It is common for clients to test for HIV antibodies because they are in a new relationship and want to discontinue using condoms with primary partners. Despite good intentions, people sometimes break agreements with their partners regarding sex outside the primary relationship. This may compromise safety, and primary relationships are the source of an increasing number of HIV infections. Whether relationships are heterosexual or gay, monogamous or "open" to sex with other partners, communication and trust are important elements in establishing and maintaining safety. This issue of PERSPECTIVES explores the HIV risks couples face and ways to reduce them.
use a female condom with new and casual partners than with regular partners. A “new” partner was a partner whom a woman first encountered during the current month; a “regular” partner was a partner she had met prior to the current month and with whom she had an established relationship; and a “casual” partner was a partner she had met prior to the current month but whom she did not consider to be regular. The study also found that consistency of condom use decreased after the status of a relationship changed from new to regular.4

In a 1998 study examining relationship characteristics, partner risk behaviors, and sexual behaviors among 123 male and 106 female STD clinic clients who had both primary and other partners, 77 percent of men and 75 percent of women reported not using condoms consistently with either primary partners or regular secondary partners. However, 57 percent of men and 66 percent of women reported using some form of birth control method with both types of partners. In addition, 44 percent of men and 76 percent of women reported that their primary partners had other sex partners.7

These data highlight three points for HIV and other STD prevention interventions. People with more than one partner may be at risk for HIV in their primary relationships, perhaps even more so than with other partners. It is important to address issues of pregnancy and STD prevention simultaneously to help clients understand how to prevent both or how to reduce STD risk while planning a pregnancy. It is also important to ask all clients, regardless of relationship status, if they have multiple partners, and, if so, about specific risk behaviors with each partner.7

**Negotiated Safety**

With casual partners, almost any incident of unprotected anal or vaginal sex is considered risky because it is usually not possible to know the partner’s HIV status and to make an accurate risk assessment. With primary partners, the decision-making process regarding condom use is often based on knowledge of the partner’s sexual history, general familiarity with the partner, agreements about monogamy, and feelings of trust, love, and intimacy. However, these factors often have little to do with actual risks. A more effective way for couples to have unprotected sex and minimize HIV risk is to consider more objective factors and establish negotiated safety agreements.8

Negotiated safety is a strategy originally applied to gay men but also applicable to all couples. Negotiated safety allows regular sex partners who have each tested HIV-negative outside the window period of infection to dispense with condom use with each other if they also agree to either be monogamous or always practice safer sex with secondary partners. If a primary partner breaks one of the conditions of the agreement, negotiated safety also requires him or her to disclose this to the other partner and for the couple to revert to protected sex until they test HIV-negative again outside the window period of infection.9

A study of 1,037 homosexually active men in Sydney, Australia found that participants in relationships with negotiated safety agreements were less likely to engage in risky sex with secondary partners than those in relationships without negotiated safety agreements: 82 percent of men who had not engaged in unprotected sex outside of their regular relationships had negotiated safety agreements with their partners, whereas only 56 percent of those who had engaged in unprotected anal sex had such agreements. The study also found that negotiated safety agreements that prohibited any sex outside the relationship and those prohibiting anal sex outside the relationship had a significant effect on decreasing the probability of unprotected anal sex with casual partners. However, agreements that allowed protected anal

---

**A significant proportion of HIV infections, particularly among gay men, results from unprotected sex with a primary partner.**

---

sex with casual partners were not significantly effective.9

In a large study of gay men attending gyms in London, nearly half of participants who reported having unprotected anal sex only with primary partners were unaware of their own HIV status, their partner’s HIV status, or both. Of the 539 men in a relationship, 173 reported engaging in unprotected anal sex in the prior three months: 81 percent with their primary partner only, 10 percent with a casual partner only, and 9 percent with both primary and casual partners. These results suggest that many gay couples have adopted the first principle of negotiated safety—to have unprotected anal sex only with primary partners—but not the second principle—to establish that they are both HIV-negative.10

Similarly, a three-city U.S. study of 416 gay men between the ages of 18 and 27 found that 42 percent of participants who had unprotected sex with primary partners did not know either their own or their partner’s HIV status. Rates of unprotected anal sex were higher among men in relationships (51 percent) than among single men (21 percent). Men in relationships who had sex with casual partners also engaged in unprotected sex at a higher rate (32 percent) than did single men. Only 17 percent of couples fit the criteria for “true safety”; both partners were HIV-negative, were mutually monogamous, and had been together for at least six months. There was no correlation between a couple’s risk behavior and the degree of satisfaction with the sex
in the relationship, feelings of love, or overall relationship satisfaction. The researchers speculated that the dynamics of being in a relationship increases the likelihood of sexual risk taking among gay men.11

