What is it about therapy that facilitates sexual negotiation and sexual behavior change among clients? How do therapists work with clients who relapse? How do therapists approach their own discomfort when discussing sex and facing clients who are putting themselves at risk? Are there lessons in the therapeutic relationship that can be transferred to a client's relationship and negotiation with sexual partners? This article attempts to answer some of these questions by presenting several case scenarios of therapy related to sexual risk, in particular among gay and bisexual men, describing the therapeutic approach in these cases, and hypothesizing about the therapist's response.

The specific clinical situations covered here were chosen because they illustrate processes inherent in HIV-related therapy focusing on sexual behavior. The sexually compulsive client presents the most extreme situation in which there is a threat of imminent seroconversion, a threat that while elevated in these cases, is one which therapists working with all gay men confront. Scenarios with couples illustrate the challenges of sexual negotiation including the connection between sex and intimacy and the meaning of specific sexual acts in gay male relationships—factors that lead to unprotected sexual activity.

Four terms are common to discussions of relapse and HIV-related risk behavior, but this article proposes more specific definitions for these concepts than have been applied in the past. "Casual," "anonymous," and "compulsive" are points on a continuum that ends with "unsafe sex." Casual sex includes any encounter where superficial knowledge of a partner is exchanged in order to ascertain sexual—or social—compatibility before engaging in what is primarily a sexual act. Anonymous sex comprises any sexual encounter where partners do not exchange names and identities. Compulsive sex refers to repeated, intrusive, or unwanted sexual behavior patterns that feel out of a person's control.

It is important to note that sex can be compulsive whether it takes place anonymously in a park or within the context of a 10-year primary relationship. Likewise, anonymous sex need not be compulsive; it can be part of a well-adapted gay male lifestyle that includes "recreational" sex. Despite the fact that many gay men practice safer sex, there seems to be a disturbing confluence between sexual compulsivity and unsafe sex. Those clients least able to control when, where, or how often to have sex frequently also lack the ability to control how they have sex.

The Sexually Compulsive Client

For sexually compulsive men, the search for sex often camouflages depression, hopelessness, anxiety, or rage. Applying the construct of addiction, sexually compulsive people are those who are unable to soothe or self-regulate their emotions without overusing sex. They frequently hold the self-concept, "Sex is all I'm good for," or "The only worthwhile thing is sex." In facing overwhelming feelings, the sexually compulsive seeks self-cohesion—the state of emotional and psychological stability—through repeated sexual behaviors. This becomes a pervasive coping mechanism.

The family histories of sexually compulsive clients usually include severe neglect or abuse, and a pervasive, overly-sexualized atmosphere or relationship. These clients have felt unprotected, abandoned, and exploited. In the present, these clients display massive "splitting" and frequent
Some things are so obvious, they have to be said out loud:

**Talking about sex in counseling is important.**

Particularly in the context of HIV-related counseling, and especially short-term counseling where risk reduction is a key issue. But sex is not always on the counseling agenda. More often, it is dealt with cursorily—a nod to safer sex guidelines and a quick sidestep as clients and counselors dance around the topic.

I guess the cat is out of the bag:

**Talking about sex is uncomfortable.**

Despite the evolution of psychotherapy over the past 100 years, the sexual revolution, and gay liberation, talking about sex is like talking about death: only when faced with the coffin is it all right to acknowledge the corpse, and even then, it is dangerous to speak its name. The irony is that while talking about sex is mighty uncomfortable in the bedroom, it seems to be even more so in the consultation room. Despite all their training, counselors remain human, trapped in a culture that is sex-negative.

Not that you needed to hear it from me, but it's okay that counselors are uncomfortable. What's not okay is giving in to the discomfort and compromising therapy in its name.

Alan, a 41-year-old seronegative lawyer, presents with complaints about compulsive, high-risk sex. Alan is overwhelmed by diminished feelings for his unemployed, HIV-infected lover, Joe, anxious about his bed-ridden alcoholic father who has recently suffered a stroke, and grieving about the death of his dog of 10 years.

Growing up in a family characterized by alcohol and extramarital sex, Alan responded through heroic overachievement. In this sexually charged atmosphere, he was responsible for being Mom's confidante and managing his awareness of Dad's secrets. Alan's exaggerated sense of responsibility gets transferred to his current relationship, where he secretly feels helpless and overly responsible for his HIV-infected lover.

