The term “sexual relapse” describes a person’s return to unprotected sexual practices after a period of consistent safer sex behavior. For many people, relapse occurs as part of the process of behavior change. Some people may experience alternating periods or episodes of engaging in unprotected sex with periods of engaging in safer sex. The degrees of risk may also increase over time. For example, episodes of unprotected anal sex without ejaculation can progress to unprotected anal sex with ejaculation. Just as a return to unprotected sex can be a gradual one, a return back to safer forms of sex may also happen gradually.

The first years of the HIV epidemic saw dramatic rates of behavior change—particularly among gay men—and, consequently, many researchers were optimistic about future efforts to limit sexual transmission of HIV infection. A comprehensive review of studies on changes in sexual behavior found that rates of unprotected anal sex decreased dramatically by 1987. In San Francisco alone, HIV infection rates decreased from a peak level of more than 3,000 diagnosed cases in 1992 to 850 in 1997.

A five-year study conducted between 1988 and 1993 found fear of AIDS to be the main reason many gay men started to practice safer sex, reduced the number of partners with whom they had sex, and decreased their substance use, which can influence decisions to engage in unsafe sex.

Although these results appeared promising, there is now a growing trend in which people who previously implemented HIV-risk reduction behaviors return to unsafe sex. In some cases, such a relapse appears to arise from a conscious decision; in other cases, unprotected sex occurs as a result of a “slip,” or spontaneous decision.

Unsafe Sex and “Barebacking”

Recent studies suggest that the popularity of unsafe sex, especially unprotected anal sex, is increasing among gay men. Some gay men have recently begun referring to unprotected anal sex by such glamorized terms as “barebacking,” “going raw,” or “skin-on-skin.” These originally referred to a premeditated act between two partners of the same HIV status who did not consider themselves to be at risk for initial infection. The terms have since evolved into the...
more mainstream realm of “casual” sex within the gay community without reference to either partner’s HIV infection status.4

According to a study evaluating the effectiveness of HIV prevention efforts in San Francisco, between 1994 and 1996 there was a 25 percent increase in the number of men who had unprotected anal sex with at least two partners, an 84 percent increase in the number of rectal gonorrhea cases in men over the ages of 14, and a 6 percent decrease in the number of men who reported consistent condom use during anal sex.5

In San Francisco, the number of rectal gonorrhea cases in men increased from 51 during the first six months of 1997 to 80 in the first six months of 1998.6 In San Diego County, the number of rectal gonorrhea cases in men doubled from seven during the first nine months of 1997 to 14 during the first nine months of 1998.7 Rectal gonorrhea cases are an indicator of unprotected anal sex among gay and bisexual men.

Another study found that the number of gay men in San Francisco between the ages of 18 and 29 who had engaged in unprotected anal sex during the previous year increased from 37 percent in 1993 to 50 percent in 1996. Twenty-two percent of the men surveyed in 1996 reported having had unprotected anal sex with a partner of different or unknown HIV status. These men also reported having more male sex partners, more sex in bathhouses and sex clubs, and more sex under the influence of alcohol. Finally, they were more likely to perceive unprotected anal sex as “inevitable.”8

Reasons for engaging in or returning to unprotected sex are unique to each individual and can result from a combination of factors. Awareness of treatment advances, accumulated stress, and relationship dynamics are just a few of the commonly cited factors influencing sexual relapse.

Implications of New Treatments

One factor that may have prompted increases in unprotected sex is the circulation of information about medical advances, including protease inhibitors, combination drug therapies, and post-exposure prevention (PEP), an experimental program that provides a regimen of antiviral therapy for people who have recently been exposed to HIV. A 1998 survey of gay and bisexual men found that 10 percent believed AIDS to be very nearly
cured, 13 percent believed HIV to be a less serious threat than it had been in the past, and 20 percent said they would stop practicing safer sex altogether if a cure was found.\textsuperscript{9}

Another study suggested that recent treatment advances affect the sexual decision making of some uninfected gay and bisexual men who had reported at least one episode of “high-risk” sex in the previous six months. Because of treatment advances, 17 percent of subjects reported being somewhat less concerned about HIV infection, 9 percent were willing to take more risks when having sex, and 11 percent had already taken a chance of getting infected during sex. During their most recent unprotected anal sex encounter, 20 percent of participants reported thinking that new therapies make HIV “manageable,” and 19 percent planned to take treatments to prevent HIV infection.\textsuperscript{10}

