In the 1970s and early 1980s, studies investigating gay male couples reported high proportions of non-monogamous behavior.1,2 Many such couples also had an “understanding” by which sex outside the relationship was not considered cheating.2 Since the advent of HIV, these once casual understandings have taken on the potential for life-threatening consequences. Research has also shown that two gay partners in a relationship are more likely to have unprotected sex with each other than two gay men not in a relationship,3 particularly if the partners are seroconcordant.4 Early HIV prevention efforts did not address how couples might sustain and negotiate non-monogamous relationships in ways that might effectively reduce HIV transmission risk.

In the early 1990s, Australian researchers reported a phenomenon whereby HIV-negative couples agreed to rules for sex outside the relationship, in particular, to have no anal sex or only protected anal sex so that they could “safely” have unprotected sex within the relationship. Such “negotiated safety” agreements were hailed as a realistic and promising approach to HIV prevention. The Victorian AIDS Council and the Gay Men’s Health Centre in Australia developed a prevention campaign consisting of 10 steps for negotiated safety, including: getting tested; waiting three months and retesting; and promising to avoid anal sex outside the relationship or to use condoms for anal sex with outside partners. Some researchers feared that negotiating and sustaining such agreements required sophisticated communication skills that most people do not have.5

**The Efficacy of Negotiated Safety**

The results of research focusing on the preventative effects of negotiated safety have been mixed. One study found that it was not only the presence, but also the type, of agreement that was important.6 Specifically, men whose agreements allowed sex with outside partners but barred any anal sex with these partners were less likely to break their agreements than were men whose agreements allowed outside anal sex with condoms or men whose monogamy agreements barred all outside sex.

Another study looked at men in relationships who engaged in “risk practice” (that is, unprotected anal intercourse with a primary partner of different or unknown serostatus, or unprotected anal sex with a casual partner, or both). The study found that subjects who had negotiated safety agreements engaged in less risk practice than those who had agreements that did not permit unprotected sex within the relationship.7 These two studies suggest that more restrictive agreements are not necessarily better at preventing risk behavior.

Estimates of men who have negotiated safety agreements range between 10 percent and 28 percent, and estimates of compliance rates are as high as 90 percent.7,8 Despite these impressive figures, none of these studies included both partners, so “compliance” is based on the report of only one member of the couple. Further, since these studies were cross-sectional, not longitudinal, it is unclear if compliance can be maintained by both partners over time. Finally, at least one study found that negotiated safety agreements were significantly compromised: the London study found that more than 40 percent of men with negotiated safety agreements who reported unprotected sex with their primary partners did not know their own or their partner’s serostatus.9

**The Gay Couple’s Study**

To further understand the nature of negotiated safety—including how agreements function, how couples navigate broken
In this issue of FOCUS, Samuel Jinich reminds us that communication within couples extends well beyond cognitive-behavioral skills such as active listening. In fact, he promotes something that sounds far more romantic: speaking from the heart. To put it in the language of psychology, effective communication occurs when “couples can learn to frame their core misunderstandings in terms of primary feelings and their unexpressed needs and dreams.”

Colleen Hoff would not disagree. In fact, the study she reports on, the Gay Couple’s Study, found that HIV prevention was not the primary motivator for agreements between partners about sex outside the relationship. These agreements were based as much on strengthening the relationship as they were on reducing HIV-related risk.

In some ways, this is a surprise. The HIV-related research literature on sexual negotiation is steeped in the assumption that communication, particularly about a topic such as sex outside a primary relationship, focuses on ways to limit HIV transmission. Clearly, these couples are speaking from the heart.

But while emotionally focused communication may be ideal for couples seeking to improve the quality of a relationship, it may, alone, be inadequate to the task of improving the quality of risk reduction. Given another finding from the Gay Couple’s Study, couples negotiating safety may want to speak from the head as well as the heart.

