132 JOB 6200 - 005-00 PAGE 0031-00 LEWIS
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Chapter 5

Heterosexuals and AIDS

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One of the greatest concerns of the general public today is whether AIDS will spread among the heterosexual community in a parallel fashion to that witnessed among gay men and IV drug users. This question has been widely debated.[1] Data indicate that as of July 6, 1987, 26 percent of all adult cases of AIDS were thought to involve exclusively heterosexual individuals. Using reported AIDS cases from 1981 to 1986, Dr. James Curran, director of the AIDS Program for the Center for Infectious Disease of the CDC, found the greatest acceleration from 1985 to 1986 among bisexual men (82 percent more cases reported in 1986 than in 1985) and among women (77 percent more cases) (see Figure 5-1).[2] The largest increase occurred among heterosexual men, and the lowest among gay men. Figures 5-2 and 5-3 show percentage increases for women and heterosexual men differentiated by ethnic background.[3] For both men and women, the largest percentage increase occurred among Whites. However, these data evaluate only changes in cases reported across a one-year period. Blacks and Hispanics already constitute a higher than expected risk group, as discussed in Chapter 3.

Debates continue regarding the extent to which the general population of heterosexuals should be concerned about AIDS if they lack the obvious risk factors of past IV drug abuse or sexual contact with an IV drug abuser (IVDA) or homosexual or bisexual male contact. The search for sources of transmission in the white heterosexual community has focused on (1) gay or bisexual males and (2) female, and in some cases male, prostitutes. In the Black community attention has centered on the male drug abuser and the female prostitute. While the actual risk to heterosexuals is certainly a source of worry for many individuals, they would be wise to remember that other factors influence what level of actual risk exists. Ethnicity is an important variable. For example, the most probable primary transmission vector into the White heterosexual population is sexual contact with a previously infected individual. In the Black and Hispanic ethnic minority communities, IV drug use is an additional important transmission vector.

In A. Lewis (Ed.) Nursing Care of the Person with AIDS/ARC. Maryland: Aspen Publications, 1988.

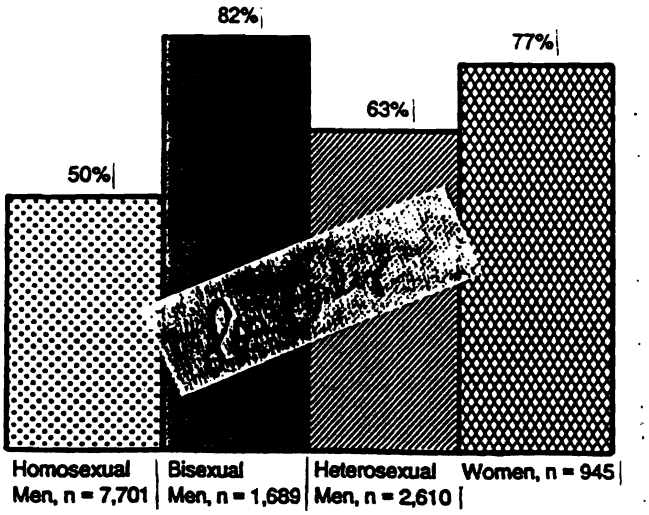

Figure 5-1 Reported Cases of AIDS in the U.S. Sex and Sexual Orientation, 1986 Percentage Increase Over 1985. *Source:* Reprinted from *AIDS Information Exchange*, Vol. 4, No. 2, pp. 5–6, U.S. Centers for Disease Control, 1987.

A sensible approach to understanding levels of risk for heterosexuals involves assessing both the *risk activities* and the *proximity* to an infectious agent (source) of transmission as a function of contacts with blood or bodily fluid from potentially positive or seropositive individuals. One way to perform this assessment is to examine all the potential sources and their degree of risk for heterosexuals. For example, heterosexual men who received blood transfusions during 1977–85, who have visited male or female prostitutes in particular geographic regions, or who were IVDAs might consider themselves at relatively high risk for infection. On the other hand, if these same heterosexual men engaged only in masturbation with the prostitutes and never shared works while abusing drugs, the risk might be considered low. Thus not all heterosexuals are at equal risk. Rather, those individuals who have come into direct contact with known seropositive populations or have a high vulnerability to direct introduction of the HIV virus into their bloodstreams are most at risk.[4] Also potentially at risk in the heterosexual group are those individuals who lack knowledge about how AIDS is transmitted and who is actually at risk. These individuals may be unaware that they have exposed themselves to the virus, and while they may not appear to have any major risk factors, their inability to assess unsafe sexual practices and to assess adequately the history of their past partners places them in a potential risk category. The degree of risk, of course, is modified by the age of the person as it relates to