Alan’s unexpressed rage and his inability to deal with conflicting tasks—his lover's potential decline, his exaggerated sense of responsibility, his own unmet needs, and his fear of loss—drive him to break his monogamous agreement with Joe and compulsively seek sexual excitement. He withdraws sexually and emotionally from Joe. He feels guilt about the growing distance in the relationship, his sexual adventures outside the relationship, and the dangers of high-risk sex. The result is a split: alongside the "good" boy is a wild, reckless shadow, heady with sexual power, and intoxicated by the chase. The good boy survives at home by rewarding Joe with lavish gifts.

Alan's behavior may be an expression of feeling abandoned, resentment at having to minister to his lover's needs, wishing to join his lover by getting infected, or replicating a pattern of familial infidelity. In Alan's case, sexual acting out appears to help him cope, but in fact postpones dealing effectively with these challenging circumstances. In response, Alan's therapist might: express empathy; ask for details about high-risk behaviors; negotiate a contract around sexual acting out; evaluate Alan for antidepressant medica-
Therapists must walk the line between respecting privacy and colluding in dangerous acts.

The Couple Dynamic

Couples also present therapists with dilemmas related to sexual activity, including whether primary partners will engage in unprotected sex within their relationship. Phil and Tom—both uninfected—have been lovers for several years. Lately, they have been exploring several options including non-monogamy. As a reflection of a deepening intimacy and trust, they have decided to dispense with condoms when engaging in anal intercourse. Annic Prieur’s study of gay men in Norway makes sense of this wish. She writes: “Accepting semen has been an important value in the gay community, a way of showing devotion and belonging.” Penetration and ejaculation allow partners to merge and temporarily let go of control and boundaries. This act of merging has often been the goal of male-to-male sexual expression.

When faced with Phil and Tom’s desire, how does the therapist support this affirmation of the relationship without betraying concerns about the fragility of monogamy for many gay and bisexual men? How does he or she raise the issue of potential dishonesty between the partners without implying infidelity? How do the partners acknowledge their own uncertainty in maintaining safety in sex outside the relationship? How do they come to agree about what is safe? Phil and Tom agree to forgo unprotected anal sex outside the relationship, but they are undecided about oral sex.

One option is for their therapist to walk Phil and Tom through these quandrums. How does each stand on anal sex, oral sex, and rimming? Do they agree with each other’s boundaries, and do they trust each other to hold to these agreed boundaries? What distinctions will they make between behaviors in and outside the relationship?

In essence, the couple is negotiating a relationship “contract,” a contract that requires at its foundation the trust that partners will keep their agreements and disclose breaches in sexual behavior. This kind of trust is important not only in negotiating a durable relationship, but also in preserving the lives of gay male partners in the midst of the epidemic. Phil and Tom’s therapist might support their agreement, yet continue to raise other concerns. For instance, how will the partners disclose and discuss breaches? What leads them to conclude they’d disclose it? In the background of these discussions are intrapsychic and relational issues—particularly fears of engulfment, dependency, and abandonment.

Sam and Peter, a second couple, present another problem with sexual negotiation. In their case, the desire to please each other runs headlong into the need to maintain secure sexual boundaries. After many years, these seronegative partners are finding unprotected anal sex to be the focus of emerging differences. Sam wants to have unprotected sex with Peter. Peter reluctantly agrees but is angry that unsafe sex is so important to Sam. He complies only because he fears losing the relationship. In response, Sam and Peter’s therapist needs to explore individual and relationship issues, define each partner’s ability to negotiate, educate about the meanings of sexual behaviors, and address the level and history of trust in the relationship.

In mixed-status couples, other dynamics emerge. A dissatisfied HIV-infected partner becomes frustrated to the point of leaving his uninfected partner, who is unwilling to participate even in protected anal sex. Even after mutual masturbation, his negative partner jumps up to wash off the “infected” semen. In this scenario, the HIV-infected man is vulnerable to feeling treated like a leper; his partner is torn by the wish to sexually surrender, the desire to please his partner, and the fear that loss of control will lead to his becoming infected.

To some men, unprotected anal sex means feeling loved. While it is important to recognize the significance of fluid exchange and penetration, therapists must help gay men understand the varieties of sexual expression, clarify their own desires, and define and challenge the straitjacket of sexual specificity. For example, Sam and Peter’s therapist might say to Sam: “You seem to equate Peter’s willingness to have unprotected anal sex with whether or not he loves you. You are wired to detect any nuance that spells lack of interest, neglect, or abandonment. But your insistence may prevent the very union you want.”

