Counseling Gay Couples

Robert Paul Cabaj, MD

The relationship between partners in a couple is the primary site at which HIV-related transmission, prevention, and support occurs. Within an intimate relationship, HIV is most likely to be transmitted or prevented, and partners are likely to provide the bulk of the support necessary to handle the emotional and practical challenges of being infected. Up to now, in the United States and other developed countries, gay male couples have borne the brunt of the epidemic. This article defines couples therapy, and uses gay male relationships to explore the effects of HIV disease on couples and the ability of couples counseling to mediate these effects.

While gay male relationships are unique, much of this article will be relevant to heterosexual, bisexual, and lesbian couples, and to both men and women. But, while heterosexual couples receive greater social affirmation, in the context of HIV-related care systems often organized by gay men and lesbians for use primarily by gay men, heterosexuals may find their needs to be less thoroughly addressed. In addition, unlike gay men, at least, perhaps, those who are White, heterosexuals have rarely developed community support for handling emotional issues and nurturing relationships.

Heterosexually-identified bisexual men, who have not been honest with female spouses about their homosexual behavior, may lack not only community support, but also the support of their partners, a crucial component for couples counseling. Finally, among Hispanics and urban Blacks—bisexual behavior is routinely practiced among men but rarely acknowledged as such.

Couples Therapy

Partners may seek couples therapy to help form and maintain relationships, to improve communication, to resolve sexual difficulties, or to help in "crisis" situations, for example, the discovery of a hidden affair, or the unemployment of one partner. Couples counseling may also be the most appropriate form of treatment when a client seeks individual counseling but refers to his partner frequently or is dealing with HIV-related or substance use issues while in a relationship.

In planning couples counseling, therapists may find it useful to evaluate couples in terms of the following four factors, three of which deal with "staging" or relative psychological development:

1. Staging in a person's life cycle, including culture, ethnicity, age, education, occupation, and past psychiatric problems.
2. Stage of relationship, and whether each individual is at the same stage. McWhirter and Mattison describe six phases: blending (merging high romantic love); nesting (working on compatibility); maintaining (the reappearance of the individual); building (collaboration and independence); releasing (trust and merging of property); and renewing (security). For couples facing illness and death, these stages are "compressed," so years of growth may occur in months.
3. For gay couples, staging in the "coming out" process for each individual, including the degree of internalized homophobia and each partner's comfort in being open to friends, family, and colleagues.
4. External influences, such as HIV-related concerns, family problems, substance abuse, and financial concerns.

Depending on the evaluation, some couples will need only education about how relationships grow and form, some will need help with communication skills, and others will need formal couples therapy, focusing on the ongoing life of the relationship, past relationships, and the influence of family history on the partners' expectations of how to be a couple. In general, therapists can model for clients how to argue and disagree, and how to communicate openly, allowing the couples new freedom for expression and alternatives to the relationship patterns that have proven ineffective in the past.

It is best for counselors to avoid individual sessions with partners while in couples therapy, although it may be appropriate to arrange one or two individual visits with each partner to formulate a treatment plan or to discuss concerns that seem to be too difficult for one partner to discuss in the presence of the other. These individual sessions are useful only if their content is eventually shared by the partners in joint sessions.

Gay Male Couples

The Kinsey Institute survey, done in the mid-1970s, disproved the myth that gay men are not able to form or sustain relationships by demonstrating that most were either in relationships or were actively seeking relationships.1 With this recognition, couples therapy becomes important in a gay context. Traditional couples therapy models, however, must be adapted for two people of the same sex, who operate using the same gender roles, and for the profound impact of homophobia and the societal invalidation of same-sex relationships. The greatest challenges male couples face include: internalized homophobia, the aversion to homosexuality that gay men, as well as most others in society, learn while growing up; conflicts that arise when two men, each with culturally defined conceptions of “maleness,” try to deal with power, control, intimacy, and boundaries within a relationship; individual concerns relating to substance abuse and HIV disease; and conflicts resulting when partners perceive the stage of the relationship differently. For example, one partner may move beyond the high romantic love phase before the other, and this may lead to feelings of rejection.

In the shadow of the epidemic, increasing numbers of gay couples, who had in the past allowed sexual activity outside their relationships, have sought to avoid breaking up and to eliminate potentially dangerous outside sexual experiences. For all gay men, discussing sex and negotiating safer sex has become important.

Since men, in general, and gay men who are struggling to accept their homosexuality, in particular, have difficulties with intimacy and sharing, they may seek help to learn how to communicate about and be comfortable with intimacy. For some, this may mean overcoming the need for anonymous and casual sex. In this context, couples may use therapy to facilitate communications about secrets, past behaviors, sexual frustrations, and other issues that, in the past when partners seemed more easily interchangeable, they might have ignored or used as excuses to break up.