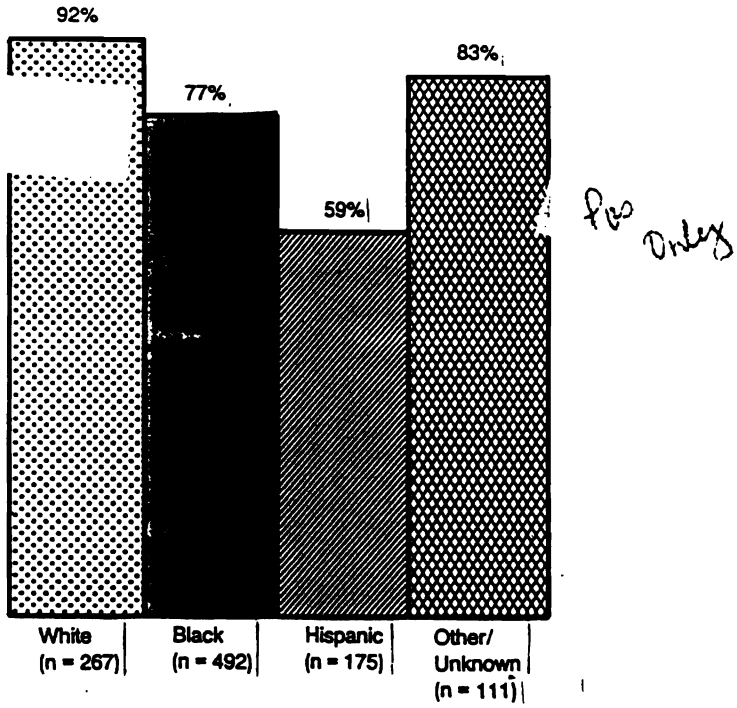

Figure 5-2 Reported Cases of AIDS in the U.S. Women by Race, 1986 Percentage Increase Over 1985. *Source:* Reprinted from *AIDS Information Exchange*, Vol. 4, No. 2, pp. 5–6, U.S. Centers for Disease Control, 1987.

exposure, sexual history, and the types of contacts the person has had with blood and bodily fluids.

CHARACTERISTICS OF HETEROSEXUAL AIDS CASES

The epidemiologic pattern of AIDS in heterosexual groups indicates distinct racial, ethnic, and gender differences. As indicated in Table 3-1, heterosexual men account for a negligible proportion of the AIDS cases among Whites. Among these men, the largest risk group identified by risk category is IVDAs, but heterosexual IVDAs still account for only 4 percent of all of AIDS cases in White men. On the other hand, Black and Hispanic heterosexual male IVDAs account for approximately one-third of AIDS cases in their respective ethnic groups. In addition, Black heterosexual men are more likely to contract HIV through heterosexual sexual contact than are either White or Hispanic men.

