Ethical Issues in a Study of Bipolar Disorder and HIV Risk Among African-American Men Who Have Sex With Men

Case Study in the Ethics of Mental Health Research

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Abstract: African-American men who have sex with men (MSM) are at increased risk of HIV infection, as are individuals with severe mental illness. This study was conducted at the behest of members of the African-American MSM community in Cleveland, Ohio, to assess the co-occurrence of HIV risk and bipolar disorder among African-American MSM. A sample of 125 participants was recruited via flyers and word of mouth at venues used by members of this community. Individuals were assessed for HIV risk and severe mental illness. Various ethical issues were presented, including participant capacity and voluntariness and the risk-benefit ratio. Divergent perspectives of the local institutional review board and the community advisory group with respect to the risks and benefits of participation required reconciliation before the study could proceed. Solutions for the resolution of such conflicts are discussed.

Key Words: African-American, capacity, community, institutional review board, men who have sex with men, research ethics.

THE RESEARCH PROJECT

The principal investigator (PI) initiated this pilot study at the behest of members of the African-American men who have sex with men (MSM) community in Cleveland to assess the prevalence of severe mental illness (SMI; schizophrenia, bipolar disorder, major depression) among a community sample of African-American men who have sex with men (MSM) and transgender men and the relationship between HIV risk behaviors and SMI among African-American MSM.

Cleveland is the seat of Cuyahoga County, from which the study participants were drawn. In 2007, the population of Cuyahoga County was 1,295,958 (47.4% male; 52.6% female). Cuyahoga County is 63% white, 29% black, 4% Hispanic, 2% Asian, and 2% other. Median household income in 2007 was $44,400. Cleveland, with a population of 444,313 according to 2006 figures, is the second largest city in Ohio, the largest city in the six-county recruitment area of this study, and ranks 39th in size nationally. Cleveland is 51% black. In 2007 and for the second time this decade, Cleveland has been named the poorest big city in America, with 32.4% of the city’s residents living below the federal poverty level. Forty-two percent of African-American men with HIV/AIDS in Ohio are exposed to the virus through unprotected sex with other men (Ohio Department of Health, 2010). Consistent with national patterns, African-Americans make up 67% of all HIV/AIDS cases in Cleveland (City of Cleveland Department of Public Health, 2009). In 2006, 76% of Cleveland black men aged 20 to 29 years at the time of diagnosis of HIV/AIDS reported MSM behavior, and 19% reported bisexual behavior. In the previous year, 64% of black men aged 20 to 29 years with newly diagnosed HIV/AIDS reported MSM, and 18% reported bisexual behavior (Bruckman, 2008).

Members of the potential participant community had approached the PI regarding the feasibility of conducting such a study because of concerns about the anecdotal high prevalence of mental illness within their community and the documented high prevalence of HIV/AIDS. They believed that additional resources for mental health care for their community might become available if research findings indicated an association between mental illness and HIV risk. Because the funding for the study was awarded from a foundation focused specifically on bipolar disorder, phase 2 follow-up for further behavioral assessment was limited to individuals with a research diagnosis of bipolar disorder. This article discusses the ethical issues that arose in the context of the study, the divergent perspectives of the community advisory group (CAG) and the local institutional review board with respect to these issues, and the mechanisms used to resolve the differences that threatened to terminate the study before it began.

We developed the initial study protocol in conjunction with members of the participant community (African-American MSM); this group developed into an informal CAG that provided feedback to us on various aspects of the study and assisted with recruitment. To the best of our knowledge, none of these individuals had previously had any interactions with any institutional review board (IRB). Our advisory group included individuals involved in HIV outreach efforts, sex work, and club performances.