A Northern California study of 32 heterosexual, “serodiscordant” couples—in which one partner is infected and the other is uninfected—found that, because of new HIV therapies, 25 percent of infected partners believed that they were less likely to infect their partners, 19 percent were less concerned about infecting their partners, and 9 percent reported that they “took more chances” related to engaging in unprotected sex. The effect of treatment advances was even greater on the behaviors and perceptions of uninfected partners: 35 percent of participants whose partners were currently on antiviral therapy had taken chances of becoming infected during sex, 28 percent were less concerned about becoming infected, and 35 percent believed they were less likely to become infected by their partners. The researchers speculated that new treatment advances may provide additional rationale for engaging in unprotected sex.\textsuperscript{11}

In a study of gay men in London, 36 percent reported being less worried about HIV infection since the introduction of new treatments. Of these men, 34 percent reported engaging in unprotected anal sex in the previous three months, compared to 21 percent of men who did not share this view.\textsuperscript{12}

The research on the impact of new treatments, however, is inconclusive. One study found that, for HIV-infected people, the potential for drug-resistance and awareness that undetectable viral loads can still be infectious appear to have increased condom use.\textsuperscript{13}

### Stress

For some people, unprotected sex may serve as a way to relieve stress and tension. A study of HIV-infected people identified problems with partners, family, friends, and personal finances to be their most common sources of stress and found a direct correlation between perceived stress and engaging in risky sexual behavior.\textsuperscript{14}

The stress and depression that often results from being diagnosed with HIV, as well as from the diagnosis or loss of a partner, friend, or family member, may also lead to risk behavior. A review of gay men who have repeatedly lost friends, family, or partners to AIDS identified a loss of hope as a common response. Overwhelmed by grief, many feel that becoming HIV infected is only a matter of time and that future planning is futile. As a result, unprotected sex and other self-destructive behaviors often become coping mechanisms.\textsuperscript{15}

### Relationship Dynamics

Research suggests that relationship dynamics play an essential role in determining the probability of sexual relapse. One study found that 58 percent of incidents under which gay men relapsed occurred with a partner the subject did not know and would not contact again, and 26 percent involved unprotected anal sex. Participants cited negative emotional states and tempta-
To help maintain their safer sex goals, couples noted the importance of creativity and of continually seeking new and safe ways to sexually express themselves.

discordant couples expressed a particular need to avoid the topic of condoms because it reminded them of their fears of the future—especially of illness and death. Unprotected sex was also common among serodiscordant couples in which the uninfected partner consistently tested negative for HIV antibodies. These test results often provided justification for continued risk-taking. Long-term partners who are familiar with one another may engage in unprotected sex because they believe they are immune from infection.  

The couples in this study also addressed factors that helped them maintain their safer sex goals. In general, participants reported that practicing safer sex eventually had become a “natural” part of the relationship. In addition, couples noted the importance of creativity and of continually seeking new and safe ways to sexually express themselves. They also discussed the need to educate themselves about HIV infection to overcome fears and fully enjoy sex with each other.  

Preventing Relapse

Most research on the prevention of sexual relapse focuses on counseling, especially in group settings where people can discuss their behaviors, gain additional knowledge about HIV transmission and safer sex practices, and work on integrating this knowledge into their daily lives.  

Success with counseling interventions appears to occur in programs that address an individual’s long-term needs. Research suggests that the longer the intervention continues, or the more contact people have with counseling groups and counselors, the more successful the results tend to be.  

One study of 318 gay and bisexual African American men 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 group that participated in the three-session intervention, while rates for the group participating in the single-session intervention decreased from 47 percent to 38 percent. Several studies have shown that counseling programs can reduce high-risk activity, but that behavior change maintenance becomes more difficult over time.  

Research also suggests that ongoing contact with counselors and with other people infected or affected by HIV can keep people aware of their risks and subsequently lead to long-term maintenance of behavior change.  