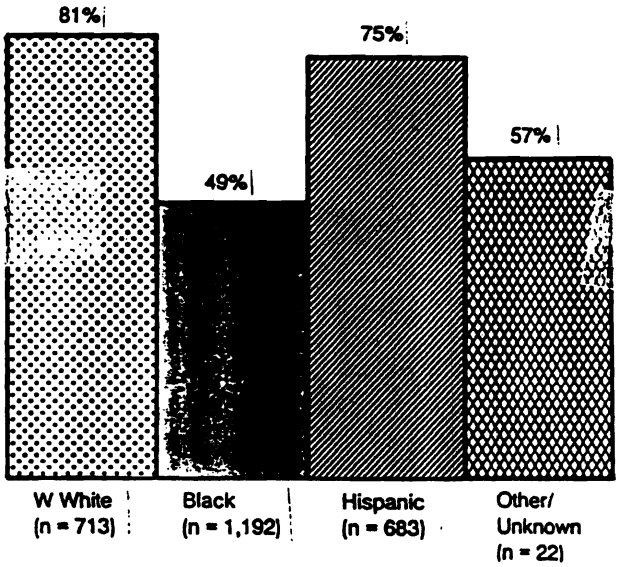

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Figure 5-3 Reported Cases of AIDS in the U.S. Heterosexual Men by Race, 1986 Percentage Increase Over 1985. *Source:* Reprinted from *AIDS Information Exchange*, Vol. 4, No. 2, pp. 5–6, U.S. Centers for Disease Control, 1987.

Blacks and Hispanics comprise the largest number of the cases of AIDS in women, 51 percent and 20 percent respectively. Examining the number of cases of AIDS in ethnic women as a function of their percentage in the population reveals that a Black woman is 13 times more likely than a White woman to contract the AIDS virus. For Hispanics, the risk ratio is approximately 9 times greater.[5] While the actual number of cases for ethnic minority women is lower than for ethnic minority men, minority women in comparison with White women are more affected by AIDS than ethnic minority men compared with White men.[6] For women the primary routes of viral transmission are first, IV drug use and second, heterosexual contact with a person at risk for AIDS.[7] It is in this latter category of heterosexual contact that women outnumber men. In many of the cases, the women may not have known about their partner's history of drug abuse or bisexuality, they may have not asked, they may have asked but been deceived. or they may have known but not realized that they were at risk.[8]

PSYCHOSOCIAL ISSUES IN CARING FOR THE HIV-INFECTED HETEROSEXUAL

In male heterosexual AIDS cases the activities that led to the infection may have involved previously hidden behaviors. For some heterosexual men sexual encoun-

ters with men or women in the sex industry, sexual encounters with gay or bisexual men, or occasional recreational use of IV drugs may have been well hidden or merely suspected but never discussed with family members. Upon discovery of HIV seropositivity the heterosexual man may worry not only about his diagnosis but about the impact of his secret activities on his relationships with his family of origin, his significant others, and, in some instances, his children. He may also be upset that people suspect he is gay or bisexual. Nursing personnel may find in some clients a reluctance to or a decision not to inform their spouse or significant other of their HIV status. In some cases clients may be reluctant to admit to a spouse or family member the activities that are suspected as the cause of the infection. The client may explain the HIV status in a manner that seems vague or implausible to family or significant others. Nursing staff may find themselves facing questions from the family about the origins of their loved one's infection or merely a desire to ask questions to clarify their understanding of how a person becomes infected with HIV. In these situations, it is important to protect client confidentiality.

Nursing staff may face an emotional and ethical conflict as a result of either the client's request not to reveal the HIV status to the significant other or a statement of intention to continue to engage in high-risk behaviors. Such statements represent a potential duty to warn and protect. The nurse who might be faced with this situation should try to request consultation *prior to* the occurrence. A sound policy coupled with an implementation plan will result in better services for clients and lessen nursing staff anxieties. The training and education department may wish to address not only the legal and professional responsibilities for nurses (see Chapter 25) but methods for coping with personal reactions to this situation (see Chapter 22).

Heterosexual men and women, particularly if both members of a couple have become infected (as happens with IVDAs), experience a great emotional trauma related to their responsibilities to their own families and children. Many parents are afraid they will infect their children. Accurate information regarding transmission of the virus, as well as specific examples of intimate activities, such as kissing or hugging, that can be continued, may be helpful. While difficult, it is important for parents to plan for the future of their children both as the parents become progressively sicker and after their death.

Families of persons with AIDS experience tremendous emotional upheaval at the impending loss of their child, parent, spouse, or significant other. Nursing staff may serve a useful function to the family and children of the HIV-infected individual by informing them of services such as support groups, bereavement groups, or places where they can volunteer their time to help others with ARC or AIDS.

