Research Update

It has always been easier to initiate behavior change than to sustain it over time. The first years of the HIV epidemic saw dramatic rates of behavior change among gay and bisexual men as reflected in a comprehensive review of studies. In San Francisco, HIV infection rates decreased from a peak level of more than 3,000 diagnosed cases in 1992 to 850 in 1997. A study conducted between 1988 and 1993 found that fear of AIDS was the main reason many gay men initiated safer sex, reduced number of sexual partners, and decreased substance use.

Although the majority of people have sustained safety over time, recent increases in rates of unprotected sex may relate both to broad social changes within the gay community, which has in some ways “reclaimed” unprotected sex, and to “relapse” among individuals who had previously implemented risk reduction. In discussing this topic, three distinctions are crucial. First, the trend toward increasing unprotected anal sex is likely occurring in several different subpopulations: people who are newly sexual and have never made the decision to reduce risk; people who never embraced behavior change; people who have made decisions to change their behaviors even if this might lead to increased HIV transmission risk; and people who wish to sustain their behavioral choices but have had difficulty doing this.

Second, not all populations experiencing high rates of unprotected sex have had the same exposure to HIV prevention interventions. For example, an urban White man who identifies as gay is likely to have been exposed to mass media education and had opportunities to participate in group and individual interventions. Alternately, an African American man who has sex with men and does not identify as gay might never have been successfully targeted for prevention in either gay or African American communities. This is particularly important since Centers for Disease Control and Prevention data estimate that 50 percent of new infections in men who have sex with men are among African American men; 20 percent are among Hispanic men.

Finally, as the concept of harm reduction has evolved within HIV prevention settings, individuals have become more knowledgeable about the nuances of risk reduction strategies and decision making. No longer are unprotected oral sex or all forms of unprotected anal sex automatically assumed to be “unsafe.” As is discussed below, this judgment is individual, based on more complex and conscious understandings of risk and on strategies that emphasize “negotiated safety” agreements between partners in ongoing relationships.

This issue of PERSPECTIVES assumes that increasing HIV rates,
where they exist, are explained partially—but not fully—by the difficulty of sustaining behavior over time. Relapse is a normal part of the behavior change process. It may arise from a conscious decision to participate in unsafe sex, or a spontaneous decision or unintended “slip.” Individuals may swing between periods of unprotected and protected sex, and a person’s degree of risk may increase gradually over time.

**Increases in HIV Risk-Related Behavior**

There is evidence that rates of new infections, unprotected sex, and markers for unprotected sex such as rectal gonorrhea are increasing in urban centers throughout the United States and particularly among men who have sex with men. A San Francisco report found an increase in the annual rate of new HIV infections from just over 1 percent in 1997 to about 4 percent in 2000. Similarly, a Seattle-Kings County report found a rise in HIV prevalence among men who have sex with men from 3.6 percent in 1997 to 6.0 percent in 1998 and 10.7 percent in 1999.

Because of the difficulty of detecting and tracking new HIV infections and because of different HIV reporting requirements from state to state, it remains unclear whether these increases reflect trends among other populations of men who have sex with men in the United States. It is likely that HIV-related risk behaviors and new infection levels will vary by location, ethnicity, and age—and in particular, whether or not someone is new to having sex with men—among other factors.

Rates of unprotected anal sex are also rising. For example, a survey of a San Francisco sample found an increase from 67 percent in 1999 to 74 percent in 2001 in the number of men who reported having anal sex in the prior six months and an increase from 32 percent to 38 percent in the number of men who reported unprotected anal sex. The number of HIV-negative men who reported unprotected anal sex with two or more partners of unknown HIV status rose from 10 percent to 15 percent; the corresponding number for HIV-positive men rose from 19 percent to 25 percent.

Finally, increases in sexually transmitted disease incidence parallel increasing levels of unprotected sex. A study of men who have sex with men in 29 U.S. cities and counties found increases in rectal gonorrhea rates from 4 percent in 1992 to more than 13 percent in 1999. In San Francisco, the number of rectal gonorrhea cases in men increased from 162 in 1999 to 237 in 2001, and the number of syphilis cases rose from only six in 1998 to 115 in 2001.

