HIV COUNSELOR
PERSPECTIVES

Volume 13 Number 1 January 2004

PEOPLE IN NEW ENVIRONMENTS

When people relocate from one environment to another, they face a host of challenges that can increase their risk for HIV infection. As Georg Bröring of the World Health Organization put it in 1993, “people in an alien environment” are influenced by the absence of familiar social and cultural cues. Their capacity to cope in these unfamiliar surroundings is one of the factors that determines their health behaviors, including activities that may lead to HIV transmission.1 This issue of PERSPECTIVES explores the conditions that may influence HIV risk for three types of what Bröring calls “mobile people”: travelers, migrants, and people who relocate within the United States.

Research Update

The research focusing on mobile populations and HIV is most abundant for issues relating to immigration into the United States. There is, however, some research on tourism, particularly sexual tourism. There is very little research that looks specifically at the HIV risk for people who move within a country. Nonetheless, it is clear that all of these populations may face challenges related to disorientation and adjustment. Depending on other factors in a mobile person’s life, these challenges may increase HIV-related risks.

Tourism

Travel and sex are each major sources of pleasure for many people, and often they coexist, leading to behaviors that can transmit HIV. Some studies find that rates of sexual contact increased significantly when people were traveling.2 One explanation for this increase is what social scientists call “liminality,” a psychological state in which the “usual rules” do not apply. Travel can serve as an intentionally liminal situation: people place themselves in a different environment, often explicitly for the purpose of relaxation and pleasure, without their usual responsibilities and the normal constraints on their time and energy.

Travelers may also be away from family, friends, sexual partners, and others in their lives whose influence determines their norms on sexual and substance use behaviors. A sexual adventure on vacation, where “nobody knows me,” may be regarded as “socially safer” than one at home, leading to a sense of freedom and disinhibition.3 A qualitative study of 35 British women traveling alone found that participants perceived vacations as apart from everyday existence.4 Anonymity was an important reason some women gave for initiating a sexual relationship on vacation: in the presence of people who did not know them, they felt less risk of being stigmatized for their behaviors. Participants who were not traveling alone cited fear of gossip and judgment as reasons for avoiding sexual behaviors.

A study of American spring-break vacationers found that travel resorts are a context conducive to HIV-related risk behavior. Because young adults travel accompanied only by peers, three conditions combine in this environment: substance use, a sexually open atmosphere, and the perception that peers are engaging in disinhibited behaviors.5

Some people find that opportunities to engage new sexual partners are greater while traveling. A study of 482 British gay men found that 49 percent had more opportunities for sex, 39 percent tended to be more sexually active, 10 percent were more likely to take sexual risks, and 11 percent found it easier to forget
about safe sex. However, increased activity did not necessarily equal greater risk: 37 percent said they took more precautions when having sex on vacation, and unprotected anal sex actually occurred in only 15 percent of sexual encounters.

Among the large number of people who are sexually active while traveling, there is a subset known as “sex tourists,” individuals who design travel plans to include sexual adventures. Choice of destination is influenced by the opportunity for sex, including commercial sex, leading to the popularity of places that have well-developed sex industries such as New York, Bangkok, San Francisco, and Palm Springs. Many of these locations are also places with high HIV seroprevalence rates.

More research is necessary to determine to what extent travel influences HIV risk behavior, since much HIV research ignores travelers as subjects, whether through exclusionary recruitment strategies or other methodological limitations. In particular, it would be useful to determine whether people actually engage more in behaviors that may lead to HIV transmission while traveling than they do while they are at home. A study of 5,676 young, unaccompanied travelers found that subjects who were most likely to find new partners while traveling were also more likely to change partners more frequently at home, and that condom use rates were actually higher with partners abroad than with casual partners at home.

Migration

Like many travelers, people who migrate to the United States often find themselves in unfamiliar territory. The values, norms, and behaviors of their home country may no longer apply; almost certainly, the culture and practices of the new society may seem confusing and may conflict with those of a person’s home country. A comprehensive assessment of HIV-related risk in immigrant populations must include an understanding of the impact of several factors beyond sex- and drug-related behavior, including: the beliefs and practices of the home country, the impact of the migration experience itself, which may include physical and psychological trauma, and the adjustment experience of the individual once in the United States.

