AIDS Counseling and Prevention among Bisexual Men

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Since the Centers for Disease Control (CDC) first defined AIDS and the populations at high risk for HIV infection, gay and bisexual men have been lumped together in an indiscriminate category that ignores differences in identity, relationships and community. Although we have learned a great deal about AIDS education and prevention for gay men, the tendency to treat “gay and bisexual males” as a single entity has meant that we know little about the impact and applicability of such AIDS prevention efforts on the behavior of bisexual men.

AIDS has forced society to discuss sexual behavior with a previously unparalleled candor. Such open discussion helps to educate the public and dispel some common biases and myths about sex and sexuality. Nevertheless, the impact of this exchange on perceptions of bisexuality has been uneven. While there is a greater awareness of bisexuality as a pattern distinct from exclusive homosexuality, sensationalistic media coverage has promulgated a stereotype of bisexual men as sexually irresponsible, promiscuous “villains” in the spread of HIV infection among heterosexuals.

Mental health professionals have an obligation to scrupulously evaluate their perceptions of bisexuality to ensure that personal assumptions and values are not communicated to the client, particularly from behind a veil of theoretical or technical jargon. Unfortunately, the general lack of formal training about sexual issues means that many therapists who provide counseling have sharply limited and misinformed concepts of sexuality.

Among the questions mental health practitioners should ask themselves when working on sexual issues with clients are: Do I have any special criteria for determining “true” sexual orientation and how people should identify themselves sexually? What is my investment in changing a person’s patterns of sexual activity or choice of partners? What are my formulations of “appropriate” or “healthy” relationships, and how do these notions influence my perceptions of heterosexual versus homosexual bonds, or monogamy versus nonmonogamy? How comfortable am I discussing sexually-explicit topics with clients? Pre-existing beliefs and values can bias the efficacy of any work on sexual issues.

Bisexuality and Identity

Perhaps the most damaging belief about bisexuality is that it does not exist. Scientific, political and moral discourse frequently presumes that the world can be divided into mutually exclusive groups of heterosexually-active and homosexually-active people. This idea finds support not only in the heterosexual community, but also in the gay and lesbian communities.

As a step toward defining AIDS intervention strategies, it is important to recognize how these categories of sexual identity are shaped by society rather than being inherently obvious constructs determined by a natural order. The significance of specific sexual acts and interactions has varied considerably over time and from one society to another. For example, in some cultures, sexual orientation is determined not by the choice of sexual partners, but by the role played in specific sexual acts and that role’s congruence with conventional gender role expectations.1

While it is clear that popular culture emphasizes the importance of sexual attraction, the divisions created by current labels of sexual orientation (such as “gay” or “straight”) are arbitrary and oversimplify the universe of sexual tastes and behaviors. The power of these labels lies in their capacity to define social identity, group ties, and social status. In the United States today, an individual’s definition of sexual orientation may be at least as powerful in determining social and self identity as ethnic background, race or gender.

Individuals may come to therapy confused about their sexual orientation or about the personal implications of recent sexual experiences and relationships. This confusion may result from inconsistencies in personal experience, sense of self, and understanding of sexual orientation. Those who try to define a social and self identity that integrates sexual experiences with both men and women commonly feel polarized and fragmented by a culture that perceives bisexuality as artificial, transitional and transitory. It is crucial that the therapist acknowledges the inadequacies of the conventional gay/straight dichotomy to describe these clients’ personal experiences.

Individuals exploring sexual feelings about and relationships with both men and women struggle against the social invisibility of the bisexual. The bisexual identity is an elusive one; adopting it does not provide any clear reference group or organized support system for most people. It does not relieve the pressure to define oneself as a member either of the heterosexual community or of the gay and lesbian community. Such demands to align oneself with one faction or another are not matched by either community’s readiness to accept bisexuality within its membership. Any degree of homosexuality can lead to ostracism by mainstream society, while anything less than exclusive homosexuality can mean rejection by the gay and lesbian community.

The sociological construct of marginality provides a conceptual frame for understanding the social forces that contribute to these difficult questions of bisexual identity and social allegiance. Marginality refers to the social position of individuals who are unable to find any clear group membership role, due to their straddling of conventional social boundaries. Such marginal status is not only stressful, but may lead to psychological symptoms in the internalization of long-standing conflict between different social groups.

“Coming out” as a bisexual may therefore be a slower and less direct process, due to the lack of validation for bisexuality, the potential for negative reactions and loss of social support, and the absence of a visible bisexual community. Further, no clear models or norms are available to clients to help them determine what identifying as bisexual might mean.