**Negotiated Safety and Barebacking**

Over the past five years, three changes in risk perception have been particularly influential in reducing or increasing HIV transmission risk among men who have sex with men. First, “negotiated safety” agreements have allowed individuals to regulate the likelihood of HIV transmission by treating different types of relationships differently. This strategy grew out of three understandings: unprotected sex is an important expression of intimacy; the trust in ongoing relationships can be harnessed to control risk; and offering more harm reduction options to people would reduce safer sex burnout and relapse.

Negotiated safety originally applied only to HIV-negative couples. It depended on the mutual agreement of each partner in an ongoing sexual relationship—versus a casual or anonymous one—to test HIV-negative, to have unprotected sex only with his or her ongoing partner or to use protection for sex outside the relationship, and to notify the partner if he or she has unprotected sex outside the relationship. Today, couples in which both partners are HIV-positive also use this strategy based on the assumption that the risk of “reinfection” with a different strain of HIV, which could happen and could complicate HIV treatment, is less compelling than the psychological and physical benefits of unprotected anal sex. In addition, recent data suggest that unprotected oral sex is a very low risk activity, making its occurrence more common, particularly within steady couples. While negotiated safety is used successfully by many people, it may not be used consistently, particularly among seronegative couples.

The second recent phenomenon affecting risk is “barebacking.” The use of this term in both the lay literature and the scientific literature has been inconsistent. Some people refer to any unprotected anal sex among men who have sex with men as barebacking; this is the least useful definition. Others limit it to intentional unprotected anal sex, which includes people who have negotiated safety agreements. Still others define it as “intentional anal sex without a condom with someone other than a primary partner.” The key factors in these more restrictive definitions are that barebacking is intentional and preplanned, not characterized by a heat-of-the-moment slip, and that when barebacking happens outside of effective negotiated safety, it can lead to increased risk of HIV transmission. There are few studies of barebacking; however, in a San Francisco study of gay and bisexual men aware of the term—using the third and most restrictive definition—22 percent of HIV-positive men and 10 percent of HIV-negative men reported having barebacked in the prior two years.

Finally, the ability to meet people via the Internet seems to facilitate barebacking, and some web sites highlight this opportunity. An
found associations between risk and mood state, including loneliness, depression, anger, and low self-esteem, according to a review of HIV risk among men who have sex with men. The review also posits that “the ability to cope adaptively with negative mood states may reduce sexual risk taking.” It is notable that a 2001 analysis of 32 studies on the topic found little evidence of any relationship between depression and sexual risk taking. However, a published response to this analysis suggests that while the review provides a “cogent synthesis,” methodological problems with the design of many of the studies analyzed diminish the significance of the analysis itself. Depressive symptoms may still play a role in risk.

Sustained evidence suggests that childhood sexual abuse increases adult sexual risk and may make it more difficult to maintain risk reduction. For example, one study of HIV-positive gay men who had a history of childhood sexual abuse found that 33 percent had unprotected insertive anal sex and 43 percent had unprotected receptive anal sex in the prior 90 days with partners who were HIV-negative or of unknown HIV status. Another study found that 59 percent of a sample of Hispanic men had experienced childhood sexual abuse, and those men had higher rates of alcohol use and unprotected anal sex.

Finally, substance use has long been correlated with both unprotected sex and the return to unprotected sex. While “it is not clear whether a causal relationship exists between substance use and high-risk sexual behavior,” studies have shown that substance use among [men who have sex with men] is strongly associated with HIV infection itself. Studies of the “circuit party” phenomenon dramatically demonstrate the connection between substance use and sexual risk. Circuit parties are events where gay men congregate for social activities and dancing in different U.S. and international cities. In one study of these events, 53 percent of participants reported having used four or more drugs, including ecstasy, ketamine, crystal methamphetamine, GHB, Viagra, and amyl nitrates (poppers). During the circuit party weekends, 21 percent of HIV-positive and 9 percent of HIV-negative participants reported unprotected anal sex with partners of unknown or opposite serostatus.