Among the values and norms that may be most relevant to HIV risk reduction are those that relate to sexuality, same-sex relationships, drug use, death, disease, and disclosure about behaviors and health. It is important to note, however, that as with any cross-cultural counseling encounter there is tremendous diversity of experience and attitude among individuals within a cultural group. Broad generalizations about cultural groups such as “Asian” and “Latino” may fail since characteristics of culture vary by country and a range of other factors, including class, gender, age, and sexual orientation.

Upon leaving the home country, the experience of migration itself can be physically and psychologically traumatic. Often the impetus for migration is that life in the home country has become intolerable, either because of war, economic conditions, or political repression. Migration, legal or illegal, may be lengthy, difficult, expensive, and dangerous, which may lead to depression, anxiety, and problems with substance use.

Once in the United States, migrants face social and economic challenges that may increase their risk for HIV. Language and institutional barriers, racial discrimination, and immigration status issues narrow employment opportunities for many. A needs assessment of Asian massage parlor workers in San Francisco found that most were refugees or recent immigrants from Thailand or Vietnam, whose limited English and immigration status restricted their employment options.

The values, norms, and behaviors of a mobile person’s former home may no longer apply in their new environment. Almost certainly, the culture and practices of a new society may seem confusing.
The immigrant experience is often a lonely one, especially for men doing migrant labor.

A New York study found that injection drug users who had recently immigrated from Puerto Rico exhibited higher levels of HIV risk behavior than other Puerto Rican injection drug users in the city and lower levels than subjects in Puerto Rico. This suggests that when practices in the home environment are more risky than in the new one, acculturation may have the effect of risk reduction. Similarly, another study found that the more recently Asian/Pacific Islander men who have sex with men had immigrated to the United States, the greater their likelihood of engaging in unprotected anal intercourse. Among Latina women, acculturation was associated with increased condom use with secondary partners.

Other research, however, suggests that acculturation may increase HIV-related risk and increase substance abuse. Acculturation may also be associated with greater sexual freedom and a greater diversity of sexual practice, including oral and anal sex. Mexican men may find American women to be more willing than Mexican women to engage in casual sexual encounters, and gay immigrants may discover a less stigmatized identity and greater sexual opportunities in the United States. These diverse findings suggest the differing impacts of acculturation on specific populations, as well as the importance of understanding to which aspect of U.S. society an immigrant is acculturating. If practices in the community to which an individual immigrates are more likely to lead to HIV transmission than those in his or her home country, acculturation may lead to greater HIV risk.

Some immigrants, primarily women and men who have sex with men, are drawn to the United States because of the greater sexual freedom here; this has been termed “sexual migration.” Gay immigrants may find easy access to sex and drugs, but more difficulty connecting in more “participatory aspects” of the gay community, because of racism, alienation, and sexual objectification. At the same time, traditional venues of cultural and religious participation may be closed to them because of homosexuality.

Relocation

Little research has explored the relationship between relocation and HIV risk. However, the experiences of migrants and tourists as well as research on social support, norms, and networks can inform an understanding of some of the issues confronting people who relocate within the United States.

People moving to a new state or a new town may experience many of the same feelings as people who immigrate to a new country. Some studies have shown an association between suicide and interstate migration, suggesting that depression is a problem for some “relocators.” Economic pressures and changes in social status may also result from a major move. Research also shows that moving is one of the most stressful life events a person can experience, and that anxiety and depression, stress, low self-esteem, and trauma can lead to behaviors that increase HIV risk.

A move to a new city usually involves a change in the type and degree of social support that is available. The idea that social support improves health outcomes is well-accepted in the medical, public health, and psychological research fields, but the concept of “social support” is a complex one, and its relationship to HIV risk may be complicated as well. To the extent that emotional and practical support act as buffers against stress, they may also reduce HIV-related risk.