Group therapy is a useful adjunct to both individual and couples counseling, particularly as a vehicle for clarifying feelings about safer sex. Safer sex is less a matter of being “taught” than it is a challenge to put sex into the context of relationships. Hearing other group members talk about safer sex can help each member to decide

References
what feels safe for him. Group therapy is so effective because it breaks down barriers—embarrassment, anxiety, vulnerability—to frank disclosure about sex, sexual preference, and fear of infection.

The Therapist’s Response

Therapists whose case loads include gay or bisexual men who engage in unsafe sex are vulnerable to feelings of powerlessness and despair. In addition, therapists form powerful attachments to their clients and derive meaning and satisfaction from the hope that therapy will influence them. Recognizing limits is crucial to protecting the therapist’s sense of self.

Facing the seroconversion of a client can feel demoralizing and defeating, jeopardizing a sense of competency. A therapist may experience anger, fear, and the urge to withdraw from the client to protect the therapist from loss. To respond to these normal reactions, collegial support is essential. Therapists may need consultation in drawing the line between responsibility and overinvolvement. Conversely, there is the opposite danger that these feelings will lead to denial, a “hands off” attitude. The therapist may assume that providing safe sex education is enough, avoiding the complex needs that clients themselves may not articulate without gentle probing.

Ultimately, the therapist’s role in monitoring his or her client’s sexual behavior is a charged issue, as the therapist walks the line between respect for privacy and collusion in dangerous behaviors. When does the clinician respect or question defenses? When does he or she say, “I need to raise this issue?” Each therapist must confront the dilemma between showing appropriate concern and acting as a sexual “policeman,” remaining true to the therapeutic needs of the client and the therapist’s assessment of sexual risk. When a client is endangering his own life or someone else’s, however, the therapist must intervene.

Among risk behaviors, oral sex may be the most difficult to navigate, posing thorny questions for both therapists and clients. Most researchers assert that unprotected oral sex is unsafe, while many activists and community leaders assert that the risk is minimal. By exploring clients’ feelings about oral sex rather than prescribing appropriate behavior, therapists can challenge client denial. Therapists can encourage this internal discussion by asking questions such as: “Are you concerned about unprotected oral sex? How did you decide about this practice? What do you say to yourself when you think about having unprotected oral sex?” The challenge in all of this is for therapists to avoid flinching from intervening when possible, and at the same time, to accept the limits of therapeutic responsibility.

Conclusion

At this point of the epidemic, risk reduction must go beyond the safe sex guidelines to the ongoing process of sexual negotiation. To help clients navigate sexual activity, therapists must blend together their clients’ psychodynamic histories, the social meaning of sex for gay men, and the medical and ethical context in which particular behaviors take place. During this process, therapists frequently become the holders of their clients’ most private—and sometimes dangerous—impulses and most shaming secrets. Just as men who engage in unsafe sex need a safe place to begin to examine their behaviors, psychotherapists also need permission, and a forum, to address their emotional concerns. If they are successful, they can offer clients frank sexual discussions in therapy, discussions that can form the foundation of sexual negotiation in their lives.

Clearinghouse: Sex and Therapy

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Risk, risk assessment, risk reduction—these words are the pulse, the recurring bass line under most discussions of counseling about sex in the context of HIV disease. But a wholly negative and inappropriately narrow focus on sexual risk is a barrier to effective counseling. Further, unaddressed anxieties of both counselors and clients compromise counseling about sex, making it either shallow or distancing. Instead, counseling should support safe and satisfying sexual relationships by providing accurate information, and by helping clients clarify sexual and reproductive goals, recognize the elements of a sexual encounter that are within their control, realistically evaluate risk posed by partners, and devise strategies to minimize risk while preserving sexual pleasure.

A brief overview of such a broad enterprise is risky business and should be complemented by special training and support. This article highlights some major challenges related to counseling about sex within the HIV environment, defining sources of discomfort and topics that deserve special attention.

Sources of Discomfort

Almost none of us receives clear and comprehensive sexuality information as we move through the critical stages of sexual development, and few adults, including counselors, have ever received holistic sexuality education. Such education approaches sexuality as a complex constellation of distinct yet interrelated elements: physical development; gender development and identity; reproductive function; sexual response; sexual orientation; sexual behavior; emotional aspects of sex; and social and cultural contexts. Misunderstandings about the meaning of and distinctions between these elements confound effective counseling and increase the discomfort about sex that is a given in our culture.

