Risk Appraisal and HIV Prevention
Walt Odets, PhD

Drawing heavily on traditional public health approaches—which have, in turn, drawn heavily on deeply rooted American values about human sexuality—HIV prevention, particularly for gay men, has consistently focused on the *elimination* of risk and relied on the provision of information to accomplish this goal. In the early 1980s, we assumed that this approach would stop the epidemic, and in the context of what seemed to be a short-term health emergency, this approach made sense. Indeed, many gay men heeded the message by adopting significant changes in sexual practice, including what was, for many, the radical solution of temporary abstinence.

As the epidemic of HIV seroconversion continued through the 1980s and into the 1990s, it became increasingly apparent that such short-term approaches were falling far short of risk elimination. While many AIDS educators had difficulty believing that informed gay men were continuing to expose themselves or others to HIV, there was substantial evidence as early as 1988 that one-third of San Francisco’s gay men reported engaging in unprotected anal sex.1 From the perspective of risk elimination and public health traditions, such behavior could be interpreted only as the product of continued ignorance, chemically-induced impairment, malice, or psychopathology.

But the evidence—which demonstrates that these factors have had a relatively small influence—supports a more complex explanation. Gay male attitudes toward sexual behavior—particularly toward oral sex—illustrate the distinctions between risk elimination and harm reduction and the role of risk appraisal in HIV prevention not only for gay men, but also for people who participate in other HIV-related risk behaviors.

**Risk Elimination versus Harm Reduction**

The message *from* gay men should have been clear: the forbidden “exchange of body fluids” was not only a medical issue, but also one laden with psychological meanings. Men were attaching importance to unprotected sex within relationships—and sometimes outside of them—as evidenced in the practice of “negotiated safety” (a process by which partners test and re-test to confirm that they are seronegative, and then make agreements about sex outside the relationship in order to enable themselves to participate safely in unprotected sex within their relationship). Men were almost universally eschewing the use of condoms for oral sex, despite suggestions from many prevention educators that unprotected oral sex “might be risky.” In other words, even as it was becoming widely accepted that prevention, rather than treatment, offered the only hope for controlling the epidemic, gay men were being motivated by feelings about trust, intimacy, and sexual communication to practice harm-reduction rather than risk-elimination approaches.

Harm reduction, by definition, is not intended to completely eliminate new infections, but gay men’s first decade of attempted harm reduction has resulted in an unfortunate and probably unnecessary rate of seroconversion, high even by the standards of harm reduction. Because this harm reduction effort has been almost completely unsupported by the public health establishment, gay men have had to fend for themselves in ignorance of facts and approaches that could have facilitated this effort. Unfortunately, many educators have used the results of this flawed harm-reduction effort to justify the retrenchment and redoubling of risk-elimination approaches; and they have
I’ve been haunted by the article I wrote for this issue of *FOCUS*. Haunted by Walt Odets’s critique of risk elimination, by the temptation to err on the side of safety—to offer readers a rote prescription that will seem to ensure safety. Haunted by stories of unprotected oral sex—the comments of *FOCUS* Medical Consultant Steve Follansbee, who after reviewing my article, told me about a newly infected patient of his who insisted that his only risk was oral sex.

Haunted by Follansbee’s expression of the provider’s dilemma: how would you feel if your client were to seroconvert after having taken your advice that oral sex is safe enough?

Fortunately, Follansbee posed another question, almost an antidote to the first, a question to ask of a client considering the risk of oral sex, or for that matter, any activity: How will you feel if you seroconvert? Will this activity have been worth it? For some of the men that Odets describes, the answer may very well be: I understood the risk, the risk was relatively low, and it was important to me—important to my partner and our relationship—to achieve this level of sexual intimacy.

**Being Haunted is Being Alive**

Risk reduction is complex. It is not the role of HIV education and counseling to propose an absolute truth where none exists, but to navigate this uncertainty, and to help clients fashion realistic, comfortable, and individual approaches to HIV-related risk—approaches like needle exchange, negotiated safety, or participation in no activity riskier than unprotected oral sex.

None of these is as effective as abstinence—but apparently, most expended little or no effort to understand why gay men had resoundingly rejected risk-elimination in the first place.

