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# Human Immunodeficiency Virus (HIV) Testing and False Disclosures in Heterosexual College Students

William D. Marelich, PhD; Tonya Clark, BA

**Abstract.** The authors assessed factors that motivate individuals to report negative human immunodeficiency virus (HIV) antibody test results, although they had never been tested. In particular, they investigated sexual intimacy motives associated with the needs for affiliation, sex, and dominance as contributing factors for faulty disclosures. Participants were 246 sexually active heterosexual students. Overall, 21% of the sample had been tested for HIV, and most individuals disclosed their results to intimate partners. Of the entire sample, 5% had previously told an intimate sexual partner they were HIV-negative, although they had not been tested. HIV testing and perceptions of partner deceptions with reference to primary prevention efforts and applications are explored.

**Key Words:** deception, disclosure, HIV testing

Our objective in making this study was to assess human immunodeficiency virus (HIV) testing disclosures in sexually active college students with a focus on why some individuals claimed that they were HIV antibody negative even though they had never been tested for HIV. Although we found that an established body of research on HIV-positive test disclosures to intimate relationship partners<sup>1-3</sup> and research on HIV-negative disclosures<sup>4</sup> we found little empirical research assessing motivations for falsely reporting negative test results. Such faulty disclosures are important because individuals who say they have tested negative for HIV, when in fact they have not been tested, could lead to the continued spread of HIV if individuals are unaware of their disease status. Given that approximately one third of all HIV-infected individuals in the United States may not know they are infected (ie, about 275,000 persons<sup>5,6</sup>), such false statements may put

partners at risk for contracting HIV and may add to the unaware infected population.

HIV and AIDS (acquired immunodeficiency syndrome) associated with heterosexual contact are a growing concern. Surveillance data from 1999 to 2002 show that 35% of new HIV cases in the United States are associated with heterosexual contact,<sup>7</sup> and worldwide surveillance indicates that heterosexual contacts are the major risk category.<sup>8</sup> Judgments of whether one's opposite-sex partners are at risk for HIV/AIDS are typically faulty,<sup>9</sup> underscoring the importance of partners openly discussing whether they have been tested for HIV instead of relying on naive perceptions. Yet, as with those who are HIV positive,<sup>10,11</sup> there may be instances when individuals purposely mislead their partners about their HIV status.

What might lead individuals to say they are HIV-negative when they have never been tested? Certainly, there may be advantages in making such disclosures. For example, stating an HIV-negative status might help one negotiate sexual intimacy.<sup>12</sup> Similar practices such as providing misleading information about past sexual partners or experiences have been noted in intimate dyads during sexual intimacy negotiations.<sup>13,14</sup> In particular, faulty negative HIV disclosures may be associated with goal-based motivations that individuals develop to satisfy their basic needs.<sup>15</sup> Because heterosexual transmission of HIV can occur through unprotected sexual contact, needs associated with sexual intimacy such as need for affiliation, sex, and dominance<sup>16,17</sup> may be useful in understanding faulty disclosures. Goal achievement may actually motivate individuals to provide misinformation to partners, especially in situations where goals and need-fulfillment are threatened. For example, the perception that a potential partner may decline sexual intimacy if an HIV test has not been performed may motivate some individuals to provide misinformation about being tested.

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Our purpose in conducting the current study was to assess HIV-testing disclosures and faulty disclosure practices. We assessed a sample of sexually active heterosexuals to determine whether they had ever been tested for HIV and their subsequent disclosure practices. Research questions included (1) what percentage of individuals has been tested for HIV and how many have disclosed their test results to partners? and (2) how many have told partners that they are negative although no formal test had been administered? We hypothesized that those with greater needs for sexual intimacy would be more likely to make faulty disclosures.