The study found that when partners did include risk reduction in their outside-sex agreements, many of the resulting agreements were vague, leaving partners with what were contradictory definitions of the activities that were considered “safe” and within the realm of the agreement. These agreements may have satisfied emotional needs to feel closer, creating stronger relationships, but they may not have satisfied the intellectual needs of agreements, and whether the serostatus of couples has a role in agreement negotiations—researchers at the University of California San Francisco undertook the Gay Couple’s Study in 2002. They recruited 38 couples and asked the partners in each couple to describe their agreements about sex with outside partners (this included agreements to be monogamous). Approximately one-third of the couples in the sample were HIV-positive, one-third were HIV-negative, and one-third were HIV-discordant. All participants had been in relationships of three months or more and were older than 18 years. Researchers interviewed couples at the same time but in separate rooms. This fostered candid responses and avoided one partner “contaminating” the other partner’s responses by telling him what to expect.

Two surprising issues emerged. First, for many couples, HIV prevention was not a primary motivator for having agreements about sex outside the couple. Second, agreements were considered an integral part of many couples’ relationships, leading to situations in which agreements and HIV prevention seemed to actually work at cross purposes. These results manifested differently depending on the serostatus of partners.

Serodiscordant couples were highly motivated to keep each other safe from HIV and other sexually transmitted diseases and described the most detailed agreements. Couples who focused on safety with each other seemed to view this goal as an important way to demonstrate the value of their relationship. However, details about safety outside the relationship seemed secondary to safety within the relationship. Serodiscordant partners frequently referred to safer sex with outside partners as a “given” or as something that each assumed, without stating, to be true.

HIV-negative couples were motivated to make agreements about outside partners to facilitate unprotected sex within the rela-
For many couples, HIV prevention was not a primary motivator for having agreements about sex outside the couple.


relationships. Trust was a primary component of these agreements: trust that each partner would remain monogamous for monogamous couples, and trust that partners would have only safe sex with outside partners for non-monogamous couples. Many couples expressed positive feelings about trusting their partners so deeply.

HIV-positive couples were the least likely to include details about HIV prevention in their agreements. When partners discussed safety, it was usually in terms of keeping each other from getting sick. When they discussed the safety of outside partners, it was often in terms of suggesting that outside partners should take responsibility for protecting themselves.

Overall, having agreements seemed to benefit relationship quality particularly when there was agreement parity: the type or explicitness of agreement did not cause problems for couples as long as both partners felt that each had the same understanding and strictures. Without parity, couples experienced friction. For example, in a couple in which one partner had lost interest in sex due to depression, the couple agreed that the second partner could have sex outside the relationship. Over time, this partner limited outside sex to one person, whom he eventually considered a “boyfriend,” an arrangement that created ambivalence for the depressed partner and friction for the couple.

Further, agreements supported relationship quality by symbolizing trust and commitment. Partners valued the fact that they could trust each other enough to have sex outside the relationship without getting jealous. In particular, HIV-negative couples who had agreements to have safe sex with outside partners and unprotected sex with each other considered that they were trusting each other with their lives. Several couples reported feeling proud of agreements to have outside partners that they felt rejected stereotypical heterosexual roles.

Many aspects of agreements seemed to support HIV prevention. For example, although each partner might describe the couple’s agreement differently and with different emphases, the essence of the agreement was the same within most couples. In addition, agreement compliance was more likely among couples who, as part of their agreement, insisted that if either partner broke the agreement he had to disclose this lapse to the other partner.

Destructive Aspects of Agreements

Despite these positive findings, there were many ways that agreements worked at cross purposes with both relationship quality and HIV prevention. First, many agreements were vague, which allowed couples to avoid detailed discussions about what was considered safe. When these topics were not discussed, partners may have had contradictory definitions of safety, which put one or both partners at risk.

For instance, in the beginning of their three-year relationship, “Jim” and “Jeff” both tested HIV-negative. Six months later, after they both tested HIV-negative again, they decided to have unprotected sex together and “safe” sex with outside partners, but they never defined what activities were safe. A year later, Jeff seroconverted. In this example, the vagueness of what was considered safe may have given Jim and Jeff a false sense security. Couples who implicitly assume safety and focus on other aspects of their agreements, for example, allowing only one-night stands or outside partners only when traveling, may benefit from the relationship support aspect of the agreement but increase their vulnerability to HIV.