**Appraising Risk**

In our daily lives, we attempt to completely eliminate risk only for activities upon which we place little or no value. For activities we do value, we routinely exercise harm-reduction approaches by weighing the relative value of the activity and the costs of taking the risks involved against the potential costs of not taking the risk. For example, a vast majority of Americans drive or ride in automobiles despite the knowledge that approximately 45,000 people—close to the entire American death toll of the Vietnam War—will be killed annually. We value mobility and all that it provides, and we experience a lack of mobility as too costly to eliminate “reasonably” conducted automobile travel from our lives. We attain this level of reasonableness by exercising harm-reduction: safety engineering for automobiles, careful road design, and the exercise of personal responsibility in when and how we drive.

Our behaviors—as opposed to our public statements—suggest that we similarly value sexual expression, including aspects of sexuality that express relationship, intimacy, and trust. But most of our AIDS prevention work to date, rooted in the assumptions of risk-elimination, has defined “safe” sexual expression in ways that large numbers of gay men are demonstrably finding unreasonable.

Contrary to the broad acceptance of the importance of vaginal sex for heterosexuals—much has been spent on developing contraceptive methods to enable sex both without condoms and pregnancy—public health messages have consistently told gay men to use condoms or abstain from anal sex. Despite a paucity of significant evidence for oral HIV transmission—and a large body of data suggesting that oral sex is an extremely low-risk activity—prevention organizations have persisted in instructing gay men to use condoms.2

Many of the same gay educators who propose unprotected sex within a mutually monogamous relationship (that is, negotiated safety) as the “most effective” prevention solution for heterosexuals,3 have also said that for gay men it may be tantamount to “negotiated danger.”4
The assumption that risk elimination is appropriate for all clients, without regard to an individual's experience of the risks and benefits, contradicts a client-centered approach.

Such unreasonable prescriptions often reflect an authentic concern for the welfare of gay men and a belief that prevention should “err on the safe side.” Unfortunately, these prescriptions also express erototrophic and homophobic values, unclarified feelings about sexuality, risk, and life, and deeply held American beliefs that it is more important to pursue longevity than quality of life. Many gay men internalize these values and, at least publicly, collude with the messages they inspire.

The United States is now almost alone among industrialized nations in advocating HIV risk-elimination. This approach conforms to a traditional reluctance to accept the costs of any “socially unproductive” activity, particularly if it is experienced as sexual, sensual, or “indulgent.” Thus, it is the rare gay man in the United States who would not feel more comfortable dying in an automobile accident—preferably while commuting to a respected job—than by contracting HIV through sexual intimacy. And it is the rare HIV counselor who would not feel similarly about those whom they have counseled. What is excluded from such formulae is the huge human cost of lives subjected to social expectations that distort or deny an individual’s feelings.

Risk elimination must, by its very nature, provide guidelines rather than assist in a clarification of personal values. In asserting that no risk is, could be, or ought to be acceptable for a given behavior, risk elimination is predicated on a set of values that is imposed on a population—values assumed on behalf of all people—and not on an individual’s beliefs. If the behavior in question is something about which people are already acculturated to feel ambivalence, shame, or guilt, most will publicly voice compliance, even as they retreat, sometimes subconsciously—into personal, often ineffective, harm-reduction alternatives. While unprotected anal sex has become the single most stigmatized behavior in the public rhetoric of gay communities, it is widely practiced, fact evidenced by current levels of new seroconversions.

This unfortunate result is a predictable and intelligible consequence of depriving gay men of the accurate education and counseling that are necessary components for authentic and lasting risk reduction. It is only with such assistance that gay men could possibly make informed, conscious decisions about balancing the potential costs of taking risks with the costs of avoiding them, and consider effective harm reduction alternatives when the psychological costs of risk elimination are too high.

Currently, gay men are in the same predicament in which we would all find ourselves if health authorities decided that automobile travel over 25 miles per hour was unacceptably risky. Such a response would seek to eliminate risk rather than educate the driving population about how to reduce risk and would fail to take into account the advantages of the reasonable and often desirable alternative of traveling at higher speeds. The results of such a prohibition—an unnecessarily large highway death toll as uneducated drivers flaunted the unreasonably low speed limit—would indicate not the need for more vigorous enforcement of a 25-mile-per-hour limit, but rather, the need to reexamine the conflict between personal and social values. As with gay men and sexual risk, the idea that the “speeders” were acting solely out of incompetence or non-compliance would miss an important point about health promotion and about human life and its potential enrichment through mobility and interpersonal intercourse.