Such discomfort has many origins. For clients, embarrassment may be accompanied by the fear that talking about sex will be punished and that counselors will judge their sexual practices as deviant, boring, titillating, or irresponsible. Issues of personal responsibility may arise, especially for people with HIV disease. In this atmosphere, clients may be terrified of making “mistakes,” and this terror may keep them from being sexual at all. Others may judge themselves in the face of past mistakes, making future safety seem impossible or irrelevant. Finally, clients may fear that elimination of sexual risk will mean the end of sexual pleasure or they may fear that counselors will not respect their sexual decision-making process. These beliefs may limit willingness to participate in counseling about sex.

Any client may be a survivor of sexual abuse or assault, and counseling may trigger the abuse experience and raise issues of trust, fear, and shame. Psychological defense mechanisms among survivors—including denial, dissociation, repetition compulsion, and splitting1—are likely to challenge therapists who counsel survivors. For these reasons alone, counselors who approach sex in therapy must seek information and training about sexual abuse in order to perform effectively and ethically. Without labeling too broad a range of sexual experiences as “abusive,” it is clear that absent clinically defined abuse, many of us will adopt some of the common defense mechanisms of survivors.


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See also references cited in articles in this issue.
For counselors, discomfort around talking about sex arises from concerns about the unknown: lack of holistic sexual education; lack of experience that seems relevant to their clients’ sexual realities; lack of clarity about how their own sexual judgments and anxieties may infiltrate therapy; and uncertainty about the appropriate language for talking about sex. Counselors may feel unprepared to approach difficult issues such as a client’s history of perpetrating sexual abuse or his or her dissatisfaction with sexual orientation or gender.

Counselors may be surprised to discover that they share societal disapproval of sexual activity and reproduction among HIV-infected people, who are expected to be perfect contraceptors, perfect sexual communicators, and perfect barrier users. While sexuality is acknowledged to be complex for other people, once an individual has HIV infection, society expects this fact alone to be the focus of sexual decisions. Against a social and professional backdrop that focuses on the rights and duties of providers to intervene in response to “reckless” sexual behavior, many counselors find it difficult to remain non-judgmental. In the end, however, counselors must provide HIV-infected clients with the same support for the full range of sexual and reproductive decisions that they offer other clients.

Language and Delivery
Harm reduction is a useful framework for sexual counseling. To implement this approach, counselors must assist clients in defining context-specific, manageable approaches towards personal risk reduction goals. To be effective, counselors must be able to speak explicitly and precisely about sex; to listen carefully in order to develop an understanding of sexual history and environment; and to be supportive of clients’ steps—no matter how small—towards realizing sexual and reproductive goals.

Follow the client’s lead in defining the language of the session. Ask clients about the words they prefer to use to describe sexual practices, identity, and anatomy; if they do not have words to suggest, start the session with this unclarity. Model clear and direct sexual communication by taking a comprehensive sexual and reproductive history. Always ask whether a client’s partners are men, women, or both; also ask about identity or orientation, but remember that orientation is not a reliable predictor of sexual behavior or partners. Counselors should never assume that clients share their definitions of general terms such as “sex” or “oral sex.” While clinical language may obscure meaning, it is equally important to remember that for nearly all clients, including sexually experienced individuals, some slang words are offensive. Knowing “street language” may be important to understand clients, but using sexually “familiar” language in a professional counseling session is generally inappropriate, particularly if client and counselor are from different cultures.

Pleasure
Pleasure is an essential topic in any sexual counseling session, deserving of as much attention as “risk” and “safety.” It may be threatening to talk about pleasure, because counselors may rightfully be concerned about being voyeuristic, and clients may be concerned about being “exposed” or being sexually exploited. Broad, open-ended questions about the client’s sexual life and relationships are a good way to approach the question of pleasure and the role it plays in active and passive decisions about sex.

Images of and desire for “good sex”—and the degree to which reality matches these ideals—are central to the process of negotiating sexual risk and sexual pleasure. Questions such as, “Are you in a sexual relationship now?” “How is that?” and “What do you most like to do with your partner(s)?” set the stage for clarifying the client’s hopes and desires.

Conclusion
HIV disease has defined a new ethical and practical mandate for counselors: develop skills for counseling about sex. Good counseling about sex is more than “damage control”; it is an opportunity to exploit the urgency of the HIV epidemic to help clients develop what has always been difficult for many people: safe and satisfying sexual relationships.

References

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Comments and Submissions
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Black Women and Sexual Communication


A small study of African-American women in San Francisco made a distinction between sexual communication and sexual negotiation and found that gender-based power differences continue to inhibit negotiation among these women. In addition, the study cites several factors that contribute to these power imbalances among African Americans: the disproportionate number of single African-American females compared to eligible African-American males, the economic and psychological dependence of these women on their male partners, and the threat of sexual abuse.

