SEXUAL RELAPSE

Sexual relapse is a term used to describe behavior by individuals who gave up high-risk practices, such as unsafe sex, at an earlier stage of the HIV epidemic, but have since fallen back into their former practices. In some cases, individuals may vow to give up a practice but fail to keep their resolution. Unsafe sexual practices include unprotected receptive or insertive anal or vaginal intercourse, oral-anal contact and unprotected receptive or insertive oral sex.

RESEARCH UPDATE

From the early 1980s when it was first learned that HIV could be transmitted during certain sexual practices, and continuing for several years after that, the prevalence of those risk behaviors declined.

This behavior change was noted most dramatically within gay communities in large cities such as Los Angeles and San Francisco, where behaviors were studied. Little research has been done in smaller communities or among heterosexuals. A survey in San Francisco found that the percentage of subjects who reported engaging in unsafe sexual activities during a 30-day period dropped from 59% in 1984 to 25% in 1987 (San Francisco AIDS Foundation, 1990). Reports of reduced rates of unsafe sex were supported for several years by cohort studies that showed declining rates of sexually transmitted disease (STD) and HIV seroconversion.

An increase in unsafe sexual activities was first noted in 1988. A survey conducted by the San Francisco AIDS Foundation in 1989 documented an increase in high-risk behavior, including a significant number of individuals who acknowledged a return to unsafe activities. Thirty percent of the 401 subjects in the survey, conducted in late 1989, reported engaging in unsafe sex within the previous month. The survey defined unsafe sex as unprotected anal intercourse, oral-anal contact, fisting or oral sex with ejaculation.

Eighty-five percent of the survey's subjects said they had made a commitment to avoid unsafe sexual behaviors. Sixteen percent of those who had made the commitment failed to keep it and had "relapsed" into unprotected sex sometime in the previous year. Relapse rates were highest among young men, people of color, and those with lower incomes. These individuals also were among the most likely to report engaging in unsafe sex. Subjects were an average of 38.6 years of age, and 83% of all subjects were white.

In a study of 389 gay men in San Francisco, 19% of the subjects reported they sometimes reverted to risky practices (Stall et al., 1990). Researchers estimated that in San Francisco as much as 75% of all unsafe sex could be attributed to relapse, with only 25% of the unsafe sex attributed to those who have never adopted safer-sex practices.

Causes of Relapse

Studies show that many factors can lead a person to relapse into unsafe behavior, including some that involve emotional issues. The factors are:

- Both partners have the same HIV status. In one study, one-third of the participants reported returning to unsafe sex practices because they had the same antibody status as their partner (Stall et al., 1988). Individuals who are both positive may feel, incorrectly, that there is no danger in having unprotected sex; this belief is incorrect because an individual may be reinfected with a different strain of HIV or may be infected with an opportunistic infection that a partner is carrying. HIV-negative individuals may decide to engage in unsafe sex when they are...
told, or they believe, that their partner is also free of infection. Many times, individuals’ trust in their partners may be misplaced. And, many people may believe incorrectly that they can discern another person’s HIV status by casual observation.

- Absence of condoms. Although individuals may regularly use a condom, they may be unwilling to forego sex when they do not have a condom readily available. In some cases, people may have condoms in their home, but may not be able to locate them during sexual foreplay, and will have sex without a condom.

- Stress. An individual who feels the burden of stress may seek to release these feelings, and may place great importance on easy outlets for reducing stressful feelings, with little concern for whether a behavior is unsafe.

- Overwhelming sexual desire. An individual’s sexual desire may overwhelm other desires, including desires for safer sex. In a study by researchers Stall et al., who surveyed patrons at gay bars in San Francisco, more than half of those who reported engaging in at least one incident of unsafe sex did so because they were “sexually turned-on” by their partners.

- Fear that a partner will disapprove of condoms or restrictive sexual behaviors. Many individuals engage in sexual practices based on their perception of the practices they believe their partners will desire. This lack of assertion can lead individuals to avoid discussing their feelings about safer behaviors. A mistaken belief that a partner prefers unsafe sex can lead a couple to practice unsafe behaviors even when each partner prefers to practice safer forms of sex.

Recent Factors

As the risk of infection through certain sexual behaviors has continued, and individuals have started to realize that they might never be able to safely resume some behaviors that were once popular, other factors have made individuals increasingly vulnerable to relapse. These are:

- Unwillingness to give up behaviors for an extended time period. In the early stages of the epidemic, individuals who gave up unsafe activities expected to do so for only a short time. Several years later, some are not willing to make the behavior change permanent.

- High-risk activity among young gay men. Younger gay men may incorrectly consider HIV to be a disease of an older generation, and therefore believe that by limiting their sexual contacts to other young partners they can have unsafe sex without risking infection.

- Resumption of sex after several years of abstinence. To avoid infection, some individuals abstained from sex in the early years of the epidemic. As they become active again, they are unfamiliar with the risk levels of certain behaviors or the role of condoms in preventing infection.

Source: San Francisco AIDS Foundation — 1989 survey of gay men in San Francisco
• Belief that promising treatments will soon be available to make HIV a less serious disease. Believing that HIV may become increasingly treatable, individuals are more willing to practice unsafe activities even with people known to be infected. In the 1990 survey by the San Francisco AIDS Foundation, 18% of those surveyed reported engaging in unprotected anal intercourse in which at least one of the men was known to be infected with HIV.