References

2. For example, “Suck Latex” was a slogan used in a 1995 campaign produced by the STOP AIDS Project of San Francisco.


Client-Centered Education

In May 1994, the Centers for Disease Control and Prevention (CDC) released new guidelines describing “client-centered” counseling for HIV antibody test site clients. Aware that purely information-based prevention was falling short of expectations, the CDC hoped to address some of the more complex individual issues—including so-called “psychosocial issues”—contributing to new infections. But this change of approach, and the relatively broad guidelines issued in support of it, have left many counselors in a quandary about exactly what client-centered counseling is and how it might be implemented.

Much of this quandary is a product of public health’s traditionally assumed values and purposes, which cannot be part of a client-centered approach. Client-centered approaches must, by definition, account for and respect the values, purposes, motivations, and individual needs of each client. The assumption of risk elimination, without regard for an individual’s experience of the risks and benefits...
involved, contradicts a client-centered approach; and it is only through a client-centered approach, itself, that it might be clear that the client wished to avoid risk at any and all cost. Client-centered counseling is, by definition, a harm reduction approach, for it helps the client weigh his or her personal values against potential risks. Most clients accept risk for activities that they value and the societal insistence on risk-elimination results only in underreporting of "risk" activity.

Unfortunately, counselors may not be able to easily determine a client's wishes because, among other reasons, clients themselves are often not clear about their feelings and values. Oral sex is a good example of an unclearly and inconsistently presented "risk" activity, and it is practiced without protection by a large majority of gay men. A risk-elimination approach would dictate that a client who reports having "a lot of unprotected oral sex" be advised to stop this practice or to use condoms consistently when having oral sex, and that he be assisted in adopting these behaviors. In contrast, a client-centered approach would examine the obvious contradictions of a client doing "a lot of" something he fears may have lethal consequences.

This line of inquiry can reveal much that is pertinent to prevention, including, perhaps, the client's perception that sex, particularly homosexual sex, is not supposed to be important to him. Alternately, another client may discover that he experiences sexual relations as unsatisfying and perhaps compulsive. And still others may find that they have not distinguished between different kinds of sexual contact, their feelings about each, and the relative importance of each in their lives. Connected to these insights, counselor and client will discover many related issues, including problems communicating about sex, confusions about relationships, and conflicted interpersonal issues.

All of these clarifications are crucial to prevention because they provide a foundation upon which an individual may begin to clarify the role and meanings of sexuality in his life, the potential risks he is willing to incur for his sexuality, and the personal costs of not taking those risks. In recognizing and respecting the complexity and range of individual values rather than assuming absolute points of unacceptable risk, client-centered counseling naturally expresses a harm-reduction, instead of a risk-elimination, approach.

Conclusion

While many counselors and educators, particularly those trained in traditional public health models, may find client-centered approaches to prevention unfamiliar, they will usually find them effective in practice. By clarifying pertinent feelings and values, clients are in a position to make better-informed, more considered, and more consistent decisions about risk.

Such beneficial results, however, require providers to discover and sustain attention to their own values and the extent to which those values influence interactions with clients. A counselor who has strong personal feelings about the importance or unimportance of his or her own sexuality, who is anxious about or averse to any risk, or who wishes to "save clients from themselves" must carefully examine the ways in which such feelings can distort or defeat a truly client-centered approach. In the end, counselors must truly respect their clients, their values, and their efforts to create a life that is rich and satisfying enough to be worth protecting from unknown, unnecessary, or unintended risk.

References


The Riddle of Oral Sex
Robert Marks

Posed by a Zen master, a *koan* is a paradox meant to induce "an intense level of doubt, allowing [people] to cut through conventional and conditioned descriptions of reality and see directly into their true nature." Labeled "the koan of HIV prevention" by educator Dave Nimmons, oral sex is characterized by compelling evidence that it is "safer" and by the widespread impression that it is dangerous. Speaking at the international AIDS conference in Vancouver, Nimmons added that oral sex evokes "our greatest anxieties about death because of the uncertainties about its risk."