## METHOD

### Participants

Study participants were 246 sexually active heterosexuals affiliated with 2 large Southern California universities. Participants reported they had had at least 1 sexual partner in their lifetimes, 73% said they had 1 to 3 sexual partners, 21% had 4 to 10 partners, and 6% reported having had 11 or more partners. Overall, 65% of our sample was female ( $n = 161$ ), 39.8% was White, 27.6% was Asian, 18.7% was Hispanic, 3.7% was Black, and 10.2% was from mixed or other backgrounds. Their mean age was 20 years ( $SD = 1.69$ , age range 18–25 years). Except for gender, the demographics of our current study group were representative of the student populations at the participating universities (eg, gender: 56%–60% female). None of the participants reported they were married.

Although we made no restrictions concerning participants' sexual preferences, the number of participants with self-reported preferences other than heterosexual (eg, same-sex partners or both men and women) was too small to be included in the analysis. We learned about sexual preference by asking about participants' gender and crossing it with the question, "How would you describe your sexual preference?" Available responses included, *I only have sex with men*, *I only have sex with women*, *I have sex with both men and women*, or *I have never had sex* (we used the latter response to remove individuals from the analyses who had never been sexually active, regardless of their sexual preference).

### Procedure

We used SurveyWiz,<sup>18</sup> an Internet survey design and implementation program, to collect data from the Internet. Before beginning our survey, we acquired institutional review board (IRB) approval and pilot tested the survey on a few university students to verify the clarity of the survey. We notified participants about the survey by means of posted flyers in the university psychology department or through psychology course announcements that directed them to the URL of the lead author's university home page on the World Wide Web. We also instructed participants to look for a highlighted Web link that read "HIV Test Motivation Survey" (located on the bottom of the home page). The only limitation in the recruitment announcements was that participants must be aged 18 years or older.

We collected data on 2-week intervals in April 2001, June 2002, and November 2002. At the beginning of the survey, we obtained participants' informed consent and reminded the participants that all survey responses were anonymous. At the end of the survey, we generated a unique identification number for each participant and instructed the individuals to retain this number to present later for research credit after the survey was completed. Nonstudent participation was highly doubtful, given (1) how the study was advertised, (2) the URL and Web link location of the survey, and (3) the time period that the survey was available on the Web.

## Measures

### HIV Testing and Disclosure Patterns

A series of items that were conceived and specifically written for the current study asked participants directly about their HIV testing and disclosure practices, including the following: *Have you ever been tested for HIV? Have you ever been asked by a potential sex partner if you have been tested for HIV?* and *Do you think someone who is HIV-positive should disclose their status to their [sic] significant other/love/relationship partner?* We used a yes–no format to assess each of these items. We measured the item, *Prior to being sexually intimate for the first time, do you ask your potential sex partners if they have ever been tested for HIV?* Responses were on a 5-point scale: *always*, *more than half the time*, *half the time*, *less than half the time*, and *rarely/never*. We made no assessment regarding HIV-positive status.

We also used open-ended fill-in items to determine why individuals disclosed getting an HIV test to their partners. One item addressed why individuals chose to disclose getting an HIV test to their partners: *[If] you do disclose your [HIV test] results, why did you choose to disclose that you had an HIV test?* The following item asked why individuals chose not to disclose getting the test: *If you have ever had an HIV test and chose not to disclose that you had the test, what was the reason?*

### Faulty HIV Test Disclosures

A single item assessed whether participants had ever told a partner that they were HIV-negative although they had never been tested. The item read, *[Have you ever] told a partner that you were HIV-negative to have sex although you had not been tested?* We used a yes–no format to score the item.

### Sexual Intimacy Needs

We used 9 items to reflect 3 primary needs associated with sexual intimacy, including *need for affiliation*, *need for sex*, and *need for dominance*.<sup>16,17</sup> We adapted the items directly from Murray.<sup>16</sup> Instructions read, "The next few items address things we may 'need' in life. Some say we need many things in order to survive (eg, food, shelter). Below we have presented a series of items and would like you to rate each item as to how much you agree or disagree with them as things you may need. The term 'Partner' used below refers to a sexual partner (eg, dating partner,

boyfriend/girlfriend, long-term partner/spouse)." Statements of need for affiliation included: "A companion in life," "Somebody to love," and "Nobody special in my life" (reverse coded). Statements for need for sex included: "To have more sex," "Sex with a lot of partners," and "To let myself go sexually with someone." For need for dominance, the statements included: "Control over my partner," "My partner to give me what I want (such as financial support, clothes, a car)," and "A partner who I can manipulate." To measure all statements, we used a 5-point scale ranging from *disagree definitely* (1) to *agree definitely* (5). Correlations across items, means, and standard deviations are presented in Table 1.