Practitioners who take on counseling couples are rewarded with the presence of an ally in the therapeutic process: the love and support between partners.

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Finally, couples may need help in deciding whether to test for the HIV antibody, why to test, whether partners will go to the test site together, whether one or both will get tested, and what impact results will have on the relationship. Always ask why the partners want to test and if the decision is mutual. This session may be a time when men “confess” sexual contacts outside the relationship, precipitating further problems in trust and communication. Newly-formed couples may use testing as a type of bonding ceremony or as a test of honesty and commitment.

Whenever possible, after initial test result disclosure, therapists should include both members of a couple in all discussions about how to deal with HIV infection. Partners hearing information together are able to discuss it subsequently and to compare their perceptions about it. This helps partners who are overwhelmed by the news to fully absorb HIV-related information on such issues as medical care, exercise, diet, legal issues, and safer sex practices.

“Magnetic” Couples

The most common class of HIV-related concerns that gay, bisexual, and heterosexual couples face relate to discordant or “magnetic” couples, those in which one partner is seropositive and the other is seronegative. But upon discovering differences in serostatus, both partners—not only the infected partner—will go through the early stages of acceptance together, sharing the disbelief, shock, anger, depression, and possible hopelessness, suicidal thinking, and the desire to end the relationship. The partnership of magnetic couples is thrown out of balance by the introduction of an experience shared by only one of them, and dealing with these feelings and the accompanying guilt, uncertainty, fear, and anxiety, redefining sexuality, and anticipating the future becomes particularly complex.

In working with magnetic couples, therapists usually face three specific issues: how to balance the needs of both partners when so much care and attention is given to the medically-ill partner; how to allow rage, frustration, and anticipatory grief expression in the relationship; and how to allow healthy partners their own time and space without feeling guilty or having the symptomatic partner feel rejected. Techniques often used among lesbians seek to achieve “intimacy through distancing,” allowing the individual to emerge without destroying the intimate relationship. These techniques are useful in couples dealing with HIV disease where the healthy partner may “hover” too near, becoming over-involved in the care of the ill partner, or the ill partner may become emotionally helpless.

Many couples seek help redefining sexuality. Negative partners may pull away fearing infection, especially if they have not in the past followed safer sex practices. Positive partners may wish to protect negative partners and may shut down sexually: impotency is a common presenting complaint. For couples where either or both men are infected, therapists should encourage partners to explore new forms of intimacy and to discuss openly eroticizing safer sex. In some cases, couples decide to engage in sexual activity outside the relationship or to introduce a third person into the sexual relationship.

Some magnetic couples want help to break up to allow uninfected partners opportunities to meet someone “healthy”; addressing fear and new ways to be intimate usually obviates this approach. Couples who were already negotiating a breakup before learning antibody test results may need support to continue to separate and to avoid remaining together out of a sense of obligation. Sometimes people seek mixed status relationships. A seronegative person may feel safe, open, and caring only with a seropositive partner, or a seropositive person may feel safe and secure only with an antibody negative partner. Many men have already lost lovers to HIV disease and may be using new relationships to help them grieve.

Practical Concerns

During the period when either or both partners are asymptomatic, counselors should consider discussing practical approaches to medical and legal issues, which can be addressed most efficiently before partners become ill. Among these issues are decisions about medical management, clinical trials, alternative treatments, occupational and financial concerns, and legal documents, such as powers of attorney for finances and health care, medical directives and “living wills,” and basic wills. Some couples may feel such talk invites disaster, but many will be relieved to find a safe context in which to explore issues that they have been afraid to address and will appreciate the resulting sense of control and responsibility they gain by such discussions. During this period, couples in which one or both partners is a parent will also want to consider the best approach to tell their children about HIV disease.

The ability of partners and institutions to provide practical support necessary for people with advanced HIV disease is compromised by several factors, including dementia, substance abuse, and the independent nature many gay men and intravenous drug users are forced to adopt. Once dementia has progressed to severe personality deterioration, partners may find it difficult to maintain positive involvement with their ill lovers. Since substance abuse affects up to 30 percent of gays and lesbians, many relationships must cope with co-dependency, rehabilitation, and maintaining sobriety in the face of HIV disease. Many intravenous (I.V.) drug users and gay men have been hurt and rejected by medical, legal, and social service systems, as well as by families and friends. As a result, they have developed independent lives and may have difficulty accepting practical support, even from their partners.

Conclusion

Couples work is complicated. Therapists must develop counseling relationships with each partner as an individual, with the partnership itself, and, in the case of HIV-infected people, with an uninvited stranger, disease. But, counselors who take on this task are rewarded with the presence of an ally in the therapeutic process: the love and support between partners. In coping with HIV, this love and support can provide an essential foundation for growth and resolution for partners and for couples.