There are many reasons why the risk of oral sex appears to be unclear, but what is most relevant for mental health providers is that this unclarity is so uncomfortable. Providers, like Zen masters posing a koan, can use this discomfort and doubt to help clients come to informed yet intuitive recognitions of their own priorities. As a starting point, this article offers a guide to interpreting the literature on oral sex.

Anecdotal versus Epidemiological Evidence

In a comprehensive research summary on the HIV-related risk of male-to-male oral sex, Nimmons concludes: "The body of literature is clear: oral sex offers a possible, but very low, risk of HIV infection. Unprotected oral sex is classifiable as safer sex or as safe compared to safest," defining "safest" as completely non-insertive forms of sex.

Yet, according to Nimmons, much of the concern about oral sex is based on two dozen case studies—single occurrences of oral transmission—from all over the world. At a recent forum on oral sex, where researcher Paul O’Malley presented five cases, attendees were adamant that it was important for them to know about anecdotal reports, stating that these reports facilitated informed decisions about risk. While this is a powerful example of proactive risk reduction, it seems disproportionately swayed by the immediacy of specific cases. British researcher Edward King, quoting Nicholas Mulcahy, discusses this exaggerated effect:

Because it personalizes an issue, a case study can have a more powerful effect on the imagination than a study with hundreds of participants. However, the sexual histories of ten individuals are not a good basis for determining the riskiness of oral sex. Large-scale epidemiology studies reduce the chance that reports of an infected person’s sexual history will distort a larger reality.

King also states that by using multivariate analysis, epidemiological studies ensure, as case studies cannot, that they uncover actual and relatively accurate relationships among variables. He explains that the widespread prevalence of anal sex among men who have oral sex does not mask which activity is actually transmitting HIV.

In virtually all such studies, a large number of uninfected men also report having had oral sex. It is the fact that HIV transmission does not typically occur unless someone has unprotected anal sex, regardless of whether or not he also has oral sex, which proves that anal sex carries by far the greatest risk, and that any risk in oral sex is very low indeed.

Case studies do demonstrate that transmission is possible and do clarify the conditions under which it is highest. To reduce risk, O’Malley echoed Nimmons, who suggests avoiding "trauma to the mouth and throat; especially vigorous or prolonged oral sex; infections or abrasions in the mouth and throat; and the use of stimulant substances that dull sensation."


See also references cited in articles in this issue.
The Vancouver Consensus

The consensus of the Vancouver panel was consistent with all of this data. There was little disagreement that oral sex is an extremely low-risk activity. Truax presented what may be the most compelling study to date: a multivariate analysis of risk assessment data from HIV antibody testing interviews with more than 50,000 men who had sex with men in 1994 and 1995.2 Of these men, 88 percent engaged in oral sex; 66 percent engaged in anal insertive sex; 55 percent engaged in anal receptive sex; and 29 percent engaged in vaginal intercourse. Anal sex and drug use were associated with increased seroprevalence; oral sex was not; and there was no statistically significant difference in seroprevalence rates between people who used condoms during oral sex and those who did not.

David Ostrow, a University of Wisconsin researcher, presented an analysis of 10 years of data from the Chicago Multicenter AIDS Cohort Study (MACS). The study found that after controlling for the same number of oral and anal exposures, the risk of oral transmission of HIV was less than 1 percent of the risk for anal transmission.7

Ostrow’s study sought—but could not—replicate the results of one of only two epidemiological investigations that supports an assertion that oral sex is an efficient route of transmission.8 This investigation, led by Michael Samuel, found “weaker, but significant associations” between transmission and receptive oral intercourse in a retrospective analysis of data from three San Francisco cohorts. However, as pointed out both by Nimmons and by Berkeley psychologist Walt Odets, the Samuel study is plagued by methodological faults. Among these faults is the fact that the weak correlation between oral sex and seroconversion emerged only after researchers dropped the variable “number of partners” from the multivariate analysis—a variable that in univariate analysis was “more highly correlated with seroconversion than any other measured factor.”9 In addition, 33 of the 245 controls (13 percent) were celibate, and further statistical analysis “strongly suggests the possibility that oral sex would show little, if any, significance if celibate controls were not included in multivariate analysis.”9 In a personal communication with Odets, Samuel states that while he believes his results correct, if it is “not replicated by someone, we’re going to have to throw it out as an anomaly.”9