Eighteen African-American women from an economically impoverished area of San Francisco, ages 18 to 25, participated in two focus groups on sexual communication and negotiation. These informal interviews were conducted in groups of nine participants by young, female, African-American moderators. The interview sample was selected based on convenience and availability from low-income housing developments.

Sexual communication, or the process of communicating about sexual safety with one’s partner, was widely practiced within the sample. All participants reported prior intentions to use condoms. Second, the sex worker initiates discussion about potential use with clients. Seven of the 36 respondents who intended to use a condom did not choose to initiate discussion due to fear of losing clients or to misconceptions that clients were safe. Third, negotiation takes place. A successful negotiation depends upon the sex worker’s ability to provide counter-arguments to client concerns and to resist pressure from clients. Of the 29 workers in
the sample who did enter into this negotiation process, most reported less than consistent success and said that they would not refuse to have unprotected sex with a client. Finally, if negotiation is successful, a condom is used in the exchange.

Participants reported five different patterns of condom use in their work: successful, in which clients complied to requests to use a condom; unsuccessful, in which workers were unable to persuade their clients to use condoms, usually due to pressure from the client or an inability to answer a client’s challenges; misinformed, which occurred among workers who believed that their regular clients were “safe”; passive, in which negotiation was not supported among peers, co-workers, or employers; and uninterested, occurring among participants who were apathetic about HIV-related risk. Intervention attempts should target these groups.

In response, negotiation skills should be taught to unsuccessful negotiators; passive and uninterested groups should be informed of the success of their peers in negotiating condom use; and misinformed workers should be provided with accurate information. Since the study found that those with low self-efficacy do not even try negotiating, skills building is particularly crucial to help these women initiate discussion.

Erotic Countertransference

Gabbard GO. Sexual excitement and countertransference love in the analyst. *Journal of the American Psychoanalytic Association.* 1994; 42(4): 1083-1106. (Topeka Institute for Psychoanalysis and The Karl Menninger School of Psychiatry.)

Sexual feelings towards clients are unavoidable and potentially useful aspects of the analytic process, according to an essay on erotic countertransference. But without proper recognition, powerful sexual feelings towards clients can bring therapists perilously close to the abyss of unethical transgression.

Erotic countertransference refers to the sexual feelings and “enactments”—ranging from overt sexual relations to more subtle forms of action such as body language, silence, word choice, even interpretation—that may occur between therapist and client. “Enactments occur when an attempt to actualize a transference fantasy [of the client’s] elicits a countertransference reaction [from the therapist].” When used appropriately, countertransference may motivate a therapist to reflect on his or her own active role in the therapeutic process and better understand the client’s perspective. In instances where erotic transference is used inappropriately, lustful feelings are enacted and disable the therapeutic relationship.

Both the client and the therapist contribute to countertransference: the client often projects identities of loved ones and sexual partners upon the therapist, and the therapist responds according to his or her past experiences. Erotic countertransference can be facilitated by several factors in the therapeutic relationship, including feelings of hostility toward a client, a need to exercise power over another individual, a perception of the client as needy with a corresponding fantasy of fulfilling those needs, defense against loss and mourning, and a desire to be the client’s exclusive love object. It is important to note that the more primitive and disorganizing dimensions of erotic countertransference may be experienced only as physiological reactions that cannot be cognitively grasped.

Mental health professionals should recognize the value of fantasy and objective self-analysis in working through countertransference. In order to avoid enactment of these feelings, consultation with a colleague is strongly recommended.

Next Month

The finding that zidovudine significantly reduces transmission from mother to fetus has been one of the major treatment success stories in the past five years. Combined with reduced estimates of the likelihood of transmission and studies that more clearly pinpoint timing of transmission, this data has changed reproductive counseling for pregnant women with HIV disease. In the June issue of *FOCUS, Ann Kurth, MPH, MSN, CNM,* Deputy Assistant Commissioner at the Indiana State Department of Health, reviews this data and its counseling implications. She discusses the likelihood of HIV transmission, the effect of HIV disease on pregnancy, and the role of treatment to protect both the mother’s and the child’s health.

Also in the June issue, *Mindy Benson, PNP, MSN* and *Maureen Shannon, CNM, FNP, MSN,* both researchers and clinicians at the Bay Area Perinatal AIDS Center, discuss the ethical and clinical issues that arise during a study on nevirapine, a drug that may be more effective than ZDV in preventing vertical transmission.
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