Gender Assumptions and HIV Counseling
Linda Poelzl

Stereotypes and mass generalizations related to human diversity are powerful forces that can be difficult to overcome for even the most educated and free-thinking individuals. It is important for HIV test counselors to have an accurate understanding of human diversity, especially in the areas of gender and sexuality, factors that frequently influence HIV infection risks.

This issue of the FOCUS Supplement examines identity issues and assumptions and stereotypes regarding gender and sexuality, and pays special attention to counseling transgendered and transsexual clients. It also addresses the subject of sexual orientation. While both gender and sexual orientation relate to identity, sexual orientation refers more to a person's gender preference in sexual partners; while gender refers to a person's identity independent of interpersonal relationships.

What is Gender?

People commonly interpret the word "gender" to have the same meaning as "sex," when in fact gender identity can be different from sexual identity. A person's physical anatomy and genetic code define his or her sex, but gender refers to psychosocial rather than biological factors. Although there is usually no difference between a person's gender and sexual identity, there are exceptions.

The process of recognizing another person as male or female often results from a complex set of learned visual, auditory, and behavioral cues that may be unconsciously perceived. From an early age, humans learn to associate certain identifying signals with male or female categories. In Western cultures, people commonly categorize as male a person who dresses in trousers, has significant facial hair, a deep voice, and a certain angular gait. If someone has a rhythmic, hip- emphasizing gait, a high voice, and is wearing a dress, most people categorize this person as female. Because we live in a predominantly two-gender society, these assumptions are usually correct. When people do not conform to society's preconceived notions of gender roles, however, observers may arrive at faulty conclusions about their identities.

The concept of gender itself is a relatively new one. Gender was originally a grammatical term, used especially in languages other than English, in which nouns are masculine, feminine, or gender neutral. Society has recently begun to examine the significance, evolution, and restrictions of the ideas of masculinity and femininity. Because it is only recently that society has begun to distinguish gender from sex, gender is often misunderstood and vulnerable to stereotype.

Gender-Related Assumptions

People tend to make assumptions about others based on stereotypes, which are by definition simplistic and inaccurate characteristics attributed by society to a given group. Gender-based stereotypes are particularly relevant to HIV prevention when they relate to sexual behavior. According to these perceptions, men are more sexually driven and promiscuous than women and, therefore, have more anonymous sex, have multiple sex partners, and constantly think about sex. Other common stereotypes portray men as being unfaithful when they are in relationships and more likely to brag about their sexual experiences, especially to other men. Since stereotypes often have some basis in reality, these assumptions may be true for some men, but they are often untrue.
Stereotypes about women, meanwhile, suggest that they do not enjoy sex as much as men and, therefore, do not seek to engage in it as often. Other stereotypes are that women need a close emotional connection before engaging in sex with a partner; they rarely have anonymous sex; they prefer conventional, "tender" sex; and they are more faithful in relationships.

Society also applies stereotypes and makes generalizations about the attitudes men and women have toward condom use. These include that heterosexual men consider themselves to be at extremely low risk of contracting HIV, and are either unwilling to use condoms or will not engage in protected sex unless a female partner raises the subject of safer sex and insists on condom use. According to societal generalizations, women value relationships more highly than men, and because they lack self-esteem will often put themselves at risk for HIV and other sexually transmitted diseases (STDs) rather than insist that a male partner use condoms.

Although some men display the attitudes or behaviors described above, the truth for most men is more complex. Many men seeking testing are concerned—sometimes overly concerned—about risk. While men may prefer not to use condoms, many say they accept them as a necessary part of a healthy sex life. Counselors must acknowledge the complexity of this issue, non-judgmentally validate a client’s feelings about using condoms, and address concerns, such as fear of condom failure, the challenge of finding a brand that fits comfortably, and the difficulties of maintaining an erection when using a condom. It is important to support both men and women in frankly discussing safer sex with partners while validating the difficulty such a conversation may pose.