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References


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Restoring Family Relationships

Gloria C. Horsley, RN, MS

Many people with HIV disease—particularly gay men and individuals who use intravenous drugs—have little or no contact with their birth families. Many have moved away from their families under strained circumstances. As HIV enters the lives of these men and women, they are often confronted with unresolved relationships from the past.

For gay men, the final decision to leave the family often occurs when they disclose their sexual preference, or “come out,” to their families. Despite this independence, however, there is often a family member who adopts the role of maintaining connections, keeping the absent member informed about the family and the family informed about him. Over the years, this arrangement becomes normal for the absent member and his family.

The diagnosis of a life-threatening disease raises questions about contacting birth family members. Should I tell them? When, how, and how much do I tell them? How will they take it? Will they think I want something from them? Will they give me the support I need? Will they try to engulf and control me? If I get sick will they try to take me away?

In the short term, these questions and the time and effort required to include birth families in therapy, may encourage clients and therapists to avoid family involvement. But clients’ needs to reconcile with their families and the possibility that estranged families may provide essential practical, financial, and emotional support may ultimately override these concerns.

Family Therapy

Family therapy should be considered when a person with HIV disease is not able to access the emotional, physical, or financial resources his or her family may be able to provide, or when it appears that in order to make psychological adjustments, the patient needs the “permission” of family members. For the therapist, working with the family provides a first-hand impression of family dynamics and their impact on the client.

Fundamentally, family therapy can succeed only if both the client and the family are willing and available to engage in the process. Work with families in crisis calls for short-term, problemsolving interventions—including the development of problem lists, assignments for future sessions, and realistic plans of action—rather than a focus on personal psychological insights. Since family members may know little about HIV infection, therapy must include an educational component, and since HIV disease is life-threatening, therapists should expect that otherwise concrete sessions may require discussions about grief and loss.

Counselors should avoid family therapy in cases where families have sabotaged past attempts at treatment. They should carefully assess family members who have been mentally ill or active substance abusers prior to therapy. The following issues should be considered prior to family engagement.

Don’t pathologize the family. Therapists’ attitudes toward their own birth families often impair their abilities to see the benefits of supporting clients in reconciling with their families. A client’s parents may not be ideal, but they are the only biological parents he or she will ever have. While clients may feel rejected by birth families, they may also have rejected family members to protect them from the pain and disruption in the client’s life.

Identify family strengths. Encourage the client to talk about the positive attributes of family members and the good times the family had together. This will help counselors approach the family in a positive manner.

Set realistic expectations. If all the family can give is a card at Christmas or Thanksgiving dinner, do not expect sudden changes. Accept however much or little a family can offer.

Case of Stanley F

A case study illustrates the appropriate context for family therapy. Stanley F, a 33-year-old White man, was suffering from depression following treatment for Pneumocystis carinii pneumonia. Six months earlier, Stanley’s lover, Fred, diagnosed with AIDS dementia, had been pressured by his family to move to Ohio, leaving Stanley to live alone. Stanley’s parents, from whom he was estranged, flew to San Francisco when Stanley was hospitalized and cared for him for two weeks after his discharge.

Stanley was sure his parents, like Fred’s, would want him to move to Arizona and away from his medical care. But, he also feared that if he did not go with his parents he might die alone. While his mother wanted him to come to their Arizona home, he was less certain about the desires of his father. He stated, “The idea of having my mother wipe my bottom is more than I can stand.”

After several individual sessions, including an assessment of his family, Stanley agreed to a problem-oriented family session to explore Stanley’s future, and his needs to be as independent as possible and to have control over his health care. Stanley’s parents, Mr. and Mrs. F, were reassured when they were told that the session would focus on problem solving and not assigning blame. The family discussed Stanley’s anger and sorrow about Fred’s move, Stanley’s desire to stay in his own apartment and to continue his current care, and Stanley’s fears of dependency on his parents.

For the therapist, working with the family provides a first-hand impression of family dynamics and their impact on the client.

Stanley’s parents explored their feelings about their son’s illness. Mrs. F said her greatest sadness was that there would be no grandchildren. Both parents said they had come to accept Stanley’s homosexuality and that they were hopeful that there would be a treatment for AIDS. They assured Stanley that they would provide him with emotional and financial support, but said that they would try to get him to come home if he became disabled. While this frustrated Stanley, he acknowledged they wanted the best for him. He said he hoped that they might consider moving in with him.

The session ended with no consensus regarding Stanley’s independent living, but Mr. F answered Stanley’s embarrassment about his mother “wiping his bottom” by saying he would be honored to help him in the bathroom. Mr. F added that he had originally come only for Mrs. F, but that he now felt that the session was one of the most important things he had done for Stanley.