Likewise, when peer norms in a social support system reject unprotected sex or unsafe drug injection, it would be expected that risk behavior would be reduced. In one study of male injection drug users, researchers found that reduced unsafe injection behavior was relat-
ed to three factors: social support, defined as having an increased number of people to talk with when upset; social influence, defined as having better argument skills about safe drug use; and a change in social network, defined as decreased number of friends who injected drugs.\(^{27}\)

However, other research points to the “dark side” of social support: it can decrease appropriate anxiety or increase denial about real health risks, and it can delay the onset of self-protective health care measures.\(^{28}\) In this way, social support is related to social norms: the extent to which someone is part of a social network, that is, has access to social support, may determine the extent to which he or she is exposed to health-positive or health-negative norms.

As with tourists and migrants, relocaters face a situation in which “the usual rules do not apply,” particularly if relocaters are away from family and friends. As with migrants, relocaters also go through an acculturation process, possibly including attitudes toward HIV-related risk.

In another example of “sexual migration,” many migrants, particularly people who identify as gay and bisexual, explicitly choose to move to places that are more tolerant of sexual diversity. These destinations tend to be major urban centers such as San Francisco, New York, and Los Angeles. Sexual migrants, whether from out of the country or within the country, may revel in this tolerance and explore as many sexual experiences as possible. If an individual is in the process of “coming out,” he or she may not yet have had the opportunity to practice risk reduction or sexual negotiation with partners. Relocation may also increase risk, because relocaters enter a new sexual network and because major urban centers usually have relatively high HIV seroprevalence rates. In communities with the same level of risk-taking, a higher seroprevalence means greater risk at each unprotected encounter.\(^{29}\)

**Reaching Mobile People**

There is not much written about specific HIV-related interventions for counseling the range of mobile people about risk. Among the key strategies mentioned in terms of prevention outreach and media campaigns are cultural competence and cultural relevance. Competency requires a willingness and capacity to understand key concepts as the client understands them and in the context of the client’s culture. These concepts may range from sex and drug use to the test counseling situation itself. Competency also requires the ability to learn from a client about the aspects of his or her experience that are most relevant to his or her life and potential risks.

Moving from one place to another—for whatever reason—is, in and of itself, challenging. Interventions that help people adjust to new surroundings, reduce isolation, and anchor their own values, norms, and beliefs in the context of the new setting are crucial to helping them protect themselves from HIV.

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**PERSPECTIVES Alert: Vaccine Trials and HIV Testing**

Participation in HIV vaccine clinical trials may cause trial participants to test HIV antibody positive even though these individuals remain uninfected. It is crucial for HIV antibody test counselors to understand why this occurs and to counsel vaccine trial participants appropriately.

HIV vaccine trials enroll HIV-negative volunteers to test the safety and efficacy of experimental vaccines. In general, these volunteers are at low risk for HIV infection, and researchers have counseled them about further reducing their risks. The National Institute of Allergy and Infectious Diseases (NIAID) has enrolled more than 4,000 volunteers in dozens of vaccine trials.

These vaccines cannot transmit HIV, but they may induce the development of HIV antibodies and cause an individual to test HIV-positive on standard HIV antibody tests. Some vaccines have produced antibody responses lasting more than 10 years.

Vaccine trial participants, like anyone else, may engage in activities that lead to HIV infection. But because a vaccine may induce antibodies in an HIV-negative person, causing him or her to appear HIV-positive, NIAID has set up a central laboratory to conduct confirmatory testing. NIAID has also instructed state HIV testing programs about obtaining confirmatory test kits and preparing confirmatory blood samples for shipment to the NIAID lab.

HIV antibody test counselors should ask all clients if they have participated in an HIV vaccine trial. Counselors should inform those who have that their HIV test may come back “HIV-positive,” even if they are in fact uninfected. HIV counseling and testing coordinators should ensure that policies and procedures are in place and available for HIV counselors to refer to when necessary. In addition, HIV counselors and other testing staff should be aware of their site’s policies and procedures for preparing samples for NIAID confirmation when a vaccine trial volunteer tests HIV-positive on an antibody test.
Implications for Counseling

When conducting HIV test counseling with people in new environments, including travelers, immigrants, and those relocating within the United States, counselors can help clients begin to assess how the values, beliefs, and practices of their old and new environments interact to affect their risk for HIV. In particular, counselors can help clients identify to what extent the feelings of “liminality,” the sense that “the usual rules do not apply,” or alienation may be increasing HIV-related risk and work with clients to develop steps toward harm reduction plans.