Participating in a 10-year California study of serodiscordant heterosexual and bisexual couples that provided access to continuous support, information, condoms, and counseling, appeared to have beneficial effects on the subjects. Many of the couples reported that participating in research projects, belonging to a group, and sharing their experiences with other couples reinforced their decisions to practice safe sex.
Implications for Counseling

When counseling about risk behaviors, it is important to determine whether clients who have engaged in unprotected sex have been doing so for an extended period, if they have ever engaged in safer sex, and if they have returned to unprotected sex after a period of consistently practicing safer sex. These distinctions can aid in beginning an exploration of the possible reasons a client has chosen to engage in unsafe sex and the extent to which this has been a conscious process. The counselor can then determine the most useful prevention intervention.

For clients who currently engage in protected sex, evaluate the degree to which they are at risk for returning to unsafe sex behaviors. Help such clients identify which situations might put them in jeopardy of engaging in unprotected sex. By anticipating potential problem areas and identifying resources, counselors can work with clients to bolster their determination and behavioral options.

Counselors can ask a client who talks about returning to unprotected sex to further discuss potential reasons for doing so, assumptions about what it will be like, and perceived drawbacks, if any. With these clients and with clients who are currently engaging in unprotected sex, acknowledge the complexity of personal desires and the many factors that affect an individual’s decision-making process.

Distinguish between a client who reports giving little conscious thought to an episode of unsafe sex and someone for whom it was a premeditated decision. Reasons for and responses to each may be different. For instance, with a client who says that an unsafe incident “just happened beyond my control,” assess the context in which it occurred and the client’s related thoughts and feelings. With a client who has consciously decided to return to unprotected sex, explore the reasons for this decision and other potentially influential factors.

Reasons for Sexual Relapse

There are many interrelated reasons a person might choose to return to unprotected sex. A conscious decision might be a result of hopes for what the client perceives to be greater intimacy than what he or she might experience by having protected sex. A client might make such a decision in response to a new or a long-term relationship, or because of the belief that, if infected, he or she will be able to effectively “manage” HIV with the latest drug therapies.

Some clients relapse because they believe they must engage in unprotected sex in order to stay in an existing relationship or to enter a new one. Others may have adopted safer practices anticipating that a cure for HIV would have been found by now. These people may have reached their limit of how long they are willing to practice safer sex. A return to unsafe behavior may also be rooted in a sense of hopelessness, for example, when a client believes that HIV infection is inevitable.

After assessing whether or not the client has made a conscious decision to return to unprotected sex, assess the client’s knowledge of risk behaviors and comprehension of his or her risks. Clarify any misconceptions and determine if the client is experiencing denial about his or her risks.

Help the client remember and articulate what may have inspired him or her to engage in safer sex in the past. Clients may be able to reflect upon their original reasons for making a commitment and use this as a foundation for understanding what, if anything, is different now. For example, if a client who has changed behavior to avoid HIV but now feels infection is unavoidable, ask what leads to this belief. The answer will provide a better context for understanding the issues related to the client’s decision to return to unprotected sex. If a client says he or she recently returned to a risk behavior after hearing a report stating that the
behavior is no longer considered risky, determine if the information in the report is accurate, if the client is misinterpreting it, or if the client is simply choosing one of several responses to an unclear risk issue. Also ask if anything has changed that has led the client to be more willing now than previously to risk becoming infected. Learn what knowledge, attitudes, and beliefs might be influencing a conscious decision to return to risky behavior.

**Spontaneous Decisions**

An unconscious decision to return to unprotected sex may suggest that the client believes the behavior is out of his or her control. Asking such a client to look at ways to make a change, for instance to take control, will have little relevance. Assess if the client feels dependent on a partner’s decision making and learn about any underlying issues that may contribute to this perception. Such issues may include low self-esteem, lack of assertiveness, or fear of abandonment.

When clients mention global issues over which they can have no control as reasons for returning to unsafe sex, help them consider more specific, personal issues. For example, a male client who is considering a return to unprotected sex after engaging in safer sex for several years might say, “We shouldn’t have to keep being safe after all these years.” Respond by helping him explore what he means when he says “we” and “shouldn’t have to.” If the client is talking about a community, such as the gay male community or the injection drug using community, help him make “I” statements to explore his feelings directly. If he cannot engage in such a self-exploitation, discuss possible reasons for this inability and perhaps provide a referral for additional counseling to help the client focus on himself.