For a number of reasons, we believed that the conduct of the study, in collaboration with members of the participant community, was critical to maximizing cultural sensitivity, appropriateness, and the success of the research. First, members of the community had approached the PI about conducting such a study out of concern for their community. It was clear that at least some individuals wished to be involved; their involvement as critical advisors throughout the study signaled the academic researcher’s recognition of the community’s values and priorities. Second, the study focused on various highly sensitive issues: mental illness, sexual behavior, and HIV; community members themselves would know best how to approach these highly sensitive topics without causing offense, both in recruitment efforts and in the interviews. Third, collaboration with the community members would facilitate co-learning, that is, the bidirectional transfer of knowledge and skills between the academic research team and the community team. Fourth, the advisory group members were positioned in their community to share the findings of the study with others and to encourage members of their community to reduce their HIV risk behaviors. Although many community-oriented studies do proceed without a community advisory group, the roles played by the members of the community advisory group to this research were consistent with a community-based participatory research approach (Israel et al., 2005, 2008).

Eligibility for participation in this study required that individuals be 18 years or older, have a residence or other connection to Cuyahoga County, self-identify as African-American, self-identify as
an MSM or transgender, and be able and willing to provide informed consent. We excluded individuals younger than 18 years and those who were unable or unwilling to give informed consent.

Participants were recruited from nonclinical sites, such as nightclubs, relevant social service organizations, participant referral, social clubs, in Cuyahoga County. However, many MSM self-identify as heterosexual and would not want to be associated in any formal way with an organization that is identified with MSM (Ross et al., 2003). Nevertheless, many of these men frequent clubs that cater to this population.

Recruitment at such sites consisted of displaying flyers about the study so that individuals were made aware of it; this was akin to an advertisement for the study. The men were then free to telephone at their convenience for additional information or to approach a study-associated individual at the club to ask additional questions. This mechanism is effective for recruiting individuals in “hidden” populations because they are able to approach study personnel or obtain the telephone number in a nonthreatening setting and can carry on a conversation to learn more about the study in a place and manner that appears to outsiders to be a social interaction, rather than an illness-associated event. Participants were also recruited through a local drop-in center for minority men and women of minority sexual identity.

Individuals who enrolled in the study were invited to provide information about the study to their friends and colleagues who might be eligible to participate. Those friends and colleagues who were interested in the study telephoned study personnel for additional information and, if they were interested, arranged an appointment to learn more and be screened for eligibility.

Study procedures included a demographic questionnaire, a self-report of sexual and drug-using behavior, and the Structured Clinical Interview for Axis I DSM-IV Diagnoses (SCID), which was administered by a trained interviewer. Individuals found to have a research diagnosis of schizophrenia, major depression, or bipolar disorder were provided with a facilitated “hard” referral for mental health services if they desired, that is, a referral to a specific program after determination by a staff member that the program potentially met the participant’s needs, that the participant appeared to meet the program’s eligibility criteria, and that space was available for a new client. As an example, if an individual wanted a referral to a substance use treatment program, a study staff member would determine which of the recovery programs in his geographic area might be appropriate for that individual (e.g., age of clients, type of drug used, residential or outpatient) and whether there were currently any openings for new clients. The staff member would then arrange the intake appointment for the client at that program and, if the client requested, accompany him to that first meeting. In addition, individuals with bipolar disorder were followed for period of 90 days from their baseline interview to determine a) whether those not in mental health care had sought and obtained such care and b) whether those found to be at high risk of HIV had modified their risk behaviors after having received an assessment of their HIV risk.

BACKGROUND: AFRICAN-AMERICAN MSM AND HIV

MSM account for more than one half of all new HIV infections in the United States (Hall et al., 2008); African-American MSM are disproportionately affected and constitute approximately one quarter of all new infections (Millet et al., 2006, 2007; Mitsch et al., 2008; Sifakis et al., 2007). One recent study found that African-American MSM have almost 7 times the odds of HIV infection as compared with white MSM (Bingham et al., 2003). In the Cleveland area, which was the site of our study, African-American men account for 39% of all reported persons living with HIV/AIDS and 43% of individuals living with HIV/AIDS by current disease status (City of Cleveland Department of Public Health, 2004). More than one fifth of these cases are attributable to unprotected sex between men. Another 10% of the cases are attributable to unprotected bisexual contact; because these individuals have had unprotected sex with both men and women, it is not known whether they contracted HIV from sexual relations with a man or a woman.