We next used principal components analysis to assess these statements as independent sets. We deemed a 3-component solution appropriate on the basis of our inspection of the scree plot, the eigenvalue greater than 1 guideline, and the strength of component loadings. We investigated both oblique and orthogonal rotations because we deemed correlations across components weak. We retained the orthogonal solution. Overall, the percentage variance accounted for by the 3 components was 61.82. Items loaded on components as predicted (see Table 2 for a summary of the statement loadings on the components). However, internal consistency (Cronbach's alpha) of the statement sets was questionable, with values of .69, .68, and .55 for need for affiliation, sex, and dominance, respectively. Therefore, we used the 9 individual statements in the subsequent analyses instead of component scores or summed scales.

### Analyses

In this article, we first provide descriptive information about HIV testing, including percentages and chi-square

tests, then summarize qualitative comments to explore reasons for disclosure to one's partner of an HIV test by looking for emergent themes.<sup>19</sup> To investigate predictions of faulty disclosure practices, we used SAS V9.0 (SAS Institute Inc., Cary, NC) for exact multivariate logistic regression. We generated effect sizes for significant results, using correlation coefficients with cutoff values of .10, .30, and .50 for small, medium, and large effects, respectively.<sup>20</sup>

### RESULTS

Approximately 21% of the study participants (52 of 246) reported that they had been tested for HIV, with 38 of 52 (73%) reporting both an HIV test and telling their sexual partners they had been tested. Overall, 92% reported that HIV-positive individuals should disclose their status. Of the total sample, 79% reported that a partner had never asked about their HIV status. Fifty-one percent reported that they rarely or never ask their intimate partners about their HIV status (men were less likely than were women to ask their partners' HIV status; likelihood ratio  $\chi^2(1, N = 246) = 5.19$ ,  $p < .05$ ,  $r = .14$ ). With the above exception, we noted no gender or race (ethnicity) differences at the level of .05 or better, using likelihood-ratio chi-square tests.

Open-ended items asked participants to explain why they did or did not disclose HIV status to their partners, asking, *[If] you do disclose your [HIV test] results, why did you choose to disclose that you had an HIV test?* All 38 participants who had been HIV tested and disclosed to their partners provided reasons for their disclosure. The majority of responses fell into three main categories: (1) providing information, (2) sexual safety, and (3) expected reciprocity. Twelve of 38 (32%) reported simply wanting to inform their partners (eg, "just in case he was curious") or said that their partners had a right to know. Conveying sexual safety to one's partner was another

TABLE 1. Correlations, Means, and Standard Deviations for Sexual Intimacy Needs

Variable	1	2	3	4	5	6	7	8	9
Need for affiliation									
1. A companion in life	—								
2. Somebody to love	0.59**	—							
3. Nobody special in my life†	0.40**	0.36**	—						
Need for sex									
4. Sex with a lot of partners	-0.13*	-0.15*	-0.19**	—					
5. To have more sex	0.06	0.04	-0.03	0.38**	—				
6. To let myself go sexually with someone	0.15*	0.12	0.07	0.32**	0.56**	—			
Need for dominance									
7. Control over my partner	0.01	-0.01	-0.02	0.16*	0.25**	0.16*	—		
8. A partner I can manipulate	-0.04	-0.05	-0.11	0.28**	0.33**	0.21**	0.26**	—	
9. My partner to give me what I want	0.25**	0.25**	0.14*	0.09	0.28**	0.16*	0.30**	0.29**	—
<i>M</i>	4.45	4.56	4.65	1.46	2.79	3.06	2.24	1.66	2.61
<i>SD</i>	0.82	0.79	0.86	0.84	1.39	1.41	0.99	0.94	1.26

Note.  $N = 238$ . Listwise deletion of data.