Finally, a 2000 Amsterdam study of 435 young gay men found higher rates of risky unprotected anal sex with primary partners even after taking into account negotiated safety. Sixty percent of men who practiced negotiated safety were in monogamous relationships, and 40 percent allowed sex outside the relationship as long as anal sex was always protected. To measure compliance with negotiated safety agreements, the study examined participants who were in a relationship for longer than six months and who had practiced negotiated safety. In this small subsample of 21 participants, there was a 10 percent rate of non-compliance to negotiated safety agreements, that is, engaging in unprotected anal sex with non-primary partners. After correcting for negotiated safety agreements and compliance with these agreements, the rate of risky unprotected sex with primary partners (39 percent) was almost twice as high as with casual partners (20 percent). These findings support the hypothesis that relationships create a perception of safety that may facilitate risk-taking behaviors. This perception of safety may lead people in relationships to engage in unprotected sex with primary partners despite the presence of HIV risk.8

**Trust and Communication**

Trust and communication play an important role in risk taking between primary partners. Research suggests that people are more willing to take risks with primary partners because of the presence of trust in the relationship, but also that relationships in which sexual communication is strong tend to promote safer sexual behaviors. The perception of trust, therefore, may not be enough in itself to decrease the risk of HIV infection in a relationship if communication between partners is poor.

According to one theory, people take risks with primary partners because of the way they interpret the function of trust in interpersonal relations. A qualitative study consisting of interviews with 16 heterosexual individuals in England found that participants justified sexual risk-taking behavior with spouses and long-term partners because they believed that marriage is safe, by definition, and that unprotected sex is required to affirm the presence of trust.12

The study’s author described three distinct constructions of trust that affected risk taking within relationships. “Trust-as-security” reflects the perception that trust functions as a guarantee of safety, making condom use unnecessary. According to this construction, people may consider unprotected sex with someone they trust to be safe. A more frequently accepted construction, “trust-as-symbolic-practice,” holds that trust is communicated to a partner through symbolic risk-taking practices including unprotected sex. Discussing sexual safety with a primary partner, therefore, undermines trust and signifies that there is something wrong in the relationship. “Trust-as-social-regulation” portrays trust as a social requirement, so that the possibility of trust being betrayed or misplaced is considered an acceptable risk to maintain a desirable form of social organization. This construction dictates that there is always a certain level of risk involved in trusting someone, but, despite occasional deceptions and betrayals, this is necessary for being a part of society, having relationships, and the functioning of “life as we know it.”12

A Dutch study of 251 heterosexual adults found that a high level of commitment to their relationship was the most significant psychological predictor of intention to practice safer sex with secondary partners. The participants in the study represented the full range of primary relationships from marriage to having a “more or less steady partner.” In addition, 45 percent had at least one secondary sex partner in the prior five years. Commitment also predicted willingness to inform primary partners about risky sex with secondary partners and to protect them against the resulting possibility of HIV and other STD infection.13

A 1998 San Francisco study of 100 heterosexual clients of a public STD clinic and their primary partners found that many participants did not know about their partners’ HIV risk behaviors. For most of the risk behaviors examined, more than one-third of participants thought that their partner had not engaged in a risk behavior when, in fact, they had. Male participants were often unaware that their partners had ever used crack cocaine or injected drugs. Female participants were often unaware that their partners had ever had sex with another man or used crack cocaine. These findings suggest that participants either had not asked about or had been given false information about their partners’ risk behaviors. Because of poor communication with partners, participants may have inaccurately assessed their risk for HIV and other STD infection.14

A survey of 816 women with at least one heterosexual HIV risk factor during the previous five years found that participants at high risk for HIV who had negative attitudes about condom use were less willing

---

The perception of trust may not be enough in itself to decrease the risk of HIV infection in a relationship if communication between partners is poor.
to communicate with their partners about HIV risk information than women with positive attitudes about condom use. A possible interpretation of this finding is that women who do not want to use condoms are less likely to ask questions whose answers would suggest that they should use them.\textsuperscript{15}