For the HIV-infected individual who wishes to remain sexually active, nursing staff may be called upon to discuss frankly the projected risk associated with

particular sexual behaviors (see Chapter 24). Some clients may need information on behaviors that can be substituted for behaviors previously used for sexual gratification as well as behaviors that may result in emotional closeness.

A particularly difficult problem for people with AIDS in the hospital is regulations that prevent visits by their children who are under age 13. Nursing staff may wish to discuss with hospital administration ways to handle this problem that do not disrupt care on the unit but facilitate meeting the needs of the individual patient.

When hospitalized, some women with AIDS feel isolated because they do not encounter any other females with AIDS. They have no source for comparison, no role model for hope, nor any source of practical advice. In this situation, nursing staff may find it helpful to arrange for a "buddy" from an AIDS support agency. Many women with AIDS also lack basic information specific to their needs. Women quite often ask how to dispose of tampons or sanitary napkins soiled from their menstrual flow. Female nursing staff may be the only source that some women will ask because of their embarrassment in asking a male physician.

Some heterosexuals with AIDS may feel uncomfortable in the presence of gay men, which is a particular concern on dedicated AIDS units with large numbers of gay men. Some heterosexuals may be reluctant to have particular family members or religious advisers visit because of the presence of openly gay men on the ward. Nursing personnel should intervene early in the client's stay if this appears to be a problem. Social support is an important element in coping with major life illnesses and, therefore, comforting clients and visitors is a priority. It may be useful to point out to such individuals the courageous role that gay men have played in advancing knowledge of AIDS through their volunteer efforts.

SUMMARY

1. Heterosexuals are likely to be concerned, and in some instances confused, about their actual risk for contracting the HIV infection.
2. The epidemiologic pattern and risk for infection differ among Whites and ethnic group members. Black and Hispanic heterosexuals are disproportionately more likely to contract AIDS or an HIV infection than are Whites.
3. Heterosexual AIDS patients may require basic information about AIDS and HIV infection.
4. Care of the heterosexual person with AIDS requires attention to the needs of spouses/significant others and children. These two groups may also rely on nursing staff as their source of information and comfort.

NOTES

1. R.R. Redfield et al., "Heterosexually Acquired HTLV-III/LAV Disease (AIDS-Related Complex and AIDS)," *Journal of the American Medical Association (JAMA)* 254, no. 15 (October 18,

1985):2094–96; U.S. Centers for Disease Control, "Human T-Lymphotropic Virus Type III/Lymphadenopathy Associated Virus Antibody Prevalence in U.S. Military Recruits Applicants," *Morbidity and Mortality Weekly Report (MMWR)* 35, no. 26 (July 4, 1986):421–23; M.M. Lederman, "Transmission of the Acquired Immunodeficiency Syndrome Through Heterosexual Activity," *Annals of Internal Medicine* 104, no. 1 (1986):115–17; M.A. Fischl et al., "Evaluation of Heterosexual Partners, Children, and Household Contacts of Adults with AIDS," *JAMA* 257, no. 5 (1987):640–44; and K. Leishman, "Heterosexuals and AIDS," *The Atlantic* 259, no. 2 (1987):39–58.

2. J. Curran, "Mayor's Task Force Addresses Heterosexual Transmission, Youth Education," *AIDS Information Exchange* 4:2 (1987):5–6.

3. Ibid.

4. Polaris Research and Development, "A Baseline Survey of AIDS Risk Behaviors and Attitudes in San Francisco's Black Communities" (San Francisco, Calif.:1987).

5. V. Mays and S. Cochran, "Interpretation of AIDS Risk and AIDS Risk Reduction by Black and Hispanic Women," *American Psychologist* (in press).

6. R. Bakeman, J.R. Lamb, R.E. Jackson, and P.N. Whitney, "The Incidence of AIDS Among Blacks and Hispanics," *JAMA*.

7. M.E. Guinan and A. Hardy, "Epidemiology of AIDS in Women in the United States: 1981 through 1986," *JAMA* 257 (April 17, 1987):2039–42.

8. V. Mays, "Women and AIDS: The Forgotten Women," (paper presented at the 95th Annual Convention of the American Psychological Association, New York, August 1987).