Undisclosed broken agreements can result in a complicated interplay of relationship and HIV prevention issues. Many study respondents refrained from disclosing broken agreements because they were afraid their partners would become hurt, upset, or jealous. Some viewed non-disclosure as beneficial to the relationship because it avoided a potentially emotional exchange. Others felt non-disclosure created a wedge in the relationship that left the partner who did not disclose feeling guilty and isolated. Obviously, non-disclosure of broken agreements endangers partners in terms of HIV transmission risk.

Counseling about Agreements

Mental health providers and health educators have a unique opportunity to help clients and their partners address the complexity of negotiated safety agreements. In order to motivate couples to directly address HIV prevention in their agreements, providers should address agreement issues within the context of the whole relationship, encouraging clients to tease out how agreement issues may influence health, intimacy, and emotional state.

For example, if a client wants to avoid a fight by not disclosing a broken agreement to his partner, the provider might ask the
client how not disclosing—and how his partner’s not knowing—will affect the couple’s relationship. Exploring this issue from several different angles can help the client or couple see how non-disclosure may take the relationship in an undesirable direction and find solutions to the barriers that make disclosure difficult. By working in the context of the “big picture”—the desire to have a loving and trusting relationship—clients and couples may be more open to resolving barriers such as guilt or fear of confrontation.

Providers have two important tasks when helping couples negotiate their agreements. First, providers must help couples manage their defenses so that they can be open to one another. Agreements will not succeed if they are based on defensive reactions. Reminding couples of the “big picture” and their reasons for making an agreement can help achieve this goal. Second, when defenses do come up during the negotiation process, providers should address them directly. This will help clients learn to identify important boundaries that, once understood, will shape a more specific—and effective—agreement.

Providers can also model boundaries—and the process of uncovering boundaries—by asking clients if they are comfortable with specific aspects of their agreements. Providers may even pose situations that challenge a client’s comfort. For example, in response to Jim and Jeff, the provider might have said, “If Jeff has insertive anal sex with outside partners and feels this is safe for him, would you agree to this approach?” This process will give clients “permission” to think through the impact of the specific provisions of the agreement and an opportunity to change provisions before they are broken.

Many gay couples, in particular, believe that the definition of safe sex is obvious. Despite this certainty, providers should urge couples to discuss in detail what each partner means by safe sex, and encourage partners to agree on mutually acceptable definitions. Including specific behaviors and how these behaviors may vary based on the outside partner’s serostatus can help in these discussions.

It is important to note that sustaining negotiated safety agreements, as with any behavior change process, requires the capacity to weather the inevitable lapse. It is useful to offer couples the opportunity to talk through their fears about their own and their partner’s potential reactions to hearing about a broken agreement. Not only can this give partners the chance to express these fears, the process of talking, itself, can give each partner the opportunity to reassure the other that each can cope with the consequences of a broken agreement.

Finally, providers should consider encouraging couples to update their agreements regularly in response to natural changes in the relationship. Partners should frame updates in positive terms as an opportunity to ensure that both partners remain satisfied with the way the agreement handles sex. It may be useful for providers to help couples develop a structure and a schedule for updates, both of which can support direct communication, help the couple manage emotional reactions, and ensure that update discussions do not occur only when one partner believes something is “wrong.”

Conclusion
Negotiated safety agreements—which can strengthen relationships as well as facilitate risk reduction—are common among gay couples. Couples who have agreements should be commended for making efforts to address relationship issues that are complex and sensitive. Mental health providers are well-positioned to help couples work through agreements and, in doing so, continue to build meaning and health in their relationships.

Clearinghouse: Couples and HIV

References


Imagine a mixed HIV status couple arguing over money. The HIV-positive partner, “Doug,” doing well on his medications and envisioning a wide-open future, is spending money “like there’s no tomorrow” and wants to move away from the city.

The HIV-negative partner, “Eric,” is more cautious and worries that the couple may one day need the money for an emergency. What if Doug relapses? Won’t living away from the city mean living away from the best doctors and hospitals?