The study also found that women at greatest risk had experienced greater past abuse than other women, were having sex with partners they may have feared, and did not see themselves as having power in their relationships. Effective interventions for these women would integrate communication and behavioral skills into a comprehensive program that addresses recovery from violent experiences, personal empowerment, and ways to reduce negative reactions from their partners. However, it is important to consider the possibility of adverse partner responses, particularly those that would place women in danger.\textsuperscript{15}

Because of social norms, power inequities, and the fact that the male condom is worn by the male partner, the male partner often has more control than the female partner over the decision to use a condom.\textsuperscript{4} As a result, a woman who wants to have protected sex with a man must often be assertive and negotiate with her partner, and power dynamics may play a role in her ability to reduce her HIV risks. In many cases, societal norms dictate that women should be passive and follow the male partner’s lead, and some cultural practices actively discourage women from being sexually assertive, especially regarding condom use.\textsuperscript{15} Female condoms have become available in recent years and are a viable alternative to male condoms. However, they are not as widely available as and are more expensive than male condoms.

**Substance Users**

Substance users in relationships face many of the same issues related to HIV risk taking as other couples, but the presence of substance use, particularly injection drug use, significantly increases HIV risk and poses unique relationship challenges.

A large study of drug users in 22 U.S. cities found that more than 80 percent of sexually active participants reported unprotected sex in the prior month.\textsuperscript{16} Research suggests that injection drug users are more likely to share needles with sex partners than with friends and other acquaintances. Injection drug users may not perceive this practice to be risky but rather consider it to be a way of communicating trust to a partner, similar to the belief that having unprotected sex with a partner symbolizes trust.\textsuperscript{3}

A qualitative study of heroin users in London found that participants considered having primary relationships to be a form of “risk management” because it was one of the few “normal” aspects of their lives and posed a lower risk for HIV infection than injection drug use. For many participants, however, the everyday challenges of a drug-using lifestyle made it difficult to maintain a relationship because the demands of addiction often took precedence over relationship responsibilities. The study examined two types of relationships that heroin users may have: relationships between heroin users, called “gear relationships,” and relationships with non-heroin-using partners, called “straight relationships.” Participants generally considered gear relationships to be less difficult to manage than straight relationships because drug use was mutually accepted and perceived as a priority of daily life.\textsuperscript{3}

Gear relationships, however, also posed challenges. Partners in gear relationships tended to “equalize” their drug-use patterns so that they both used the same quantity, and this usually led to one partner increasing his or her intake. Attempting to reduce or stop drug use was more difficult in gear relationships because of the proximity to the other drug-using partner, and attempting to alter the daily pattern of drug use sometimes jeopardized the relationship’s stability, often forcing a person to make the difficult choice of giving up drugs or giving up a partner. While a shared commitment by both partners to stop drug use provided mutual support and was considered the most effective way to stop using drugs, there were also more opportunities to return to drug use if one of the partners relapsed. Finally, heroin tended to become the defining feature of gear relationships, and because heroin use tends to decrease sex drive, this can have an adverse effect on sexual communication.\textsuperscript{3}

The London study also found that drug users in straight relationships often did not tell partners about their drug use, and the demands of living a “double life”—as a drug user and as a partner in a “normal” relationship—resulted in a continual source of stress. In addition, straight relationships have the potential to encourage non-using partners to initiate drug use.\textsuperscript{3}

A Baltimore study of cocaine and opiate users found that consistent condom use was more likely among participants who were HIV-positive, not living with their partners, and not financially interdependent with their partners. Forty percent reported consistent condom use in the prior three months, a higher rate than found in previous studies of similar populations. One-fifth reported having given condoms to their sex partners, and 37 percent had discussed condom use with their partners. HIV-positive participants reported consistent condom use with 63 percent of their sex partners, compared with 37 percent of HIV-negative participants. About 40 percent of all participants reported living with their partners, and 30 percent provided their partners with financial assistance. More than half were in monogamous relationships, and sex partners knew each other an average of four years.\textsuperscript{17}
Implications for Counseling

A significant number of clients test for HIV because they are in new relationships and want to stop using condoms with their primary partners, often because they have decided to be monogamous or to practice safer sex with partners outside the primary relationship. The main challenge for counselors working with clients in relationships is to explore and highlight the importance of candid communication with partners about sex to protect the couple from HIV.