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Concerns in Bisexual Relationships

Since clients may be isolated both from an organized bisexual community and the gay and lesbian communities, practitioners must talk explicitly about sex and health issues. As one of their clients' few resources, therapists have a responsibility both to educate about HIV infection, antibody testing and safer sex guidelines, and to help in the skills-building necessary to negotiate safer sex practices with both male and female partners. The therapist can assist clients in identifying their AIDS-related obligations with regard to disclosure to sexual partners, defining these responsibilities so they reflect a client's particular situation and skills. Acknowledging same-sex experiences to heterosexual partners sometimes may be too emotionally-charged and potentially risky; this does not preclude consistently adhering to safer sex practices and identifying oneself to partners as being "at-risk."

For those in heterosexual relationships, coming out as bisexual to partners is complicated by the AIDS epidemic. It is one thing to work out guidelines for safer sex with new sexual partners; it is another to make changes in ongoing relationships. Added to the typical concerns that a person may have when his or her partner "comes out" as bisexual—emotion, commitment, the stability of the relationship, competition, jealousy—comes suspicion of the partner as a source of HIV infection. "Closed" bisexual husbands who come out to their wives are bound to find their spouses raising the issues of AIDS and other sexually transmitted diseases. The vulnerability and sense of betrayal wives may feel when faced with disclosure of their husbands' bisexuality is compounded by the fear that this secret may have lethal consequences. The therapist must be sensitive in such delicate situations and be supportive of both bisexual clients and their partners. Concern about AIDS may aggravate a heterosexual partner's homophobia and biphobia, and simultaneously provide a rationale for such judgmental attitudes. While the threat of HIV infection may mean that individuals will demand more conservative relationship rules than they would have considered in the past, it is important that the health rationales guiding such changes be free of moralistic judgments.

AIDS Prevention

Addressing the risks of HIV infection among bisexually-active men and their partners is a significant challenge, because such AIDS prevention efforts—whether public education messages or more personal and intensive interventions—require the ability to characterize a population and define appropriate ways of reaching this population. In this context, the discordance between a man's self-identity or group affiliation and his sexual behavior becomes a stumbling block for AIDS education. This is especially important in terms of educating men who are sexually active with other men, but who define themselves as heterosexual, are in heterosexual relationships, and remain aloof from the gay or bisexual communities. Their lack of involvement with these communities may mean that they are unmindful of the risks their sexual behaviors create for themselves and their partners. Since these men do not see themselves as gay, and since AIDS education directed at the general population has been inadequate, undue in this group may fail to see the personal relevance of risk reduction messages.

Adequate sex research has yet to be done on a representative population of Blacks or Latinos, but some researchers have reported higher levels of bisexual activity in these groups as compared to White samples.1,2 CDC breakdowns of reported AIDS cases offer some support for this premise, as the proportion of bisexual-active men in the joint category of "gay and bisexual men" is higher for Blacks and Latinos (31 percent and 20 percent, respectively) than for Whites (13 percent).3

Given these concerns and the fact that the population of bisexual men is diffuse and lacks clear gathering sites, multiple educational approaches are needed. While closeted bisexuals may seek anonymous sex in parks and public rest rooms, educating these men in such settings is expensive and of unknown efficacy. It is debatable whether prevention programs in still-existing bathhouses can be effective, due to the difficulty of encouraging and enforcing safer sex norms in a situation long associated with unrestrained—and unsafe—sex.

Since many bisexual men are closeted, more sexually explicit prevention messages directed to the general population are needed. Any efforts targeting the Black and Latino communities must be culturally sensitive to the range of meanings attached to same-sex sexual behavior and the various implications of such sexual relationships within the broader context of an individual's support network. In addition, there are a variety of loosely organized bisexual organizations across the country that conduct some AIDS education on their own, but could benefit from involvement in more coordinated prevention efforts. Clearly, those affiliated with a bisexual organization differ from those who are bisexual-include but heterosexually-identified. Some of these organizations, however, capture a subgroup of those with stronger links to the homosexual mainstream than to the gay and lesbian communities. The use of these organizations to develop and promote prevention programs is consistent with the proven model of the gay community's efforts to create unique risk reduction interventions for its own population. Nonetheless, the fact that many bisexually-active men are unaffiliated with bisexual organizations poses a challenge to planning educational campaigns, and demonstrates the difficulty of using the gay community's strategy for less well-defined groups.

Additional prevention efforts can be focused on sexual subcultures whose members may be more bisexual-active. For example, "swingers," people in steady sexual relationships who attend private or commercial sex parties, may engage in homosexual as well as heterosexual sex.

Over the past few years, as the AIDS epidemic has shifted from being viewed as a gay White man's disease to a public health threat of concern to the general population, we have experienced clear shifts in the public's treatment of sexual behavior and sexuality. Despite the increased focus on sexuality, society in the United States remains entrenched in beliefs about sexual behavior and sexual orientation that are stumbling blocks in the effective communication of HIV risk-reduction messages. Bisexuality must be acknowledged and addressed if we are to move beyond scapegoating to the promotion of sexual health.