When the partners fight, they seek to be understood by winning the argument. They do not listen to each other. They feel hurt and misunderstood. They do not perceive the emotional narrative that runs beneath their differences.

Couples like Doug and Eric come to therapy looking for change. Yet all too often, the change each partner seeks is a change in the other partner. Doug wants Eric to loosen up and celebrate Doug’s new lease on life. Eric wants Doug to exercise better judgment and to share the burden of planning ahead. In couples counseling, both men seek help in coming to agreements and improving their communication skills.

From Active Listening to Emotionally Focused Couple’s Communication
Samuel Jinich, PhD

In emotionally focused therapy, the therapist reframes the couple’s interactions in terms of the partners’ emotional responses and attachment needs.

Active Listening and Cognitive Skills
Couples therapists, depending on their theoretical orientation, view communication problems differently. For example, cognitive-behavioral therapy posits that if partners begin to behave more positively toward each other, they will think and feel differently toward each other. It applies skills-based instruction and training to guide the couple toward these changes.

Guidelines for constructive communication can provide couples with the structure they need to interact effectively. Such guidelines can help partners learn to focus more attention on the process of communicating and less attention on the content of the conversation. One cognitive-behavioral approach is “active listening.”

Essentially, during active listening, one partner states his or her concern, and the other listens and then paraphrases the concern. This process continues, back and forth, until the first partner, the Speaker, feels that the second partner, the Listener, has heard the content adequately. The Listener then validates the Speaker by telling the Speaker the ways in which he or she understands the Speaker’s problem and why the Speaker’s perspective makes sense to the Listener, in this way expressing empathy. This approach might help Doug and Eric begin to soften their conflictual style, ensure that they understand each other, and develop greater acceptance for each of their individual experiences.

Couples can be taught additional problem-solving skills, for example, positive, non-coercive ways of influencing each other. Couples can also be taught to control the negative communication practices that may have become habitual in their relationship. This is particularly important because some marriage experts suggest that although communication skills are useful to learn, couples do not apply them effectively dur-
ing moments of conflict. For example, one study found that most partners who maintained happy marriages, rarely engaged in communication that resembled active listening when they were upset.²

Researchers Susan Johnson and John Gottman have offered alternatives to active listening. These empirically based approaches to couples therapy involve improving a couple’s communication by coaching partners to express themselves both more emotionally and more empathically.

Emotionally Focused Therapy

Johnson’s Emotionally Focused Therapy emphasizes identifying self-sustaining, reciprocal, negative interaction patterns, the most basic being the pursuer-distancer or attack-withdraw pattern.³ This pattern can be seen in the way in which Doug and Eric react to conflict. Whenever Doug begins to discuss a fun, yet costly idea, Eric emotionally withdraws and feels resentful. In response, Doug becomes angry and complains loudly. Both partners feel unsupported and their needs go unmet.

The goal of emotionally focused therapy is to create new emotional experiences in order to promote new interaction patterns. In emotionally focused therapy, the therapist reframes the couple’s interactions in terms of the partners’ emotional responses and attachment needs.

The therapist encourages the partners to identify with their own primary feelings (hurt, fear, insecurity, loneliness) and needs, and to accept and respond to their partner’s feelings and needs. He or she further helps the partners take risks to express these feelings, thereby deepening the partners’ connection and understanding of each other.

For example, the therapist might help Doug and Eric recognize the hurt and fear that precedes Doug’s expression of anger, or the helpless despair that underlies Eric’s numb withdrawal. Eric feels hurt that Doug does not recognize what he has gone through, and feels unappreciated; Doug also feels hurt and misunderstood and does not think Eric “gets” him.

Sound Marital House

The goal of Gottman’s Sound Marital House approach is to increase the amount of positive affect in the non-conflict contexts of the relationship and decrease negative affect during conflict resolution.⁴ The therapist teaches partners to remove blaming from complaining, and to make their complaints as concise as possible. Using Sound Marital House theory, therapists teach partners to describe, rather than evaluate or judge, what they are experiencing and to express clearly what each needs from the other. Central to this approach is being polite, expressing appreciation, and stating feelings using vulnerable emotional terminology rather than resentful terminology. Further, the approach emphasizes accepting, rather than resisting, a partner’s influence.