Questions in the counseling session related to the state or country of the client’s birth may raise issues of immigration or relocation—but not necessarily travel—to the counselor’s attention. But the fact that a client is from somewhere else may not be related to increased risk. Only listening to a client’s story will inform the counselor if adjustment to a “new environment” is related to risk in that client’s particular case.

The Condition of Immigrating

Immigrants have often experienced trauma either in their home countries—ranging from poverty to political oppression—during the migration itself, or in the United States. When immigrants come in for HIV testing, many may be suffering from post-traumatic stress, anxiety, depression, and other stress-related or mental health conditions. They may also experience power imbalances in sexual relationships, related to past trauma, the necessity to engage in sex work or survival sex, or the compulsion to stay with a partner for economic support or legal immigration status. These issues, among others, may combine to make health promotion low on the client’s “hierarchy of needs.” Clients presenting with multiple psychosocial issues need counselors to remain client-centered by focusing on HIV risk and by making appropriate referrals to mental health providers, substance treatment, and other social services.

It is unwise, however, to generalize about the effect of the migration experience based on country of origin, since people immigrate for a variety of reasons under a variety of circumstances. What is critical is that the counselor listen for cues in the client’s story as to the challenges, adjustments, and ways of acculturating to U.S. language, values, and norms—that may increase HIV risk for that particular client.

All “mobile clients”—immigrants, relocaters, and travelers—go through a process of adjusting and acculturating to their new environments. Since research is not conclusive about the effects of this process, it is again crucial to listen to each client’s story to uncover their greatest difficulties and the psychological and social factors that might increase their risks. Asking clients about their motivations for a move may uncover other important transitions, such as coming out, a new job, or moving away from family. Be aware of socioeconomic factors—a client’s housing or financial status—as well as psychosocial ones. Ask if a client is satisfied with the transition and if he or she feels connected to friends. There may be a relationship between these answers and a client’s sexual and drug use behaviors.

Crossing Cultures

HIV counseling always calls upon counselors to engage in a conscious use of self to assist clients in identifying and modifying behaviors that increase risk. Counselors must always be aware that their values and experiences may differ from a client’s. Counseling immigrants clearly calls upon the skills of client-centeredness, self-awareness, and neutrality, in part because clients are literally “coming from a different place.”

A Counselor’s Perspective

“Lots of folks who move here are surprised by how much unsafe sex there is. They say, ‘There’s so much candy here, it’s intoxicating.’ As a result, some are confronting their fears of HIV for the first time.”

At times, lack of familiarity with a client’s culture can lead counselors to feel inadequate. While an active interest in a client’s culture can be helpful in the counseling relationship, it is not essential to know a great deal about a given culture in order to be present. It is essential to communicate an openness and curiosity about the client’s experience and an interest in the relationship between culture and behavior for that client. Clearly, it is essential, when offering counseling to monolingual clients, to provide services in the client’s language.

Equally important is the counselor’s examination outside of counseling of his or her own biases, cultural “filters,” and stereotypes. Amanda Houston-Hamilton and Noel Day assert, for example, that providers may “assume powerlessness among whole populations [such as] low-income, immigrant women of color.” But, they state, such cultures may also possess dynamics that could foster HIV prevention. For example, if there are cultural aspects that empower certain women to speak with authority in certain contexts, these cultural strengths might offer prevention opportunities.

Asking clients where they see opportunities to reduce risk is a beginning point to any counseling intervention, especially cross-cultural ones. This approach avoids the trap of mak-
ing assumptions about the effects of different cultures on individuals and the trap—among counselors who appear to share a culture with their clients—of over-identifying with the client and failing to acknowledge his or her unique experience. This question may also indicate a client’s place on the Stages of Change continuum.

Relocation

Clients relocating within the United States face a process of adjustment and acculturation to the new environment. Even moving from one U.S. city to another may expose a client to a new set of values, norms, and behaviors. For example, a newly out gay man moving from a rural area to an urban one with a large gay community may initially be overwhelmed by the sexual opportunities he finds in the new environment.

As with all clients, it is important for counselors to seek to understand how a client’s sexual or drug-using behavior is influenced by his or her perceptions of peer behaviors. Ask “How has your sex life or drug use changed since you moved to the city?” Explore with these clients how they can build support around maintaining behaviors that are less likely to lead to HIV transmission.