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References

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Homosexuality and Bisexuality among Latino Men

Ernesto de la Vega

Bisexual behavior among men within traditional Latin American culture is not always an expression of sexual identity; it is often the result of culturally polarized perceptions of masculinity and femininity. Mental health professionals and educators working with HIV infection must recognize the role of bisexuality in Latin culture in order to provide appropriate AIDS prevention education to a group separated from mainstream culture in the United States. This article discusses the expression of bisexuality among Latino men who have maintained ties to their traditional culture, as well as some aspects of the Latin American homosexual experience.

Bisexuality and Homosexuality

The conservative and rigidly-defined sexuality that is common in Latin American culture sometimes forces those who do not fall into typical definitions of Latin male and female roles to make hard choices between the two. The result is that traditional Latin culture does not produce the spectrum of sexual identity that exists in some places in the United States: a flexible range among men and women from homosexuality to bisexuality to heterosexuality. Instead, it often maintains rigid sexual definitions by describing homosexual, feminine men, who are unable to conform to the macho image required by their culture, as “pseudo-women” and members of a “third sex” subject to discrimination.

Yet many heterosexual Latino men engage in same-sex activities with homosexuals. Heterosexual or bisexual men who have sex with homosexuals are often convinced that they are not having sex with other men, at least not with men who conform to the definition of man that they use to describe themselves. Thus same-sex practices in Latin culture are often numerous, anonymous, and shrouded in an atmosphere of denial that the cultural invention of a “third sex” allows.

Some Latino homosexuals reject this publicly feminine role because it is associated with the social oppression of Latina women, because it may interfere with financial and emotional bonds with the extended family, and because Christian traditions condemn homosexuality. Instead, these men adopt macho roles, and either marry or parade an endless procession of girlfriends while seldom abandoning their homosexual identity. The culturally confusing result is that many Latino men who identify as homosexual will be bisexual in behavior and heterosexual in appearance.

There are other cultural reasons for bisexual behavior. During puberty, the male adolescent in Latin culture is sometimes considered to be “sexually uncontrollable,” and he is allowed a period of sexual experimentation, with both men and women. This experimentation is reinforced by the social encouragement to male youths to assert themselves over everyone and everything, particularly the feminine, to prove their virility and strength as part of a growing machismo. In this way, men may identify as heterosexual, but may participate in bisexual behavior as a result of coming-of-age rituals. This underlies the belief among some Latino men that, “I am so strong that I can even fuck [penetrate] another man.”

In addition, older Latino men may have sex with pubescent youth, who appear feminine, because of difficult access to women. It also must be noted that many young men, regardless of sexual identity, engage in same-sex behavior for money, for drugs or for food; poverty is a crucial factor in bisexuality in Latin America.

Sexuality in Latin American Culture

Bisexuality in Latin American culture cannot be discussed without understanding the role of sexuality in general. Sex is a taboo subject among Latin Americans. Yet, while Latina women are still expected to be virgins at the time of marriage, Latino men are not only free from the requirement of pre-marital virginity, they are encouraged to experiment sexually.

Sexual education among Latin people is almost totally lacking. In some places it is only because of fear of AIDS that Latin community leaders are finally considering the subject of sex. This is dangerous, as it equates sex with illness and death, and perpetuates fear of sex within a culture where sexuality is already shrouded in great mystery. For some of the poorest Latina women, sexuality is something which happens to them in the dark and in silence, something they do not talk about even with their husbands. At a time when safer sex requires extensive sexual knowledge and interpersonal negotiations, Latina women, who have little control over their sexuality, are hard-pressed to even acknowledge it. Latina women in traditional families are often made solely responsible for birth control. But since many Latina women lack any real authority over the sexual act with their partners, condom distribution and AIDS education must include both partners. The husband of a woman who presents him with a condom may feel castrated by his wife, who all of a sudden has assumed an authority she has never had before. A wife whose husband presents her with a condom may feel he is treating her like a prostitute, or that he may be trying to protect her from a venereal disease caught while he was cheating on her.

Sexuality is one of the few areas where the poor feel that they have some control over their lives. Any AIDS prevention or sex education for low-income Latin people must answer the question: What are health educators offering in return for what they are taking away from a people who historically have suffered so much loss?

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AIDS Prevention among Same-Sex Couples

The sex-role dynamic within Latin same-sex couples is parallel to the dynamic that functions within heterosexual couples. Many Latin same-sex couples describe their roles as “husband and wife” and pattern their relationships using traditional heterosexual images: macho versus effeminate, dominant versus submissive.

In such a couple, the more feminine partner, as is often the case with Latina women, may feel weak and with little sexual authority within the relationship. Yet he will be, more often than not, the partner who is more aware of the need for safer sex and, most of the time, is less likely to have sex outside the relationship. He may tolerate the sexual adventures of the macho partner for fear of losing the partner if he objects. In cultures of poverty, a partner often means more than love; he also may mean housing, food, and physical protection.