Communication

Communication about sex and sexual issues is often difficult for couples. As with other sensitive issues, counselors should approach discussions of communication gently and respectfully. Begin by assessing if clients have told their partners that they are testing for HIV antibodies. If not, use open-ended questions to explore why they have not.

One reason clients may not tell partners about HIV testing is that they would rather not disclose prior risk behaviors. If this is the case, explain the importance of testing for both partners in a relationship. A good way to lead into such a discussion is by asking a client about his or her partner’s risk. Other useful statements are: “Tell me what you know about your partner’s prior sex partners and condom use,” and, for female clients with male partners, “Do you know if your boyfriend has had any male partners?”

If clients have never discussed these issues with their partners, ask why. An effective way to frame this inquiry is to convey the importance of good communication. “It seems that you’ve assumed a lot of information about your partner’s sexual practices. I’m wondering how you feel about bringing up some of these questions with your partner, including the fact that you are concerned enough about him or her to test for HIV. If this makes you feel uncomfortable, you can blame me by saying that your HIV counselor encouraged you to talk about this.”

Some clients test for HIV at the same time as their partners. This suggests that the couple has already had some discussion about HIV and sex, and it is useful for counselors to affirm and support the couple’s ability to communicate. As with other clients, it is also important to discuss possible risks related to the window period of infection and when clients should return for another test.

Negotiated Safety

It is common for primary partners in “open relationships”—in which both partners condone having sex with people outside of the relationship—to protect each other from HIV infection by establishing negotiated safety agreements. The term “negotiated safety” referred originally to unprotected anal sex between gay men of the same HIV status, but the concept is a useful risk-reduction strategy for all couples, regardless of gender or sexual orientation.

Negotiated safety guidelines require both partners to test for HIV antibodies outside the window period of infection and to share test results with each other. If both partners test HIV-negative, the couple may safely discontinue condom use as long as they remain monogamous or always practice safer sex with other partners. If there is ever a possible exposure to HIV during sex with an outside partner, for example, in case of unprotected sex or if a condom breaks, the partner involved would inform the other partner, and the couple would return to condom use until receiving an HIV-negative test result outside of the window period.

Counselors should help clients examine if negotiated safety might work for them or, with clients who already have negotiated safety agreements, if it is effective. For example, ask what would happen if a condom broke or if one of the partners did not use a condom for anal or vaginal sex. If clients have not talked about these possibilities with their partners, encourage them to do so. It is easier to discuss “slip-ups” or broken agreements before they actually happen.

Unlike people in open relationships, partners in monogamous relationships often do not discuss the possibility of having sex with other people. In response to questions about monogamy, clients may say they trust their partner. However, trust can have different meanings for different people. Some people may trust a partner to never have sex outside of the relationship. Others may trust a partner to disclose if he or she had sex outside of the relationship. Still others may trust that all sex outside of the relationship would be pro-

A Counselor’s Perspective

“Talking about sex with a client sometimes makes me feel like I’m being intrusive, but discussing how couples communicate deepens the conversation to include even more intimate details.”
tected. If the issue of trust comes up, help clients realize how communication about trust and safety are linked. For example, a counselor might say, “I’m wondering what you mean by trust and if you’ve discussed it with your partner.”

**Broken Agreements**

If clients say they would break up with a partner who “cheated,” reflect back to them both the pain that being “cheated on” would cause as well as the consequences of such ultimatums. Explain that people who engage in sex outside of the relationship are less likely to tell their partners about it if they believe this will cause an end to the relationship. Both partners may then be at risk for HIV and other sexually transmitted diseases (STDs) due in part to the ultimatum that is perceived to be non-negotiable. However, people who expect their partners to be understanding are more likely to be honest, thus helping to sustain and protect the relationship. In many cases, people who have broken monogamous agreements love their partners, express remorse about their mistakes, and do not want their relationships to end.

When counseling clients who have a history of having sex outside of monogamous relationships, ask what it was like for them, what happened in cases when their partners found out, and what they think led to their actions. Clients who are able to identify specific triggers, for example, a combination of anger toward their partner and alcohol use, will be better equipped to prevent future recurrences. Ask such clients what they would do to protect themselves and their partners in case they have sex outside of the relationship. It may also be useful to provide referrals for relationship counseling.

Out of concern for their clients, and often based on their own experiences in relationships, counselors sometimes convey the message that clients should not trust their partners to honor their promises of monogamy and, therefore, should not abandon condom use. Instead of introducing doubt into a client’s relationship, however, it is more constructive for counselors to approach the issue of trust within the larger context of communication between partners.