†Reverse coded.

\* $p < .05$ . \*\* $p < .01$ .

**TABLE 2. Loadings and Percent Variance for Principal Components Analysis With Varimax Rotation on Sexual Intimacy Needs**

Variable	Loadings after rotation†		
	1	2	3
1. Need for affiliation			
A companion in life	.83	—	—
Somebody to love	.82	—	—
Nobody special in my life‡	.70	—	—
2. Need for sex			
Sex with a lot of partners	—	.66	—
To have more sex	—	.79	—
To let myself go sexually with someone	—	.84	—
3. Need for dominance			
Control over my partner	—	—	.74
A partner I can manipulate	—	—	.63
My partner to give me what I want	—	—	.73
Percentage variance after rotation	23.38	20.84	17.60

Note.  $N = 238$ . Listwise deletion of data.

†Loadings under .40 have been suppressed.

‡Reverse coded.

theme noted by 18% of those tested (eg, "so she would know that . . . I was healthy"). Another 13% disclosed to their partners so that they could know their partners' status (eg, "because I wanted to know if he had been tested"), suggesting an expected reciprocity or exchange of information.

We asked nondisclosers, *If you have ever had an HIV test, and chose not to disclose that you had the test, what was the reason?* Of those who were HIV tested but did not disclose the results, 50% (7 of 14) provided reasons. Five individuals noted that there was no reason to bring up that they were tested (eg, "didn't feel the need to say"), especially if the test was negative ("it was negative, so it was not an issue"). Two others indicated that their partner simply never asked.

Next, we investigated motives for deceptive testing disclosure practices, addressing the issue of telling a past partner of a negative HIV test when the participant had never been tested. Of the 246 participants, 12 responded yes to the following question: *Have you told a partner you were HIV-negative to have sex although you had not been tested?* To examine possible motives underlying these faulty disclosures, we used multivariate logistic regression.<sup>21,22</sup> We identified 2 groups of individuals—those who made faulty HIV-negative disclosures ( $n = 12$ ), and a second group that consisted of those who made no faulty HIV-negative disclosures ( $n = 234$ ). We conducted separate analyses for each set of needs-associated statements (ie, affiliation, sex, and dominance), and we used group membership as the criterion (coded "0" for *no faulty disclosure*, and "1" for *faulty disclosure*). We used the direct method of variable entry, in which all predictors are entered simultaneously. Because of the small proportion of cases reporting faulty disclosures, we requested *exact analyses*, which provide more accurate solutions with small samples or small probabilities.<sup>22</sup> We based

model evaluation on the chi-square score (provided for exact estimates).

Multivariate logistic regression results are presented in Table 3. For the affiliation statements, the model was significant,  $\chi^2(3, N = 238) = 10.77, p = .01, r = .21$ . Adjusting for other variables in the model, only the statement "Need a companion in life" reached significance,  $b = -1.08, p = .01$ , indicating that those less likely to want a companion in life were more likely to make faulty disclosures. Regarding need for sex, the overall model did not approach significance,  $\chi^2(3, N = 238) = .60, NS$  (not significant). We noted a similar finding for the need for dominance statements,  $\chi^2(3, N = 238) = 3.96, NS$ .

We used a nested model approach to assess the stability of the need for affiliation finding. First, we fitted a model with the 6 statements representing need for sex and need for dominance. A second model was then fitted with all 9 statements, including those associated with need for affiliation. We found the change in the likelihood ratio chi-square between the models to be significant,  $\chi^2(3, N = 238) = 10.38, p < .02$ , indicating that the affiliation statements (as a group) remained viable above and beyond the other 2 statement sets. Further, the statement "Need a companion in life" remained significant at the  $p < .05$  level.

