104 African American church attendees from Louisiana agreed that the government intentionally allows

marginal education, drugs and crime to affect African American communities.⁵⁶ Crocker et al.⁵⁷ also noted that beliefs supportive of conspiracy theories were held by college students; this held true even when the researchers controlled for socioeconomic status.

However, healthy paranoia can be minimized with increased familiarity, consistent and transparent interactions, and shared common experiences.^{58–60} Because of mistrust, some African Americans use health services less than their White counterparts, which contributes to disparities in health outcomes.⁶¹ Some African Americans may prefer to receive medical treatment from African American doctors rather than from other health professionals.^{62,63} They may also be reluctant to adhere to health-related information provided by African American persons whom they do not trust,^{62,63} especially if they are affiliated with institutions or programs that have exploited people.⁵¹

Historically, a mistrust of outsiders has been fostered by segregated housing. Tightly knit communities, including churches and schools, created social networks that shared mutually supportive strategies for protection and for economic and educational advancement.^{64,65} Today, interventions should incorporate the strengths of social networks to promote HIV counseling, testing, and prevention in neighborhoods and communities.^{11,66} Skills used to scrutinize “outsiders” should be extended to identify high-risk individuals within a community as well.

For successful HIV prevention efforts, understanding these 4 coping strategies is essential because they can serve as a bridge between past experiences and new HIV prevention skills.⁶⁷

AN ALTERNATIVE MODEL FOR PREVENTION

HIV interventions are often guided by conceptual models that focus on knowledge, perceived risks, peer support, and the skills needed to reduce risky behaviors.^{38,68,69} I propose the Sexual Health Model, which promotes 3 key concepts—interconnectedness, sexual ownership, and body awareness—that incorporate past beliefs and practices with new strategies for HIV risk reduction within a cultural context.^{44,70,71}

Interconnectedness grows from the common belief that being in a relationship and having a family defines identity and enhances personal value.⁷⁰ The Sexual Health Model acknowledges these beliefs but also emphasizes that personal health, along with families and social networks, is an important component of interconnectedness, regardless of relationship status.⁷¹

Sexual ownership—“owning” one’s sexuality—requires one to make decisions about sex, to be responsible for one’s sexual and physical health, and to communicate one’s sexual orientation. Its importance grows out of historical and external factors that influence personal control. Through the Sexual Health Model, sexual ownership also promotes skills to enhance personal control, as one learns to assess risky people, risky behaviors, and risky circumstances that can limit self-protection.

Body awareness is limited by cultural and religious prohibitions about body touching, condom and contraceptive use, and some sexual practices. The Sexual Health Model provides knowledge about how the body works, diet and exercise for a healthy body image, mind—body health, and skills

needed to identify and articulate problems that require treatment.

CONSIDERATIONS BEFORE INTERVENTION IMPLEMENTATION

There are 2 issues for investigators to consider before they incorporate cultural and contextual strategies into traditional HIV prevention approaches. First, the combined effects of stigma due to HIV status, poverty, race, gender, sexual orientation, or other factors may heighten symptoms of psychological distress and trauma and reduce the effectiveness of any intervention unless these problems are addressed and monitored.⁶⁷

Second, the cultural competence of investigators is an integral component of HIV prevention. Their level of knowledge and understanding of a specific culture determines how well they can communicate and interact within that culture.^{72–74} Competent investigators have an essential set of skills that increase the likelihood that they and their staff will understand and actively incorporate historical and cultural factors into traditional HIV prevention interventions (G. E. Wyatt, J. K. Williams, and H. C. Ramamurthi, unpublished data, 2008).^{72–74} The following skills can be developed for culturally condoned coping strategies.

An adaptive duality can be addressed by teaching individuals the skills needed to align their risk-reduction efforts with their behaviors, whatever their sexual orientation or culture-derived role in a relationship or family. Advocacy skills involve testing for HIV and sexually transmitted diseases, counseling, social support, and treatment—for main and secondary partners—to ensure that

disease transmission is not increased by unprotected sex with male and female partners (body awareness). Regardless of whether individuals fully disclose their behavior to sexual partners, an open discussion of past and current sexual experiences with health and mental health providers is essential. Ongoing group support can facilitate the development of sexual communication and practices (sexual ownership) along with personal responsibility to maintain gender- and culture-bound roles and relationships (interconnectedness).

To address external factors that influence personal control, individuals can identify and discuss the effects of past experiences and relationships in which someone else controlled them (interconnectedness) and prioritize those in which future personal control is essential, such as with birth control and condom use. Methods of self-protection that minimize power struggles in relationships should be adapted (sexual ownership). The goals of maintaining a healthy body image with diet and exercise, along with physical and psychological health, should be established and monitored daily (body awareness).

To refine indirect communication skills, individuals can (1) learn culturally congruent “talk and listen” and conflict-resolution techniques for clear, nonconfrontational sexual and health-related communication^{72,73} (sexual ownership)⁷⁵; (2) learn to integrate factual information into sexual discussions when possible (body awareness); and (3) learn to practice communication styles for different people and occasions (interconnectedness).

To minimize mistrust of outsiders, individuals can learn how

to (1) specify the information needed to become more familiar with and fully informed about known and unknown people or situations; (2) participate in activities so that mutual trust and respect can be established; and (3) develop skills to document, discuss, and report perceived racial, health, or sexual orientation–related discrimination and sexual exploitation to authorities.

Innovative HIV interventions will be most effective if they address HIV risk reduction within the African American cultural context by incorporating key African American protective strategies. Adapting and building on these long-established strategies is a process that is consistent with other interventions^{72,73,75} and will help individuals, families, and communities to recognize that survival is best realized when HIV/AIDS prevention skills are implemented daily.² ■

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