Therapists train partners to make repair attempts as soon as conflict arises, by making statements or taking actions—silly or otherwise—that can prevent negativity from escalating. For example, a couple might agree in advance to say, “Please say that more gently,” or “Can I take that back?” when either feels an argument is becoming too negative.

Not all conflict is bad. According to Gottman, the difference between couples that argue and stay together and couples that argue and break up is in the way that they argue. The most obvious sign is the way discussions begin. Discussions that begin with criticism or sarcasm are said to have a “harsh start-up,” doomed most relationships to failure. Gottman’s research shows that “softened” start-ups, which consist of accepting the influence of the partner, making repair attempts, de-escalating conflict with humor and affection, and having the willingness and ability to compromise, best predict a long-lasting happy relationship.

Conclusion

Using a combination of these approaches, couples can learn to frame their core misunderstandings in terms of primary feelings and their unexpressed needs and dreams, rather than as accusations. With practice, they can learn more about each other’s needs and concerns and how to communicate with affection and deeper understanding about the full range of relationship and HIV-related challenges.

References


Authors

Samuel Jinich, PhD is a psychologist in private practice in San Francisco, specializing in couple therapy. He is an adjunct faculty at Alliant International University in San Francisco and a former president of the San Francisco Psychological Association.

Comments and Submissions

We invite readers to send letters responding to articles published in FOCUS or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals. Send correspondence to rmarks@itsa.ucsf.edu or to Editor, FOCUS, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.
Perceptual Agreement about Sex in Couples
Harvey SM, Bird ST, Henderson JTL, et al. He said, she said: Concordance between sexual partners. Sexually Transmitted Diseases. 2004; 31(3): 185–191. (University of Oregon, Eugene; Oregon State University, Corvallis; Alliant International University, Los Angeles; Children’s Hospital of Orange County, Orange, California; and University of Oklahoma Health Sciences Center, Oklahoma City.)

A multisite investigation of concordance in couples found that male and female partners are most likely to have discordant perspectives about the issue of which partner has more power in the relationship and in sexual decision making compared to a range of other topics.

Researchers identified women aged 18 to 25 who had male sex partners aged 18 or older and recruited a total of 112 couples from four U.S. cities: 30 from Atlanta; 39 from Los Angeles; 21 from Oklahoma City; and 22 from Portland, Oregon. Further eligibility criteria included having had sex without a condom during the previous three months and having ever participated in at least one of five HIV risk behaviors. The mean age was 21.5 years among women and 24.2 years among men.

Researchers conducted interviews between July 1998 and April 1999. Sexual partners participated in the interviews individually but concurrently. Interviewers asked about relationship characteristics, sexual behavior, risk factors, and partnership power dynamics.

In general, partners had nearly perfect agreement on their answers regarding relationship characteristics, which included the number of months the partners had been together, and whether the partners live together, were married, and had children together. Couples were also concordant in their reports of types and frequency of sexual behavior and patterns of condom use.

In more than half the couples, however, partners disagreed about which partner each perceived as having more power in the relationship. Notably, the couples were most likely to agree about these questions when partners responded that both partners have equal levels of power. When a partner reported that either the man or woman had more power, the other partner was unlikely to agree.

Similarly, at least 40 percent of couples gave discordant responses to questions on decision making within the relationship. When partners reported unequal power or dominance in decision making, the following results were most common: men have more power in the relationship; women decide when to get pregnant; men decide whether to use a condom; and men decide what to do during sex.

Twenty-two percent of men and 14 percent of women reported having had sex with someone other than their main partners in the prior three months. There was substantial agreement between men’s perceptions of whether their partners had had sex with someone else and their partners’ reports of such activities. There was only fair agreement, however, between women’s perceptions and their male partners’ reports of sex outside the relationship.