Assess clients’ sense of self-control in order to make subsequent interventions and to determine realistic client goals. Be aware that clients who have little impulse control or who have addictive or com-

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**References**


Case Study

Jolene is a 25-year-old heterosexual woman who consistently engaged in protected sex as a teenager and into her early twenties, but in the last two years she has found protected sex to be “more of a bother.” She says that as she gets older, it is harder to find partners because men are married and she does not see herself as being as attractive as she once was. She worries that insisting on safer sex is going to drive away potential partners.

Determine if Jolene’s understanding of safer sex is accurate and which specific practices she has used. Ask her how many times in the last two years she has engaged in unprotected sex. This will provide a better sense of how entrenched the risk behavior is and which stage of behavior change Jolene is in.

If her risk behaviors have occurred in the previous six months, it may be useful to consider her in the “action” stage of behavior change; if her return to risky behavior has been consistent for more than six months, she is probably in the “maintenance” stage of change. Similarly, assess Jolene’s stage of behavior change regarding practicing safer practices again. Is she thinking about it? Is she ready for action?

The counselor may want to make a list with Jolene, orally or on paper, of what initially led her to adopt safer sex practices, as well as other reasons she might now consider to be relevant. Acknowledge Jolene’s feelings about it being “harder to find partners” and explore with her how and where she meets potential partners. It may be that helping Jolene broaden her sense of options will open her mind to the possibility of returning to safer sex practices.

Explore what has led Jolene to feel that she is not “as attractive as she once was.” Is this a shift in self-perception? Has she been getting feedback from others about this? Assess the root of this idea, and acknowledge its inherent difficulties.

Evaluate Jolene’s sense of her ability to control whether she engages in protected or unprotected sex and whether she believes that unsafe behaviors have occurred consciously or spontaneously. Learn what, if anything, motivates her to engage in both protected or unprotected sex. If Jolene’s actions are repetitive and she perceives her behavior as being out of her control or as something that “just happens,” a counseling referral to a provider familiar with compulsive sexual behavior or related impulse control issues may be appropriate.

Perspectives: Returning to Unprotected Sex
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: The term “barebacking” refers to unprotected sex of any kind between two HIV-uninfected people.
3. True or False: People in a long-term monogamous relationships are not at risk for sexual relapse.
4. Which of the following are methods for maintaining safer sex goals? a) being creative in considering alternatives to unsafe sex; b) participating in group discussions focused on sexuality and HIV infection; c) learning about HIV infection and related risks; d) all of the above.
5. True or False: Research indicates that faith in new HIV treatments is the overriding reason people engage in unprotected sex.
6. Which of the following may contribute to relapse behavior? a) grief and stress; b) pressure from a partner; c) getting caught up in the excitement of a sexual encounter; d) all of the above.
7. True or False: Returning to unprotected sex can occur spontaneously or as the result of a conscious decision.
8. True or False: According to available research, a person who completes a relapse prevention intervention will maintain goals to consistently engage in safer forms of sex over the long term.

Discussion Questions

1. How can counselors respond to clients who state that they have little concern for becoming infected with HIV and, therefore, feel it is relatively safe to engage in unprotected sex?
2. How can counselors respond when clients who engage in unprotected sex have little understanding of their actions?
3. How can counselors assess if a person might be susceptible to returning to patterns of unprotected sex and then develop strategies to prevent such a return?
4. How might research about people returning to unprotected sex be applied to counseling clients who have returned to other unsafe behaviors, such as unsafe injection drug using practices?
5. Because follow-up services can be important in helping people make or sustain behavior change, how can counselors help clients to pursue and access referrals?
6. How can counselors respond to weariness, frustration, or other reactions to clients who report that they have returned to engaging in unprotected sex?

Answers to Test Yourself

1. True.
2. False. Barebacking refers to unprotected anal sex between two men of any HIV status.
3. False. Sexual relapse can occur in monogamous or non-monogamous relationships.
4. d.
5. False. Although new medical developments appear to influence some people’s perceptions of HIV risk, there is no evidence that this is the overriding cause for a large-scale return to unprotected sex.
6. d.
7. True.
8. False. Counseling may help people maintain safer sex goals, but many interventions have not been successful in helping people adhere to their goals over the long term.

Using PERSPECTIVES

PERSPECTIVES is an educational resource for HIV test counselors and other health professionals. Each issue explores a single topic. A Research Update reviews recent research related to the topic. Implications for Counseling applies the research to the counseling session. Also included are a Case Study and two sets of questions for review and discussion.

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