Finally, the Vancouver panelists responded to a recent study in which six out of seven rhesus monkeys became infected with simian immunodeficiency virus (SIV) after it was dabbed on the back of their mouths.11 At the forum, Kenneth Mayer of Brown University stated that the sample was extremely small and that, for a variety of reasons, comparing virus grown in cell culture to body fluids containing the virus “is comparing apples to oranges.”2

As many researchers have noted, there has been no perfect study of oral sex risk—that is, none that has looked at a large sample of people who have participated only in oral sex over a long period of time. This fact does not invalidate the conclusions of epidemiological studies to date or estimates of the risk of oral transmission. But such studies would deepen our understanding of the conditions under which transmission does occur. Such a study might investigate substance use; number of partners; frequency and length of oral sex sessions; degree of trauma caused by oral sex to the mouth and throat; the presence of trauma prior to oral sex; condom use; ejaculation and swallowing semen; concurrent sexually transmitted diseases; and less obvious situational factors such as whether people who engage in unprotected oral sex also “screen” their partners and in what ways.

Sitting with a Koan

The epidemiological data, having withstood rigorous statistical analysis, overwhelmingly suggests that the risk of oral transmission is minimal; but, as O’Malley remarks, for the individuals in his case studies, “The risk was not low, but 100 percent.” This contrast is crucial not simply because it defines the poles of the debate, but because it defines the koan. Resolution is likely to be most influenced by which of these two types of information a person finds most compelling.

Sitting with such a koan is, by definition, uncomfortable. The task of the HIV educator or counselor should not be to respond by making the process simple but, like the Zen master, to sustain the paradox.

Effective counseling will build a context for decision-making by raising consciousness about four factors: the actual risk of transmission from oral sex; the factors that are within a person’s control to increase or decrease this risk; the meaning of oral sex in a person’s life; and the extent to which a person is comfortable taking any risk. Prevention approaches that simplify this process do gay men a disservice. We are all capable of understanding the contradictions posed by uncertainty, risk, and desire.
Recent conceptions of risk reflect a shift emphasizing the fact that individuals rather than the environment or interactions among people have control over health risks. According to a review of the literature, current health promotion for safer sex, diet, and substance use focus on self-control as the primary way of reducing risk.

In the early twentieth century, theorists espoused a “passive responder” model of stress, emphasizing external causes as the stimulus for behavior. For example, alcohol abuse was defined as reflecting the addict’s victimization—as the creation of the world in which an addict lived—rather than resulting from a moral failure on an individual’s part. These early models concluded that individual behavior was a reaction to circumstances outside the body and that individual identity was characterized by passivity and the absence of agency.

In the 1960s, social theorists began to define people in terms of their ability to process and appraise information, and this shift marked the emergence of the individual as an active and interactive agent. The Health Belief Model conceptualized external events as “cues to action”; an individual perceived and evaluated these cues and developed health behaviors in response. According to the “interactive appraiser” model, stress was no longer a response to an external threat; it was the result of the individual’s appraisals of the character of the threat and his or her ability to cope with it.

By the 1980s, theorists criticized the Health Belief Model because it did not recognize the contribution of self-confidence, characterized as “self-efficacy,” to an individual’s commitment to behavior change. The individual was perceived as primarily interacting with the “inner self,” and the environment was removed from the equation. The resulting “intra-active” model of identity suggests that self-efficacy is the best predictor of human behavior. In response to this shift, modern addiction treatment emphasizes self-control: it construes the inner self as changeable and able to be mastered through a well-developed sense of self-efficacy. Applying this perspective, health risks do not arise from HIV itself, but from the presence or absence of the self-control necessary to manage the changeable drives that expose the body to the threat of infection.

Changes in perceptions of hygiene are also relevant to disease prevention. These perceptions have evolved through four models: the “quarantine model” (a focus on separating healthy and unhealthy spaces); the “sanitary science model” (a focus on substances like sewage); the “personal hygiene model” (a focus on other people and personal interactions); and the “new public health” (a focus on risks as being everywhere and achieving prevention through constant and pervasive observation). The next incarnation might more profitably focus—as does psychological theory—on the self as the source of risk and on self-control as the tool of prevention.