Research indicates that the disproportionate rates of HIV among African-American MSM cannot be explained by greater sexual risk taking, such as a greater number of sexual partners, engaging in commercial sex work, or engaging more frequently in unprotected anal intercourse or by drug or alcohol use (Millet et al., 2006). The increased incidence and prevalence of HIV among African-American MSM may, however, be attributable to a greater likelihood of having another sexually transmitted infection, which is a marker of risk (Fleming and Wasserheit, 1999); infrequent or delayed testing for HIV, which may result in the unknowing transmission of HIV to sexual partners (Centers for Disease Control, 2005; Tieu et al., 2009); partner selection, which may include older men who are more likely to be HIV-infected (sexual mixing; Service and Blower, 1995); and anorectal douching, which may increase the probability of HIV transmission because of the vulnerability of anal tissue to abrasion during penetration (Smith, 2001).

Previous research had reported high intercorrelations between psychosocial problems, such as depression, polydrug use, childhood sexual abuse and partner violence, and HIV seropositivity (Stall et al., 2003). Numerous United States–based studies had found an association between severe mental illness (major depression, bipolar disorder, and schizophrenia) and HIV risk. Studies of HIV seroprevalence among individuals with SMI have found seroprevalence rates ranging from 4% to 22.9% (Cournos et al., 1991, 1994; Empfield et al., 1993; Lee et al., 1992; Meyer et al., 1993a, b; Saks et al., 1992; Schwartz-Watts et al., 1995; Silberstein et al., 1994; Stewart et al., 1994; Susser et al., 1993; Volovka et al., 1994). Research relating to HIV risk behaviors among SMI individuals indicates that as many as 40% of some samples have had more than one sexual partner during the year preceding the study (Hanson et al., 1992; Kelly et al., 1992); sexual intercourse with a known injection drug user has been reported in as many as 20% to 26% of SMI individuals (Knox et al., 1994; Steiner et al., 1992). As many as 27% or more of SMI samples have reported trading sex for drugs (Kalichman et al., 1994; McKinnon et al., 1996).

The PI and colleagues had found from a previously conducted NIMH-funded study with severely mentally ill Puerto Rican and Mexican women that those with a diagnosis of bipolar disorder had higher levels of sexual risk compared with those with a diagnosis of either schizophrenia or major depression (Lou, 2011). Accordingly, we hypothesized that bipolar disorder might be associated with the high levels of sexual risk taking that had been reported by community members and were reflected in the published literature. Repeated findings in the mental health literature of the overdiagnosis of schizophrenia among African-Americans and the underdiagnosis of bipolar disorder lent further preliminary support for this hypothesis (Kennedy et al., 2004; Strakowski et al., 2003; Trierweiler et al., 2006) in that some of the men may have had misdiagnoses of schizophrenia.

ETHICAL ISSUES

Informed Consent: Capacity

Although the mere fact of having been diagnosed with a mental illness should not serve as the basis for automatically assuming that the individual lacks capacity (National Bioethics Advisory Commission, 1998), the capacity of individuals found to have a research diagnosis of mental illness could be at issue depending on the severity of their mental illness symptoms. We were able to secure the gratis services of a psychologist not associated with the study to review the mental health assessments for any potential indication of symptoms that could suggest a lack of capacity. Staff were trained to terminate eligibility interview with any individual who appeared to lack capacity at the time.
because of substance use and to invite the prospective participant to reschedule an eligibility interview for another time if they so desired.

**Informed Consent: Voluntariness**

The Nuremberg Code states explicitly that research may not be conducted without the voluntary consent of the study participant. However, the life situation of many individuals with a severe mental illness may affect the extent to which their consent is truly voluntary. One research study in the United States found that 21% of adults with serious mental illness live below the poverty threshold, compared with 9% of the general adult population (Barker et al., 1992). Many homeless individuals have mental illness (Isaac and Armat, 1990). Lack of adequate medical care may be associated with the poverty and lack of stable housing that they experience (Douaihy et al., 2005). Consequently, the possibility of participation in research that both offered a monetary incentive and provided individuals with facilitated, hard referrals to relatively scarce and hard-to-find mental health services amenable to behaviorally nonheterosexual minority men could be perceived as sufficient inducement to cause individuals to disregard any associated risks and to overemphasize the direct benefits that they might derive (National Bioethics Advisory Commission, 1998).