Moving is one of life’s most stressful experiences. Ask recent relocators, “What are your usual ways of coping with stress?” Focus, in particular, on those that relate to sexual and drug-related risk. Separation from family and old friends may lead to feelings of isolation and disconnection, which for some people may lead to behaviors that may expose them to HIV. Moving may also induce a sense of freedom and independence, particularly for young adults leaving home or finishing school, people who have recently left a relationship, and those coming out as gay, lesbian, bisexual, or transgender.

References

Travel

Since it is not standard counseling practice to ask testing clients about their travel habits, this issue is most likely to be raised by clients themselves. When it comes up, counselors should be alert for cues as to whether travel is related to risk for this particular client. Assess whether the client’s risk behaviors are different while he she is traveling, and help him or her identify steps toward reduction for these journeys, as well as for their “home” life.

Ask whether the client usually travels alone, with a primary sexual partner, or with others. Keep in mind that those who travel with a partner may still engage in secondary sexual relationships while traveling. Ask clients who are involved in primary relationships if the couple has any “rules” regarding sex outside the relationship. If so, ask if there are exceptions to the rules or if the rules change at all when one or both partners are traveling. Asking “How do you meet your sexual partners?” may also elicit whether travel may be common in the client’s life and relevant to HIV-related risk.

Some couples maintain a “don’t ask, don’t tell” policy when partners are out of town. The task of the client-centered counselor is to help the client become aware of any HIV-related risks they may be taking during vacation or business travel, gently expose inconsistencies in behavior that could lead to HIV exposure, and assist the client in taking steps that integrate this awareness. In cases where clients take more precautions against sexually transmitted diseases when traveling, affirm this and help these clients extend this sense of self-protection to local partners.
Review Questions

1. People in new environments may experience a sense of “liminality,” which is: a) an emotional state that limits people to familiar behaviors; b) a psychological state in which the “usual rules” do not apply; c) a state in which the “usual rules” are reinforced by the norms of the new environment; d) none of the above.

2. True or False: Studies regarding the effect of acculturation on HIV risk have consistently concluded that the less acculturated a person, the greater his risk for HIV.

3. HIV-related risk factors faced by people either relocating within a country or immigrating from a different country include: a) acculturating to new norms; b) dealing with isolation; c) handling financial pressures; d) all of the above.

4. Sexual migration refers to relocation or immigration of: a) large numbers of people of the same gender; b) people who choose where to live based on opportunities for sex; c) gay, lesbian, bisexual, or transgendered people who choose to move to places that tolerate sexual diversity; d) none of the above.

5. True or False: The most important factor in assessing a mobile person’s risk is how well they are adjusting to their new environment.

6. Broad generalizations about cultural groups such as “Asian” and “Latino” may fail since characteristics of culture vary by: a) country; b) class; c) gender; d) all of the above.

7. True or False: Interventions that help people adjust to new surroundings, reduce isolation, and anchor their own values, norms, and beliefs are crucial to reducing HIV risk.

Discussion Questions

1. In what ways do the challenges faced by migrants of any sort—tourists, relocaters, and immigrants—raise similar HIV-related risks?

2. How can counselors help clients determine the place of HIV-related risk within a hierarchy of needs that may include the effects of poverty, discrimination, and poor living conditions?

3. What approaches might help counselors recognize whether the social norms of a client’s new environment are either supporting or undermining HIV-related risk?

4. How can counselors best examine their assumptions about people from other places and how these assumptions affect counseling?

5. Under what circumstances might a counselor discuss HIV-related risk related to tourism in a counseling session?

6. How might counselors discuss risk with men who have sex with men but who identify themselves as heterosexual?

Answers to Test Yourself

1. b.

2. False: Different studies have measured acculturation differently making firm conclusions elusive. In general, greater acculturation may be associated with higher levels of HIV knowledge, but greater knowledge may not lead to HIV risk reduction.

3. d.

4. c.

5. False: Adjustment may be prominent among risk-related factors, but factors ranging from the individual person’s psychology to his or her age and the length of time he or she has been in the new environment will all combine to influence risk.

6. d.

7. True.
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