**HIV Treatment Success**

HIV treatment success has led to greatly improved lives: more people with HIV are living longer and more of these individuals feel healthier. While increased sexual activity remains a life-affirming result of this change, it also increases the number of people who might transmit HIV.

Awareness of the success of HIV antiviral treatment advances may also underpin a commitment to unprotected sex. Data from as early as 1997 has implicated “treatment optimism” based on the success of combination drug regimens, but probably for only a minority of people. A 2000 review of the literature concluded “that optimism may indeed be associated with sexual risk-taking, at least among HIV-negative gay men.” A large collaborative study of gay men in London, Paris, Vancouver, and Sydney/Melbourne found associations between treatment optimism and high-risk sexual behavior, but few men in these cities were actually optimistic about HIV treatment. Finally, post-exposure prevention—also known as “morning after” treatment—seems to have little effect on sexual risk.

Successful HIV treatment—which reduces HIV viral load to below the level of detection—may diminish the likelihood of infecting someone else. But this finding has not been proven conclusively, and the belief that it is true may encourage behavior that leads to HIV transmission. One study found that individuals who achieved “undetectable” viral

---

No longer are all forms of unprotected anal sex assumed to be “unsafe.”
loads felt less infectious and doubled their likelihood of unprotected sex.\textsuperscript{24}

If reduced viral load does lead to diminished infectivity, however, it may offer another explanation for what appears to be a rise in rates of unprotected sex but not in new HIV infections: “At a community level [in communities with access to treatment], the amount of HIV, or the ‘community viral load,’ has likely diminished over time, meaning that there may well be a lower probability of HIV transmission.”\textsuperscript{6} This hypothesis should be considered cautiously, because what happens on a community level will differ from what happens for specific individuals, whose infectivity will be determined by their own biology.

**Preventing Relapse**

Several studies have shown that counseling programs can reduce high-risk activity but that maintaining behavior change is more difficult.\textsuperscript{25} Further, research suggests that ongoing contact with counselors and with people infected or affected by HIV can sustain awareness of risks and help maintain behavior change over time.\textsuperscript{26}

Counseling interventions that succeed in reducing relapse address the long-term needs of individuals: the longer an intervention continues or the more contact people have with counseling groups and counselors, the more successful results tend to be.\textsuperscript{27} Group counseling, in particular, allows people to discuss their behaviors, gain additional knowledge about HIV transmission and safer sex, and integrate this knowledge into their daily lives and behaviors.\textsuperscript{28}

Within the context of HIV counseling and testing, one study found that an intervention consisting of three counseling sessions was more successful in curbing unprotected anal sex than a single session. After one year, the frequency of unprotected anal sex had decreased from 45 percent to 20 percent for the three-session group, while rates for the single-session group decreased from 47 percent to 38 percent.\textsuperscript{17}

However, for “repeat” testers—defined as having tested three or more times—other factors may undermine the preventive effects of counseling. A British study found that gay male repeat testers—but not heterosexual male or female ones—were significantly more likely to report unprotected anal sex with a partner who was either seropositive or of unknown status than those who had had one, two, or no prior tests.\textsuperscript{29} A study of testing in seven U.S. cities among younger gay men found that more than 75 percent of repeat testers who acquired HIV had tested HIV-negative within one year prior to their most recent test.\textsuperscript{30}

**Implications for Counseling**

When counseling about sexual risk, it is important to determine to what extent clients have considered or made behavior changes in the past and whether they have returned to unprotected sex after a period of consistently practicing protected sex. For clients who have returned to unprotected sex, this dialogue can aid in exploring the reasons for this choice and identify future prevention strategies. For clients currently engaging in protected sex, the discussion can affirm these behaviors, and help these clients evaluate the degree to which they are at risk for returning to unprotected sex.