**Age and Sexual Orientation**

A client’s age or sexual orientation may further complicate gender stereotypes. People in their late 50s and older—often considered to be “older people”—are generally perceived within society to be asexual, or at least less interested in sex than younger people. The assumption is that when older people do have sex, it is conventional, heterosexual, and occurs in monogamous relationships. In fact, press reports about widespread interest by men of all ages in the new anti-impotence drug Viagra suggest that many older men are extremely interested in sex.

Older people may seek HIV testing after re-entering dating environments because a long-term partner has died. Older men experiencing natural, age-related changes in erectile functioning may be especially resistant to condom use and need more support and validation in this area. Women who may have never talked about sex with partners may face the potentially uncomfortable prospect of discussing sex with men. Because of stereotypes that older people are not sexual, test counselors may feel uncomfortable asking older clients...
certain questions, such as if they have ever engaged in sex for money or drugs or if they engage in anal sex.

In addition to stereotypes related to age, stereotypes about sexual orientation and gender include the idea that all gay men engage in anal sex, while heterosexuals never do. Young gay men are often assumed to be taking risks that increase their chances of HIV infection. A common assumption about effeminate gay men is that they are all “bottoms,” or receptive partners in anal sex.

Transsexual and Transgendered Clients

Counselors may believe their skills are particularly challenged by transsexual or transgendered clients, who do not fit into commonly accepted gender identities. To effectively serve these clients, however, counselors must overcome any initial judgments and discomfort.

At some HIV counseling and testing sites, the risk assessment form that clients complete includes gender categories for transgendered clients in addition to options for males and females. Having this information, counselors may ask more specific questions about a client’s gender. When a client who appears to be transgendered has not indicated this on the risk assessment form or when a site uses a form that only has categories for male or female, counselors need to be especially diplomatic when discerning this information. Simply asking, “Do you have a penis?” for example, or “What kind of genitals do you have?” will offend most clients. An open-ended question such as, “What kind of sex do you have?” is a more sensitive and useful way to ease into the subject.

As with other genders, there are common stereotypes about transgendered people. These include that transgendered male-to-females are prostitutes, drug addicts, or both; that transgendered female-to-males do not have vaginal sex, even if they have vaginas; and that male-to-females engage primarily in receptive anal sex but not receptive oral sex—even if they have not had “bottom surgery” and still have male genitals. For a male-to-female, bottom surgery refers to the removal of the penis and testicles and creation of a vagina. “Top surgery” involves breast implants to augment hormonal breast development.

The Gender of the HIV Counselor

Counselors must be aware of how their own assumptions about a client’s gender and sexual identity may affect their abilities to perform a thorough risk assessment as well as how their own gender and sexual identity may affect interaction and rapport with the client. This awareness may help counselors identify what they need to learn, such as the basics of sexual anatomy and unfamiliar sexual practices. A heterosexual female counselor performing a risk assessment with a gay male client, for example, may feel uncomfortable discussing certain sexual practices that are unfamiliar to her. A gay male counselor who has never had sex with women may feel unprepared to discuss the risks of having sex during menstruation.

People may assume that a client will be more comfortable with a counselor of the same gender, but this is not always true. Some men, for instance, may be less comfortable talking with other men about emotions and may work better with female counselors.

To maintain a non-judgmental attitude, counselors must be aware of their perceptions of clients’ genders and the information that clients disclose. Do this by being alert to feelings and locate where these are occurring in the body. For instance, counselors can assess whether there are particular reactions in body language or internal states, such as stomach tightness or shoulder tension, in response to a client. Examining physical reactions can make it easier to then identify emotional reactions.

Counselors can be alert to counseling responses. For instance, if counselors find themselves not coming from a neutral place or faltering in their active listening skills, they can recognize this, seek to restore their skills, and, outside the counseling session, process what is occurring with a helpful peer or supervisor.

Education about sexual and gender diversity can be particularly helpful responses to biases and lack of knowledge.* Get to know people who do not conform to strict gender categories or behaviors, invite a diverse range of speakers to share their experiences of HIV test counseling, and talk with peers and supervisors about counseling clients on issues of gender and sexual diversity.