A relatively small incentive of $10.00 was offered to individuals for their participation in the initial interview. We believed that this relatively minimal sum was unlikely to persuade individuals to participate in the study if they were not inclined to do so for other reasons. This amount had been established in consultation with members of our CAG and with members of the participant community. Whether a particular sum of money represents an undue inducement that might “pull” someone toward participation or, together with personal situational factors, “pushes” someone toward participation so that it is experienced as coercion, requires an objective evaluation on the part of the investigator but is ultimately a subjective sense on the part of the participant. Members of the CAG believed that a greater amount might be somewhat coercive because some of the prospective participants might be homeless because of family difficulties related to their sexual orientation, but a lesser amount would not adequately compensate them for their contribution.

**Risks and Benefits**

**Risks**

Confidentiality and privacy were of primary concern to the investigators and the community. Many of the potential participants might self-identify as heterosexual and have built their lives on this identity, shielding their same-sex sexual behaviors from discovery. Consequently, a breach of confidentiality or privacy could result in major disruption to their lives and emotional and financial trauma. As an example, we believed that some of the individuals might be married and that their spouses and other family members would not know about their sexual relations with other men. A breach of confidentiality with respect to their sexual activities could ultimately result in a disclosure to family members, with ensuing consequences. Accordingly, procedures were established to minimize the risk of intentional or inadvertent breaches, including the use of locked cabinets for data storage, unique identifiers for participant data, deidentified data entry, separation of informed consent forms from collected data, limited access by personnel to data, an NIH-issued certificate of confidentiality, and enclosed interview rooms. The unique identifiers allowed us to combine the data collected at the baseline interview with the data for the same individual that were collected at later points in time, without using the individual’s name or other identifying information. Enclosed interview rooms ensured that the interview would not be overheard by persons other than the interviewer; this is in contrast to open cubicles that would have permitted others to overhear the conversation and to look in and associate the information overheard with the face of a particular individual.

A potential risk at both the community and individual levels was the possibility that community members would believe that the very fact of conducting the study would result in additional resources for the community, apart from any that were a part of the study itself (this might be analogized to the therapeutic misconception, whereby individuals who were advised that they will be participating in research and may not derive individual benefit nevertheless believe that the arm of the study to which they are assigned will provide them with therapeutic benefit). The community members who initially approached the PI about the possible study did not have this expectation. The PI and these initial individuals went to great lengths to explain to the CAG members the difference between research and care and that researchers cannot guarantee the outcome of their studies or the availability of care or resources after the conclusion of the study. These same issues were explained to prospective participants in the context of the informed consent process.

Because of the stigma associated with mental illness in this community, we were advised by members of this community and our CAG to refrain from using terms such as bipolar disorder, mental illness, and so forth in our flyers. Instead, we referred to emotional problems, troubles, or health and provided details about the mental illness aspects of the study to individuals who contacted us. This is an approach that we had used in previous studies because of the sensitivity of mental illness; individuals seen reading the flyers or seen speaking with study staff might be assumed by others to have a mental illness and be ostracized and/or victimized as a result. As an example, one of the flyers that we developed used the following language:

*We are looking for you if you are the following:

*African-American MSM (men who have sex with men)
*18 years or older
*Cuyahoga County resident
*Often have mood swings

You may qualify to participate in a study about the relationship between HIV risk and (emotional) mental health.

Mental health evaluation provided at no cost.
Compensation is provided.*

Individuals who responded to the flyers were provided with full details about the subject matter of the study.