Counselors can help all clients identify those situations and feelings (sometimes called “triggers”) that might put them in jeopardy, as well as the factors that assist them in maintaining their commitment. By anticipating potential problem areas—as well as addressing actual ones—counselors can work with clients to bolster determination and behavioral options. During these discussions, it is useful to distinguish between a client who reports giving little conscious thought to an episode of unprotected sex—for example, someone who says the incident was “beyond my control”—and someone who says the incident was “beyond my control”—and someone who says he or she made a conscious decision in advance. Clients in the first group may have more difficulty identifying and implementing behavior change than those who make conscious plans to engage in a risky activity. To approach this topic in a neutral way, ask questions such as, “How did it feel at the time to take the risk?” To identify realistic prevention goals, assess a client’s sense of self-control. For example, ask: “Was what happened different from what you intended? What changed your intention or the outcome?”

Clients who use substances or have compulsive behavior patterns or little impulse control may need services beyond HIV counseling.

**Safety within Primary Relationships**

Within primary relationships or regular sexual partnerships, partners may consciously decide to engage in unprotected sex for many reasons ranging from the desire to deepen emotional intimacy to the wish to introduce variety into their sexual lives. But unprotected sex in such relationships is not necessarily unsafe sex.

“Negotiated safety” permits unprotected sex between partners in a stable relationship who have both tested either HIV-negative or HIV-positive. It requires that both partners be monogamous or practice only protected sex outside the rela-
tionship, and clearly communicate any violations of the agreement or, for HIV-negative couples, any changes in HIV status. Counselors can determine if clients are negotiating safety by asking about any “rules” they have in their sexual relationships with primary or steady partners, and they can help clients explore the trust, communication, and understanding of risk required by this strategy. If these elements are not consistently present, the “safety” is gone, sometimes increasing danger by leaving partners with a false sense of security.

Relationships may also complicate safety by creating dependency or power imbalances between partners. For example, a client may feel dependent on his or her partner for making sexual risk decisions. Assess to what extent this may be true, and explore any underlying issues—for example, low self-esteem, lack of assertiveness, fear of abandonment, domestic violence, or child sexual abuse—that may contribute to this situation. Clients coping with any of these issues might benefit from a referral for professional counseling.

New relationships as well as ongoing ones may be the catalyst for a return to risky behavior. A client who is suddenly single or in a new social circle may discover that the social reinforcement they had for safer behavior is gone.

### New Challenges to Risk Reduction

The longevity of the AIDS pandemic has created challenges for the maintenance of safer sex practices. Three factors are particularly relevant to this issue: “safer sex fatigue,” new generations of people who are becoming sexually active, and HIV treatment optimism.

Many people adopted safer practices never anticipating that they would have to sustain them for decades. A return to unprotected sex may be rooted in safer sex fatigue or the belief that HIV infection is inevitable. Clients who are no longer willing to protect themselves in certain ways may be willing to try new approaches, for example, moving from protected anal sex to unprotected oral sex, or from monogamy to negotiated safety.

The treatment advances of the last several years have themselves persuaded some individuals that HIV has been nearly cured, making safer sex unnecessary. Counselors can respond to these beliefs by acknowledging the real value of treatment advances, while helping clients explore whether their concern about HIV has decreased so much that it threatens their commitment to reducing risk. Counselors can help clients weigh the adjustments required by safer sex against those required by HIV antiviral therapy, which can have significant side effects and can be complicated, difficult to sustain, and sometimes unsuccessful.

Younger people who did not live through the early epidemic may be more likely than others to experience optimism-related risk. Education on the difficulty of treatment may be central in reducing relapse: HIV is still a life-threatening condition.

### A Counselor’s Perspective

“When clients downplay an episode of unprotected sex, I often find they are afraid they will engage in unprotected sex again or that they have not considered how to prevent it in the future.”

“After I began listening to clients’ reasons for breaking their commitments to safer sex, I have had a new empathy for them and am more able to help them regain that commitment.”