**References**


Case Study

Josh is a 27-year-old gay man who has been in a relationship for four months. He and his partner, Bill, have been using condoms consistently with each other and other partners during this time. Josh and Bill both agreed to test for HIV so they can stop using condoms during anal sex with each other. Josh says that if he and Bill both test HIV-negative, they plan to establish a negotiated safety agreement that would allow them to continue having safer sex with other partners.

Counseling Intervention

Begin by affirming the communication in Josh’s relationship. Discuss the window period of infection and encourage him to discuss it with Bill. If Josh is still in the window period, help him figure out when he should return for another test. Also affirm his consistent condom use with Bill and with other partners.

Help Josh explore any risks he and Bill may have overlooked. For example, how would they react if a condom broke or if one of them failed to use a condom during anal sex with another partner? In case any instances like this occur, explain to Josh the importance of returning to condom use for anal sex with Bill until they test HIV-negative after the window period. Ask Josh how he would feel about talking to Bill about this, and encourage him to do so.

Ask Josh if he and Bill have discussed oral sex with outside partners and how they feel about any possible risks if one of them took ejaculate into their mouth. If he says that they are comfortable with the risks of oral sex, move on to a discussion about sexually transmitted diseases (STDs) other than HIV. Ask Josh if he and Bill have talked about what they would do to protect themselves from other STDs. If they have not, educate him about the risks of STD infection, and encourage him to talk with Bill about testing for STDs regularly. To help with this, provide him with a referral for STD screening.

Disclosing Test Results to Partners

Disclosing test results to partners is usually challenging for clients who test HIV-positive. If clients bring this up, help them explore disclosure strategies and how they believe their partners would react. If clients say that they are not ready to tell their partners about an HIV-positive test result, explore how they would be able to withhold the information from their partners while not placing them at risk for infection. Also provide clients with referrals for their partners to obtain information about HIV, antibody testing, and support groups for partners of people with HIV.

Many counties have partner notification programs that contact partners of clients who test HIV-positive and encourage those partners to test for HIV, while keeping the name of the client confidential. Provide referrals for these programs to clients who are unwilling or unable to disclose their HIV status to partners. Counselors can find out about partner notification programs in their area from their local health department.
Test Yourself

**Review Questions**

1. True or False: A significant proportion of HIV infections results from unprotected sex with primary partners.

2. Which of the following factors is effective in minimizing HIV risks for couples who have unprotected sex? a) knowledge of the partner's sexual history; b) negotiated safety; c) familiarity with the partner; d) mutual feelings of trust, love, and intimacy.

3. True or False: For many couples, unprotected sex is an expression of intimacy and trust.

4. True or False: Injection drug users are more likely to share needles with sex partners than with friends.

5. Which of the following are essential elements of negotiated safety agreements? a) both partners must test HIV-negative outside the window period of infection; b) the couple must be monogamous or always use condoms with partners outside the relationship during anal and vaginal sex; c) a partner who breaks a condition of the agreement must notify the other partner, and they must resume condom use until they test HIV-negative outside the window period; d) all of the above.

6. True or False: Consistent condom use is more common with primary partners than with casual partners.

7. True or False: Good sexual communication between partners tends to promote safer sexual behaviors.

8. Which of the following are important points for prevention interventions for couples? a) educating clients with more than one partner that they may be at risk for HIV in their primary relationships; b) addressing pregnancy and STD prevention at the same time to help clients understand how to prevent both or how to reduce STD risk while planning a pregnancy; c) asking all clients, regardless of relationship status, if they have multiple partners, and about risk behaviors with each partner. d) all of the above.

**Discussion Questions**

1. Why may discussions about sex and sexuality be difficult for couples?

2. What can counselors do to remain neutral about issues of trust and negotiated safety if they have had traumatic experiences of their own in relationships related to these issues?

3. What is negotiated safety, and what are some challenges couples may face in implementing it?

4. What are some of the challenges of disclosing HIV-positive test results to a partner?

5. What are some ways in which sharing drug-injection equipment can be an intimate experience for couples who inject drugs?

**Answers**

1. True.

2. b.

3. True.

4. True.

5. d.

6. False. Research has systematically shown that consistent condom use is more common with casual partners than with primary partners.

7. True.

8. d.
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.