AIDS educators and professionals need to empower “feminine” males in Latino homosexual relationships in the same way that Latin American men in general must be empowered. At the same time, while trying to modify the authority of dominant partners, educators must respect the more “feminine experience” of homosexuality of many Latino men. Educators must reach out to bisexual men, who do not identify as homosexual, in similar, non-threatening ways, for instance, in the context of general AIDS education to heterosexual Latino men or to the Latin family. Since most Latino men who engage in bisexual behavior identify neither as gay nor bisexual, AIDS counseling and education should focus on sexual behavior and avoid using labels to define identity.

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Recent Reports

Hope for Compound Q. The recent release of information regarding GLQ223, also known as Compound Q, has focused attention on a proposed antiviral drug that in laboratory experiments kills only those cells infected with HIV. While there are no data about the toxicity or efficacy of GLQ223 in human beings, researchers are cautiously optimistic that the drug may represent a powerful treatment against HIV.

The drug was developed by researchers at the University of California San Francisco, Genelabs, Inc. in Redwood City, California, and the Chinese University in Hong Kong. The only published report about GLQ223 was in the Proceedings of the National Academy of Sciences, USA (April 15, 1989), although information has been disseminated in the popular press.

GLQ223 differs from other antiviral AIDS drugs, such as AZT, in two crucial ways: it seems to kill HIV-infected cells, rather than simply interfering with viral replication or dispersal; and, while it also kills infected T-4 cells, it is the only AIDS treatment that destroys infected macrophages, immune system cells considered to be reservoirs for HIV replication.

GLQ223 is a purified extract of a protein derived from the root of Trichosanthes kirilowii, a Chinese cucumber. An impure form of the protein is used in China to induce abortion. Researchers warn that this form of the drug, widely available in China, causes blood clotting and may lead to stroke or heart attack. They urge people with HIV infection not to treat themselves with other forms of trichosanthin and to wait for the results of the San Francisco clinical trials on GLQ223, expected in six to nine months.

Heterosexual HIV Transmission. The Staten Island Hospital (Archives of Internal Medicine, March 1989).

A small study of predominantly White middle-class heterosexuals found that HIV infection was spread primarily through sexual contact with middle-class intravenous drug users, contradicting the stereotype that I.V. drug use and this mode of transmission are confined to urban poor people of color.

The researchers reviewed the office records of a physician in private practice in Staten Island, a borough of New York City. Thirty-nine patients, 35 women and four men, were found to have regular sexual partners who were HIV positive ("source contacts").

Of the 39 source contacts, 32 were I.V. drug users, five were bisexual men, one was a male transfusion recipient, and one had acquired HIV through heterosexual contact with a female I.V. drug user. Overall, 28 of the 35 female patients (80 percent) and all of the male patients were exposed to HIV through sexual contact with I.V. drug users.

Demographics of the sample were striking: 35 of the 39 patients and 34 of the 39 source contacts were White. Twenty-eight of the patients were married to their HIV antibody-positive source. Thirty-four of the 39 patients lived in private residences. The mean household income of all patients was $41,200. All but two patients, who were attending high school at the time of the study, were high school graduates. None had a history of regular alcohol use. The mean number of lifetime sexual partners among the male patients was 2.3. The median duration of sexual relations with HIV-infected partners was six years. Only five female patients had engaged in anal intercourse, and none of these was seropositive.

After excluding the four patients who presented with hepatitis B or HIV infection, seven of the 30 patients who agreed to be tested for HIV antibody were seropositive. All seven were heterosexual partners of sources with AIDS or ARC; none of the 10 heterosexual partners of asymptomatic HIV-infected individuals was seropositive.

Despite the fact that 23 of the 32 patients became aware of their partners' risk behaviors before the partners were diagnosed with HIV infection, condoms were not used regularly in these relationships. Many patients had little knowledge about the risk of heterosexual transmission of HIV; many were not aware that an asymptomatic person with a history of I.V. drug use could be infectious.

Next Month

Perhaps more than any other disease, HIV infection challenges physicians to deal with difficult psychosocial concerns as well as complex clinical issues. The challenge is compounded by the fact that these begin for many before the appearance of serious symptoms and may continue for an extended period of time. In the July issue of FOCUS, Lisa Capaldini, MD, a San Francisco physician, discusses recommendations for monitoring and treating HIV infection, and ways of responding to the emotional needs of both patients with HIV infection and the primary care physicians treating them.

Also in the July issue, Pierre Ludington, of the AIDS Health Project, and Paul Wychules, of Body Positive in New York, discuss the role of peer support groups in offering people with HIV-infection emotional support and help in making medical decisions.