Help clients remember and articulate what may have inspired them to engage in safer sex in the past. Clients may be able to call upon their original reasons as a foundation either for a new commitment or for insights into what is different now. For example, if a client feels HIV infection is unavoidable, discuss with him or her what has led to this belief. If another client says that a behavior—for instance, unprotected oral sex—is no longer considered risky, help the client determine if this is a reasonable response based on the current research. Also ask if anything has led the client to be more willing to risk infection. Learn what knowledge, attitudes, beliefs, or changes in circumstances might be influencing a decision to return to unprotected sex.

Work with clients to analyze the risks they feel comfortable in taking. In practice, individuals continually choose from a menu of options along the continuum of risk. While a client may not be willing to “use a condom every time,” he or she may be willing to use harm reduction techniques to decrease risk. These might include having oral sex instead of anal or vaginal sex, not allowing a partner to ejaculate inside him or her, not having sex under the influence of substances or limiting the use of alcohol and drugs, or avoiding “trigger” situations that lead a client to cross his or her chosen safety limits.
As always, the goal is to assist clients in making informed choices and plans. In this context, clear communication is essential. Be sure that both counselor and client are using the same definitions of terms such as monogamy, negotiated safety, barebacking, and risk. Correct any inaccurate information that may be influencing a client’s risk analysis, but avoid assuming that a client is making an uninformed choice simply because a behavior seems risky.

Acknowledgment to clients the real challenge of maintaining behavior change over time. The rewards of unprotected sex—perhaps including greater sexual stimulation, intimacy, and spontaneity—are tangible and immediately reinforcing, while the rewards of safer sex are more abstract. It may be helpful to ask clients to draw on successful experiences they have had sustaining long-term change, for example, getting in shape or maintaining sobriety. Ask them to identify factors that sustained that change, for instance, social support, a regular routine, or a clear plan. Then help identify similar tools regarding HIV-related behavior change and how to implement them.

Some studies suggest that “repeat” testers—those who have tested three or more times previously—report higher levels of unprotected anal sex than those who are not repeat testers, and that repeat testers are more likely to acquire HIV. Ask clients about the meaning of testing for them. Do they believe testing itself has a preventive effect? Does it motivate them to stay safe or does it reinforce the belief that risky behaviors are not really dangerous to them? A counselor might say, “Your interest in testing suggests you want to be

**References**


Case Study

While Ted, a 25-year-old man who has sex with men, had consistently engaged in protected sex for eight years, in the past two years, he has concluded that protected sex is “not worth the hassle.” Ted says it is getting harder to find partners because he does not think he is as attractive as he once was. He worries that insisting on safer sex is driving away potential partners.

Affirm Ted’s decision to test and his recognition that he may be at risk. Determine if his understanding of safer sex is accurate, what practices he uses and how often, any behaviors he finds to be “less of a hassle,” and whether he has changed the type of unprotected sex in which he is engaging.

Because of his consistent history of protected sex in the past, it appears that Ted has already been through the precontemplation, contemplation, and action stages of change, but that maintenance may be what is “too much of a hassle.” Assess Ted’s stage of behavior change regarding returning to protected practices. Is he thinking about it? Is he ready for action?

Make a list with Ted of reasons that initially led him to adopt protected sex as well as new ones that seem compelling. It may be especially effective to include the physical, emotional, and social pros and cons, so that Ted can weigh competing thoughts and feelings. This process is sometimes called “decisional balancing.”

Consider using this technique to explore Ted’s ideas about what having HIV might be like. If Ted expresses that “HIV is not so bad anymore; all my friends have it,” acknowledge the experience of Ted’s friends, and explain to him that the treatment process varies widely from individual to individual. Also explore whether Ted experiences a sense of futility, including what it might be like for him to be the only one in his social circle who is HIV-negative.

Acknowledge Ted’s feelings that it may be “harder to find partners” if he is unwilling to engage in unprotected sex. Explore with him how and where he meets potential partners. Does he identify as gay? Does his social circle support his sexuality? Does it support maintaining protected sex? Is he seeking a stable relationship or casual ones? Also explore what has led Ted to feel that he is not “as attractive as he once was.”