**Risk Perception among Homosexual Men**


In a sample of 165 gay Dutch men, participants with steady partners were significantly more likely than those men with casual partners to perceive unprotected anal sex as low risk, even though a majority of those with steady partners did not know either their own or their partner’s serostatus. This risk perception discrepancy may be the result of high levels of optimism and a focus on the self.

Researchers developed a questionnaire that addressed issues such as risk-perception and optimism, confrontation with illness and social closeness of AIDS, egocentrism, previous risk behavior, relationship attributes, and defensive denial. Forty-five of the respondents had had unprotected anal intercourse with casual partners. The remaining 120 men had had unprotected anal intercourse only with steady partners, defined as partners with whom they had had a relationship for at least six months and with whom they had contact at least once a week.

While almost 96 percent of participants who had unprotected anal intercourse with casual partners perceived this as risky,
Only 40 percent of the men who engaged in the same behavior with steady partners believed that they were at risk for HIV infection. Those who exhibited optimism were less likely to recognize that they were at risk for transmission; men who did not acknowledge their risk for HIV infection were more likely to think that others were at higher risk of HIV infection. Men who did acknowledge personal risk were more likely to engage in defensive denial by reasoning away and playing down this risk, and were more likely to have had sex previously with a partner with HIV disease.

It is important to note that although most men identified unsafe sex with casual partners as risky, they continued to engage in this behavior. Awareness is only one stage in risk reduction, and other factors, ranging from attitudes towards condoms to affective feelings and the desire to please a partner, play a strong role in a person’s willingness to risk unprotected anal intercourse.

How Could I Forget?


When asked to recall their sexual behavior over a three-month period, gay men participating in a small Seattle study significantly underreported incidents of unprotected anal intercourse and other high-risk behaviors. In addition, exaggerated reports were associated with low-frequency behaviors and underreports were associated with high-frequency behaviors.

During their participation in a 13-week risk reduction counseling program, 87 participants completed weekly surveys detailing sexual behavior, including types of partners—primary, occasional, one-time—and types of activities—oral and anal sex, receptive and insertive, with and without condoms, and with and without ejaculation. At the end of the three-month period, researchers asked participants to recall their behaviors. The majority of participants were White, and 93 percent had attended some college or had a college degree. Of the 86 percent who had been tested for HIV antibody, 16 percent were seropositive. The median age of the sample was 35.

Participants were able to remember with reasonable accuracy whether they had engaged in specific types of sexual activity, but they were not able to remember how many times they had done so. For behaviors occurring between one and 20 times in a three-month period, underreporting increased as risk increased, and underreporting of unprotected anal activity was significantly more likely than underreporting of all of the other behaviors combined. One possible interpretation of this bias is that information consistent with self-concept was more accurately remembered than was inconsistent information: participants had devoted months of effort to becoming safer and may have had considerable investment in viewing themselves as making progress. Another interpretation is that participants felt more pressure at the end of the study to report favorable results than they did during the study when there was still time to change.

This study raises questions about the reliability of data collected in other surveys on risk behavior. It is significant that the riskiest behavior, unprotected anal intercourse, was consistently underreported; this behavior is often used as an indicator of general levels of risk as well as behavior change and risk-reduction among study populations. The researchers conclude that when a study uses a three-month reference period, statistics should be analyzed prudently. They suggest that the most accurate data can be collected using “ever/never” variables rather than highly specific questions.
DID YOU KNOW?

You can access a FREE searchable archive of back issues of this publication online! Visit http://www.ucsf-ahp.org/HTML2/archivesearch.html.

You can also receive this and other AHP journals FREE, at the moment of publication, by becoming an e-subscriber. Visit http://ucsf-ahp.org/epubs_registration.php for more information and to register!

ABOUT UCSF AIDS HEALTH PROJECT PUBLICATIONS

The AIDS Health Project produces periodicals and books that blend research and practice to help front-line mental health and health care providers deliver the highest quality HIV-related counseling and mental health care. For more information about this program, visit http://ucsf-ahp.org/HTML2/services_providers_publications.html.