#### COMMENT

Although only 5% of the sample reported they had made a false HIV-negative disclosure without being tested, this finding is still of concern, given that such claims could lead to the continued spread of HIV.<sup>5</sup> Counter to our hypothesis that sexual intimacy motivations would be positively associated with faulty disclosures, we found that the need for affiliation item "need a companion in life" was inversely

**TABLE 3. Exact Multivariate Logistic Regression Analyses of Sexual Intimacy Needs on Faulty HIV-Negative Disclosures**

Predictor set	Parameter estimate	OR	95% CI
<b>Model 1: Need for affiliation</b>			
A companion in life	-1.08†	0.34	0.15-0.80
Somebody to love	0.26	1.30	0.53-3.48
Nobody special in my life <sup>1</sup>	1.25	3.48	0.97-84.86
<b>Model 2: Need for sex</b>			
Sex with a lot of partners	0.23	1.26	0.55-2.54
To have more sex	-0.02	0.98	0.54-1.73
To let myself go sexually with someone	-0.12	0.89	0.51-1.52
<b>Model 3: Need for dominance</b>			
Control over my partner	-0.10	0.91	0.42-1.89
A partner I can manipulate	0.02	1.02	0.38-2.13
My partner to give me what I want	-0.52	0.59	0.29-1.09

Note.  $N = 238$ . Listwise deletion of data. Model 1: Score  $\chi^2(3) = 10.77$ ,  $p = .02$ . Model 2: Score  $\chi^2(3) = 0.60$ , *NS* (not significant). Model 3: Score  $\chi^2(3) = 3.96$ , *NS*. OR = odds ratio; CI = confidence interval. †Reverse coded.

related to faulty disclosures; those who reported a lower need for a companion in life were more likely to make faulty disclosures. Lower affiliation desires may be associated with a propensity toward casual intimate relationships, with faulty HIV-negative test disclosures possibly functioning to remove sexual intimacy barriers.<sup>12</sup> This agrees with a recent research finding that those individuals in closer relationships are less likely to lie about sexually related information.<sup>23</sup> Furthermore, the findings are in accordance with research on disclosure to sexual partners of HIV-positive status, with 17% of women and 19% of heterosexual men indicating nondisclosure of their serostatus mainly to nonexclusive sexual partners.<sup>24</sup>

Needs beyond those associated with sexual intimacy may possibly be influencing faulty HIV-negative disclosures and warrant investigation. For example, recent research suggests that those who monitor their social behaviors in an effort to appear more desirable to potential partners are more likely than others to report deceptive dating behaviors.<sup>25</sup> Therefore, applying Murray's topologies<sup>16</sup> needs associated with "desirable presentations" such as success and abasement should be investigated. In addition, our results suggest that need for affiliation should be further pursued, and future research should focus on higher levels of this need and its association with truthful disclosures.

How can individuals ensure that their partners are being truthful when they disclose HIV testing results? First, one must ask partners whether they have been tested for HIV. In the current study, 79% of the participants reported that a partner had never asked about HIV status. Individuals should recognize that the simple cues and decision rules used to discern whether someone is HIV-negative could be incorrect. These include such decision rules<sup>9</sup> as "he is like me so he likely doesn't have AIDS, or judgments based on partner characteristics such as "she is beautiful so she doesn't have

AIDS."<sup>9(p485)</sup> Primary prevention efforts should focus on moving individuals away from using these "idiosyncratic decision rules" and toward using behavior-based information to make such judgments (eg, partners' condom use) in conjunction with HIV-testing discussions.<sup>9</sup>

An equally important issue regarding relationship deception that was not addressed in the current study is related to the gender of men's sexual partners. Some men may appear outwardly heterosexual and may even be in long-term heterosexual relationships, yet they may have sex with men clandestinely. The prevalence of this type of deception is unknown in university populations, but one general population survey of young men (aged 15-22 years) who have sex with men indicates that almost 4% self-identify as heterosexual; of these, 3.8% tested positive for HIV.<sup>26</sup> Further, although broader seroprevalence rates for university students have yet to eclipse the 1% estimates from the 1990s,<sup>27,28</sup> a preliminary report from North Carolina indicates an "epidemic" of HIV infection among college-enrolled males who have sex with men.<sup>29</sup> These recent numbers argue strongly for increased surveillance in university settings and underscore the need for primary prevention efforts that focus on empowering students to ask partners about their sexual histories and preferences.