Conclusion

While making judgments is to some extent unavoidable and sometimes necessary, counselors must be aware of these tendencies. By educating themselves, counselors can broaden their perspectives of gender identities, sexual practices, and risk behaviors, and therefore enhance basic client-centered principles of counseling and risk assessment.

* For more information about gender and sexual identity and for referral sources, contact the San Francisco Sex Information Switchboard, 415-989-7374, P.O. Box 881254, San Francisco, CA 94188-1254. The Switchboard operates Mondays to Fridays from 3-9 PM Pacific Time.

References


Authors

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Case Example: Overrated Sex and Communication

Larry is a 31-year-old male client who “came out” as a gay man only a few months ago. This is his first HIV antibody test, and he says he is nervous. Larry had never had sex with anyone before coming out. He tells the counselor, Paula, that sex is “highly overrated” and that he has not liked it very much.

Keeping a relaxed and non-judgmental attitude, Paula explores the specific behaviors in which Larry has engaged. Larry says he has only had oral sex, and that he cannot imagine discussing condoms. He has considered asking his partners to refrain from ejaculating into his mouth but has been too unsure of himself to say anything. After an incident in which Larry’s partner ejaculated into his mouth, Larry became worried and decided to test for HIV. Paula describes the various avenues for HIV transmission and explains that although oral sex with ejaculation poses lower risk for infection than unprotected anal sex, it is still a risky behavior. It becomes clear to Paula that Larry is uninformed about sex in general and is uncomfortable discussing sex with his partners. She tactfully reflects this observation back to him and begins a discussion about Larry’s preferences in sexual behaviors, ways in which he may explore his sexuality comfortably, and the safer sex practices he may want to consider adopting.

When Paula asks why Larry thinks sex is “overrated,” he explains that the sexual experiences in which he has engaged were casual and nearly anonymous. He says he longs for a “relationship” and believes that emotional closeness could help make sex more satisfying. In addition, he is disturbed that his sexual encounters have not been preceded by negotiation about safety, HIV status, or the activities in which he and his partner would engage. His partners have usually asked him to perform oral sex on them and did not offer to reciprocate.

Paula suggests to Larry that his perception of sex being overrated may change if he becomes able to speak more freely with partners and ask for what he wants. She encourages him to educate himself about sex and sexuality and explores referral options with him.

Case Example: Lesbian-to-Gay-Man Transition

Chris is a 28-year-old transgendered female-to-male client. The counselor, Anne, mistakenly believes Chris to be a woman, then corrects this by reviewing his risk assessment form, which states that he is transgendered.

The form also states that Chris’s sexual orientation is “homosexual.” To clarify this item, Anne asks Chris if his sexual partners are men, and he says that they are. He also adds that before he underwent the sex-change process, Chris identified as a lesbian, but he retained his homosexual identity and is now a gay male.

As with all of her clients, Anne makes sure to maintain a non-judgmental, accepting, and inquiring attitude with Chris. She asks him if he has had a sex-change operation. Chris explains that he has been on hormones for about one year and is considering having “top surgery” but not “bottom surgery.” From this information, Anne concludes that Chris has female genitals.

Anne asks Chris what kind of sex he prefers. When Chris tells her he likes oral and anal sex, Anne continues the discussion asking open-ended questions such as, “What kind of oral sex do you like?” and “Which fluids, if any, do you exchange with your partners?” The discussion eventually reveals that Chris enjoys giving oral sex and being the insertive partner in anal sex while using a dildo. Chris does not enjoy being the receptive partner in vaginal sex and only occasionally receives anal sex, in which case he and his partners always use a condom. During oral sex, Chris says he either uses a condom or does not allow semen to get into his mouth.

Anne acknowledges that these safe-sex practices put Chris at low risk for HIV infection. Anne asks Chris about his level of desire to maintain a commitment to safer forms of sex. Chris’s response is positive and Anne continues the session with confidence in her client’s decision-making ability.
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