**Benefits**

Each participant was provided with a summary of their HIV risk and assessment of their mental status at the conclusion of the study. The level of HIV risk was premised on their responses to questions relating to their sexual behavior and substance use and a comparison of these responses with factors known through empirical literature to increase risk, such as unprotected anal intercourse with multiple partners of unknown HIV seropositivity. Participants were advised that the assessment of their mental status was derived from the responses they provided to questions on the SCID, that this was a research diagnosis, and that they might wish to follow up with a mental healthcare provider to confirm the diagnosis. Individuals were also provided with a personalized referral to appropriate providers for mental illness, substance use treatment, and HIV testing and counseling services if they wished (several individuals did, in fact, request referrals for mental health services and substance abuse treatment). Because culturally sensitive counseling services for
African-American MSM are extremely limited in the geographical area encompassed by this study, the identification of appropriate resources and a “hard” referral to a provider required a significant allocation of staff time and effort. If a participant requested it and signed an appropriate release, the PI provided the results of the HIV risk assessment and mental health to his primary care physician.

**Oversight: Divergent Views of the IRB and the CAG**

Although the IRB and the CAG members were in agreement as to the risks of participation in the study, their views diverged significantly with respect to how the risks manifested, the potential benefits of participation, and the risk-benefit ratio. In addition, each board challenged the authority of the other to make decisions for this community with respect to the sufficiency of the protections that were designed to minimize risk.

Both IRB and CAG members observed that a breach in confidentiality or privacy could potentially result in the stigmatization of a participant. The CAG members believed that confidentiality and privacy were central to the greatest potential risk and that measures that had been put into place and that stigmatization was unlikely to occur as a result of a breach. However, IRB members questioned whether the PI was the appropriate individual to conduct the research, suggesting that because she was known within the African-American MSM community for research relating to HIV/AIDS and to mental illness, any interaction itself with the PI could constitute a manner of breach that could lead to stigmatization. The IRB’s focus on the potential for stigmatization was consistent with its ethical obligations. Guideline 19 of the Council of International Organizations of Medical Sciences 1991 International Guidelines for Ethical Review of Epidemiological Research states:

> Ethical review must always assess the risk of subjects or groups suffering stigmatization, prejudice, loss of prestige or self-esteem, or economic loss as a result of taking part in a study. Investigators will inform ethical review committees and prospective subjects of perceived risks, and of proposals to prevent or mitigate them. Investigators must be able to demonstrate that the benefits outweigh the risks for both individuals and groups…It is unethical to expose persons to avoidable risks disproportionately to the expected benefits, or to permit a known risk to remain if it can be avoided or at least minimized (Council for International Organizations of Medical Sciences, 1991).

The two boards also differed with respect to their perceptions of participant benefits. Where the IRB saw no direct participant benefits, the CAG saw several. First, the CAG members noted that individuals who wished so would be provided with the results of their HIV risk assessment and the SCID used to assess whether an individual commented on the need for individuals to have the information, their views diverged significantly with respect to the sufficiency of the protections that were designed to minimize risk.

**Risk-Benefit Ratio**

Assessment of risks and benefits and the risk-benefit ratio of any study ultimately depend on one’s values and priorities. For a discussion of risks and benefits, see the following:


**Further Reading**

CONCLUSIONS AND RECOMMENDATIONS

The initiation of the study was welcomed by the community and was successfully undertaken and completed. No adverse incidents occurred during the course of the study.

Important lessons learned in this situation are potentially relevant to the resolution of conflicts that may arise between community members and ethical review committees in the context of other investigations. First, it is critical that at least some individuals in the community and on or associated with the ethics committee have an understanding of the issues as seen by the other party. The resolution of the conflict here may not have been possible without the understanding of the IRB staff members that was critical to the resolution, suggesting that this may be a valuable approach in future such situations.
Incentives and Voluntary Consent

Incentives, whether monetary or nonmonetary, may negate the possibility of true voluntary consent, depending on the nature and quantity of the incentive and the context in which it is offered. The following references may provide guidance in determining the appropriateness of a particular incentive.


Institutional Review Boards

Criticisms have been leveled against IRBs for inefficiency, for engaging in mission creep, and for unnecessary demands. IRB functions and operations are discussed in the following:


Community Consultation

Community consultation is increasingly recognized as a condition for the conduct of ethical research. For example, local community advisory boards are required at each site of the US National Institutes of Health AIDS Clinical Trials Group (ACTG), the multicenter research network established in 1987 for the development and evaluation of HIV/AIDS treatments. A discussion of community involvement may be found in the following:


DISCLOSURE

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REFERENCES