Discover whether substance use plays any role in Ted’s behavior, potentially making him feel attractive or breaking through shyness, and if a referral to substance abuse counseling or treatment is appropriate.

In addition, explore Ted’s comments that he is feeling less attractive, afraid that insisting on safer sex will drive potential partners away, and concerned that safer sex is “too much of a hassle.” These comments may mean that Ted is grappling with conditions such as depression, distorted body image, low self-esteem, or anxiety, that may require a referral for psychological assessment and individual or group counseling.

Aware of your health status. Would you like to discuss ways of improving your chances of staying healthy?” For clients who are using testing as a way to motivate themselves to remain safe, consider making referrals to community educational, social, or support groups.

Be aware of the complexity of feelings—guilt, shame, self-blame, relief, and resignation—clients who test HIV-positive after a return to unprotected sex may experience. Support clients in viewing themselves as concerned, responsible people who can take control of their own health by seeking medical care and who can prevent the spread of HIV by developing a new risk-reduction plan. Referrals for medical follow-up, case management, and counseling are crucial.

Counselor Issues

Counselors may feel pressured to ensure that clients renew their commitments to protected sex and may blame themselves for their clients’ relapses. They may also become increasingly frustrated with the prevalence of unprotected sex. It is important for counselors to understand that a client’s intention to engage in unprotected sex is his or her own decision.

Behavior change is an incremental, long-term process unique to each client, and relapse is an expected stage of the behavior change cycle. Also remember that just as risky behavior may increase gradually over time, so may a return to safer sex. For example, a client may be willing to move from unprotected anal sex with ejaculation to unprotected anal sex without ejaculation, before, or instead of, making the switch to using condoms. The focus of counseling must always be on working with clients to set realistic individual goals.

Finally, counselors themselves may struggle with their own fatigue after “selling” safer sex messages over time. Self-care, peer support, and supervision can help counselors manage these emotions and tailor their counseling most effectively.
Test Yourself

Review Questions
1. True or False: An increase in rectal gonorrhea rates can be an indicator of an increase in unprotected anal sex among gay and bisexual men.
2. True or False: People in long-term monogamous relationships are not at risk for sexual relapse.
3. Among the key factors that correlate with unprotected sex among gay men are: a) substance abuse; b) a history of childhood sexual abuse; c) a desire for intimacy and spontaneity; d) all of the above.
4. True or False: Research indicates that faith in new HIV treatments is not a risk for sexual relapse.
5. True or False: Returning to unprotected sex while remaining client-centered?
6. How can counselors assess the degree to which clients who return to unprotected sex understand their risks?
7. How can counselors help clients sustain their risk reduction choices over time?
8. How might research about sexual behavior change than sustaining changes over time.

Discussion Questions
1. How can counselors assess the degree to which clients who return to unprotected sex understand their risks?
2. How can counselors help clients basic balance the reality that HIV disease is less threatening than it once was with the fact that it remains a life-threatening condition?
3. What approaches can help clients sustain their risk reduction choices over time?
4. How can counselors manage their own feelings about each other before having sex? 
5. Which of the following are methods for maintaining safer sex goals? a) being creative in considering alternatives to unprotected sex; b) participating in group discussions on sexuality and HIV; c) learning about HIV and related risks; d) all of the above.
6. True or False: Returning to unprotected sex can occur spontaneously or as the result of a conscious decision.
7. d.

Answers to Test Yourself
1. True.
2. False. Sexual relapse can occur in monogamous or non-monogamous relationships. People in long-term relationships face specific threats to risk including safer sex fatigue, and the commitment to protected sex may wane over time.
3. d.
4. False. Although new medical developments appear to influence some people's perceptions of risk, there is no evidence that this is the overriding cause for a large-scale return to unprotected sex.
5. True.
6. b.
7. d.
8. False. Counseling, particularly long-term counseling, can help people maintain safer sex goals, but prevention interventions have, in general, focused more on initial behavior change than sustaining changes over time.
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.