HIV Risk Management among Couples

A Swiss study of gay male relationships found that most participants—84 percent—practiced HIV risk reduction methods with their partners. Such methods included abstention from anal sex, consistent condom use during anal sex, and "negotiated safety," defined as having unprotected anal sex after both partners have tested HIV-negative.

In 1997, researchers developed a questionnaire and placed it in four Swiss gay newspapers and distributed it through gay organizations, bars, and saunas. The surveys asked participants about their sexual behaviors, relationship status, partner and relationship characteristics, and HIV risk management. A total of 1,097 gay men filled out the survey, of which 81 percent had been tested for HIV and 11 percent were HIV-positive. The average age of the sample was 37 years.

Seventy-two percent of participants reported having had a steady partner within the prior 12 months, and more than 80 percent of the sample had had more than one sexual partner in the prior 12 months. Of those reporting a steady partner, the length of the relationship...
ranged from one month to 43 years, with a median of three years. Fifty-one percent of participants described their relationships as exclusive.

Choosing from among the four main HIV risk management strategies offered, 16 percent of participants said they abstained from anal sex with their steady partners, 43 percent reported consistent condom use with their steady partners, and 25 percent said they practiced "negotiated safety." Another 10 percent did not use condoms despite the fact that partners did not know each other's serostatus, basing their decision either on assessment of past risk (6 percent) or the desire to remain monogamous (4 percent).

Three-quarters of participants with steady relationships in the prior year reported having talked to their primary partners about ways of managing HIV risk. Of the 24 percent who had not had this discussion, 65 percent reported that they did not do so because they had assumed there was an absence of risk.

The following variables, in order of importance, were significantly associated with consistent condom use within couples: HIV serostatus (more consistent use with discordant or unknown status); duration of the relationship (more consistent during the first two years, and particularly the first six months of the relationship); existence of other sexual partners in the prior year (more consistent use when there are other partners or when it is unknown); sexual behavior (more consistent use of condoms when there are periods of high frequency of anal intercourse); attendance at saunas and gay events (more consistent use associated with more frequent attendance); and education (more consistent use among those who graduated from high school).

Communication among Couples


A cross-sectional study on heterosexual, gay male, and lesbian couples found no differences in communication patterns based on sexual orientation.

A total of 121 couples in Montreal and neighboring suburbs participated in the study. Among these were 42 heterosexual, married couples; 46 gay male couples; and 33 lesbian couples. All couples had to have been living together for at least two years.

After completing questionnaires and rating relationship quality, partners together completed two 20-minute videotaped tasks. First, couples participated in the "support task": each partner in turn told the other partner his or her most significant personal problem unrelated to the other partner. Then, couples participated in the "conflict task": partners were asked to identify a problem in their relationship and then reach a solution.

Researchers observed the interactions, noting positive and negative forms of communication in both the support task and the conflict task. Positive forms of communication included self-disclosure, validation, attention while listening, and solution proposals; negative forms included countervalidation, dominance, and withdrawal. Sexual orientation did not have any significant effect on positive or negative communication patterns in either task or in terms of self-reported relationship quality.

Positive communication patterns in the support task were associated with higher self-reported relationship quality, and negative communication patterns in the conflict task were associated with lower relationship quality. Moreover, positive behaviors in the conflict task were uniquely associated with relationship quality.

Next Issue

Caring for people with triple diagnosis—HIV, a psychiatric disorder, and substance use—is perhaps the greatest challenge facing mental health providers working with HIV. In the March issue of FOCUS, Ramon Matos, MFT, the Clinical Coordinator of the Assertive Case Management Program of the UCSF AIDS Health Project, reviews the philosophy behind the range of current approaches. He goes on to describe a different strategy, assertive case management, which prioritizes relationship building with clients as the primary intervention leading toward care for all three diagnoses.

Also in the March issue, Edward R. MacPhee, MD and Antoine Doualty, MD, both at the Western Psychiatric Institute and Clinic of the University of Pittsburgh, define triple diagnosis and its manifestations and discuss an integrated, multidisciplinary approach to care.
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.