Conclusion

Family therapy is a powerful mode of treatment especially in times of crisis. The process of HIV disease causes a disruption in family equilibrium; this provides the counselor with an opportunity to be a catalyst in the process of family healing and change.

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References
Recent Reports


Active participation of clients is crucial to the success of social learning-based marital therapy. In a Washington state study, 19 of 32 heterosexual, White couples changed from a "distressed" to a "non-distressed" state, based on questionnaires of marriage satisfaction, after a course in therapy lasting an average of 23 weekly sessions. Of the remaining 13 couples, four reported improvements in marital satisfaction but remained distressed, six failed to improve, and three reported that marital satisfaction had deteriorated. Clients responded to the Dyadic Adjustment Scale (DAS) to rate marital satisfaction, and both clients and therapists responded to process rating scales after each session. Therapy sessions lasted between 60 and 90 minutes. Male clients averaged 43 years of age; women clients averaged 40 years. Couples had been married an average of 11 years and had an average of two children.

According to therapist and client ratings, couples who made the greatest gains in therapy were those who believed they were actively and collaboratively participating in therapy, and those who complied with homework assignments. In addition, client competence and involvement in therapy (as rated by therapists) and therapist competence and nurturance (as rated by male clients) were significantly correlated to therapeutic success.

Correlations between therapists’ and clients’ ratings of the significance of specific events in therapy were often not significant, indicating that interpretations of sessions may differ. The researchers warn that the study—designed to begin to identify predictors of marital therapy outcome—is limited by its size and the fact that the therapists and clients, as active participants in therapy, may be biased reporters.


A survey of gay male couples showed that an overwhelmingly high rate practiced monogamy, but almost half did not practice safe sex, and that relationship conflicts were most likely associated with financial and birth family issues.

The study of 92 couples was based on a questionnaire sent in 1987 to members of a national organization of gay couples. The median age of survey participants was 30, and a third of the couples were at least 10 years apart in age. Couples had been in their relationships an average of eight years, with a range between less than one year and 35 years. Forty percent of all couples had met in a gay bar, and one-quarter of the 92 couples moved in together within one month of meeting. Twenty-seven percent of all couples had previously been in one or more committed relationships. Thirteen percent of the couples had celebrated their commitment with a ceremony, while more than one-third said they would choose such a ceremony if it were available. Fifty-one percent of couples had a will, 37 percent had a power of attorney, and 14 percent had a relationship contract (which are not recognized by statutory or case law).

In response to questions regarding sources of conflict within the relationship, 39 percent of the couples reported having conflicts regarding financial issues, despite the sample’s generally high-income levels, and 23 percent stated that friction with birth family members was a source of conflict within the couple and that partners were often torn between loyalty to their families and loyalty to their partners. While more than two-thirds of respondents said that parents and siblings of partners were generally supportive of the couples, a substantial minority of families disapproved or were unaware of the relationships. Family-related conflicts may also occur when unsupportive family members impose their expectations that their sons will date or marry women. Other relationship conflicts included those regarding health issues (8 percent) and career (6 percent).

Fifty-four percent of the couples engaged in “safe sex”; 27 percent used condoms all the time, and 69 percent did not use condoms at all. Of 83 couples who replied to a question about sexual exclusivity, 96.4 percent described their relationships as monogamous. Since the study surveyed members of a relationship-oriented association, researchers cautioned against generalizing the findings of this survey, specifically regarding the finding of monogamy.


A longitudinal, qualitative study of 27 families in which a family member had AIDS uncovered four unanticipated analytical themes: the emotional exile of these families from their relatives and friends; the stifled communication about AIDS and HIV-related matters within the immediate family; the multiple and intense stressful life events preceding the AIDS crisis; and the family’s emotional havoc as atypical of other life tragedies. Forty-five family members, including parents and lovers and spouses, were each interviewed for several hours. Unlike most studies in which researchers attempt to distance themselves from subjects, the intimacy that developed between the interviewer and subjects was encouraged or intended.

Next Month

The life-threatening nature of HIV disease remains central to HIV-related counseling despite the experiences of long-term survivors, advances in currently available treatments, and the tantalizing promise of a cure. As has been the case throughout the epidemic, this aspect of care continues to be one of the most difficult for health care providers. In the May issue of FOCUS, Jeremy S. Gaies, PsyD, and Michael D. Knox, PhD, both at the Department of Community Mental Health at the University of South Florida, discuss the process of delivering psychotherapeutic care to people dying of HIV disease. They examine not only the issues for HIV-infected clients, but also the psychological concerns of practitioners counseling dying patients, and offer practical approaches for adapting therapy for these clients.

As a client’s condition declines, he or she must begin to consider where and how to die. Also in the May issue, Jeannee Parker Martin, RN, MPH, of Visiting Nurses and Hospice of San Francisco, examines the criteria that are part of this decision and elaborates on the options.