The HIV-testing rate in this study was 21% (95% confidence interval [CI] = 16%-27%), slightly below comparable figures for residents in Southern California (eg, 35%-37%).<sup>30</sup> The lower rate may be a result of the focus on heterosexuals, who typically test at lower rates compared with their representation in the US population.<sup>31</sup> Overall, increasing HIV testing within this population would be advisable, given that college students' sexual activities can be surprisingly "risky" with multiple partners, "hookups," 1-night stands, negative attitudes toward condom use, and alcohol use.<sup>32-36</sup> How might testing be increased? One

approach is to frame testing messages in a manner that will lead to action. In particular, loss-framed messages have been shown to increase detection behaviors,<sup>37,38</sup> including health behaviors such as HIV testing.<sup>39</sup> However, loss-framed messages are best used when testing outcomes are uncertain. Because HIV prevalence in college populations is generally low and perceived risks of contracting HIV are also low, individuals may believe that they would test negative; hence, they do not get tested. In such situations, gain-framed messages might be more appropriate if the screening behavior were reframed as *health-affirming*.<sup>38</sup> For example, getting an HIV test might be framed as verifying one's negative HIV status (eg, "Getting tested for HIV is the best way to affirm that you are disease-free").

Another way to increase testing is to diffuse the notion that HIV testing is "normative" in college populations. Although HIV and getting an HIV test are stigmatized,<sup>40</sup> there have been dramatic shifts toward normative HIV testing in high-risk groups.<sup>41,42</sup> Hence, if testing can become the norm in these high-risk populations, then shifting perceptions in less-risky populations is possible. Altering normative beliefs regarding what college peers typically do and perceptions of what others might think if one is tested should show increases in testing behaviors. One theory of behavior change that includes the theory of reasoned action<sup>43,44</sup> might be best applied to increase testing behavior. Altering subject norms and attitudes toward HIV testing should influence the behavioral intention to be tested and subsequently affect actual testing behavior. The theory has been shown to be successful in application to HIV preventive behaviors, including an HIV test.<sup>45</sup>

### Limitations

We recognize several caveats in our current study that we should mention. The convenience samples of university students we used differed demographically from those at US universities as a whole (eg, across US campuses, 68.3% of the students are White, 11.3% are African American, 9.5% are Latino, 6.4% are Asian, 4.5% are "other," and 56.1% are female).<sup>46</sup> Hence, generalizations of our results to noncomparable settings should be made with caution. In particular, our sample underrepresents African American students, who account for 74% of new heterosexually acquired HIV cases in the United States.<sup>7</sup> Our sample also overrepresents women, a low-risk category on campuses compared with other categories<sup>27</sup> but a group that accounted for 29.5% of new HIV infections from 1999 to 2002 and 64% of new heterosexual cases.<sup>7,47</sup>

Another limitation includes using the Internet for data collection; although access to the survey was limited, some nonstudents may have responded. In addition, responses were based on self-report, which may be biased because of social desirability in reported sexual behaviors and HIV testing information. However, one advantage of our data collection method is that participants could complete the survey in the privacy of their homes and were assured that the survey was anonymous. Biases might also

have resulted from how "sexual partner" was defined; a better approach would have been to define "sexual partner" as *someone with whom the respondent has regular sexual intercourse*.

The study would have benefited from collecting data from all sexual preference or identity categories (eg, lesbian, gay, bisexual, and transgender) to allow for comparative analyses across groups. This would have required a much more aggressive data collection effort, yet accessing such populations using Web-based surveys has been shown to be efficient and valid.<sup>48,49</sup> We did not assess HIV status; therefore, there is no indication of whether any of those individuals who made faulty disclosures were HIV-positive, which would pose an increased risk for spreading HIV. Last, the public health risks associated with faulty HIV-negative test disclosures when one has never been tested do not equate to risks associated with nondisclosure of HIV-positive serostatus. Therefore, generalizing the current results to HIV-positive populations should not be undertaken.

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### NOTE

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