• Belief that permanent behavior change is not possible. Many individuals return to practicing unsafe sex when they become convinced that they are not capable of permanently changing their behaviors. These individuals may state that they lack the “will power” necessary to practice only safer forms of sex. Individuals who did believe they were capable of making changes are much more able to reduce their risk activities.

• Beliefs about the activities of peers. Many individuals who perceive that their peers are resuming unsafe sex are likely to feel pressured into returning to unsafe sex as well. Peer pressure can have a rapid multiplying effect on the prevalence of unsafe sexual activities.

• Effects of alcohol or drug use. Intentions to refrain from unsafe sex are often made while sober. Resistance is weakened when a person is under the influence of alcohol or other drugs.

A Related Issue: The Prevalence of Unsafe Sex

Unsafe sex continues to be a common practice in both small and large cities.

A San Francisco AIDS Foundation survey found that 30% of gay and bisexual men reported engaging in unsafe, unprotected sex in the previous month. About 18% of the men said they engaged in unprotected anal intercourse in the past year, and 36% of those between 18 and 29 years old reported engaging in this practice.

The percentage of individuals who reported engaging in unsafe sex was statistically unchanged from the results of a 1987 survey, but it is significantly lower than in 1984, when 59% of subjects reported engaging in unsafe sex in the previous month. Eighteen percent of all survey respondents reported engaging in unprotected anal intercourse during the previous year. Incidence of anal intercourse declined in the 1989 survey compared to 1987, but other unsafe sexual behaviors, such as oral sex involving the exchange of semen, and oral-anal contact, dramatically increased.

A survey of 858 individuals taking antibody tests through the Alternative Test Site (ATS) program in California showed that about 25% of all subjects reported engaging in "risky" behavior in the last 30 days (Truax SR et al., 1989). The survey, conducted at test sites across the state in 1988 and 1989, showed that 39% of all subjects reported using a condom during their last intercourse. Sixty-one percent of the subjects who identified as being gay stated that they used condoms during their last intercourse, compared to 21% of those who reported that they were intravenous (I.V.) drug users.

Rates of unsafe sex have been studied less frequently in smaller cities, and thorough studies of risk behavior in smaller cities in California have not been conducted. But a recent study of small cities in the southern United States found that many individuals practiced unsafe sex and condoms were not often used by individuals.

A study of 355 gay men patronizing gay bars in three small cities in Louisiana and Mississippi found that 23% of the respondents reported engaging in receptive unprotected anal sex within the previous two months, and 25% reported engaging in insertive, unprotected anal sex. Twenty-nine percent of the subjects reported engaging in receptive unprotected oral sex with ejaculation during the two months prior to the survey, and 35% reported engaging in insertive unprotected oral sex with ejaculation during this time. Subjects, almost all of whom were white, had a mean age of 28.3, and a mean education of 14.6 years. Eighty-three percent of all subjects reported being sexually active over the previous two months, and 48% had multiple sex partners.

Infection with sexually transmitted diseases (STDs), an effective measure of the rate of unsafe sex, increased among gay men in some parts of the country last year. In King County, Wash., which includes Seattle, clinicians report the number of rectal gonorrhea cases in sexually active gay men may have tripled in 1989, compared to 1988, while the rate of gonorrhea among heterosexuals declined.
Individuals under the influence of alcohol or another drug are significantly more likely to engage in unsafe sex. Even a small amount of alcohol can impair motor coordination and judgment, and some drugs, like crack cocaine, can heighten sexual desires and enhance sexual activity.

Under the influence of drugs or alcohol, individuals may have ambivalent feelings toward accepting risk, or they may believe there is no chance of becoming infected. Also, because of a loss of motor coordination, individuals may have difficulty properly applying condoms.

One study of gay men found that those least likely to have ever followed safer sex guidelines were most likely to be habitual users of alcohol and other drugs during sexual activity (St. Lawrence et al., 1990). And those most likely to relapse into unsafe sexual behaviors were also more likely to have been under the influence of alcohol or other drugs at the time of relapse.

In a study in Oakland and San Francisco, 25% of young, urban crack users reported either giving or receiving sexual favors for drugs or money, and 73% stated they had engaged in at least five behaviors that put them at increased risk for HIV or other STDs (Fullilove et al., 1990). This study of 222 black adolescent crack users and sellers showed that a large number reported having sex while under the influence of crack. A large number of the subjects reported that they "usually" do not know ahead of time if they are going to have sex because "it just happens."

While rates of HIV infection among gay men are declining in many regions, the rate of new infections in many cities is still increasing among substance abusers and their sexual partners.

**Differences for Single Men**

Reasons cited for relapse are different for men in a relationship compared to those who are single. Single men most often state their reasons for relapse as drunkenness, an absence of condoms or a request from a partner that condoms not be used. Men in relationships respond that they have relapsed into unsafe activities because they are "in love," or because they believe that their partner has the same antibody status.

Men more likely to relapse are those who state that they "run in a fast crowd," in which risk-taking
A Related Issue: Relapse in Safer Needle Use

While relapse into unsafe sexual behaviors has been documented, formal studies of relapse into unsafe needle-using habits among intravenous (I.V.) drug users have been minimal or non-existent. Unsafe needle use includes sharing needles or not washing them. Risk of HIV infection among I.V. drug users can be greatly reduced by cleaning needles with bleach before their use.

A specialist in counseling drug users reports that I.V. drug users may have a relatively low rate of relapse in safe needle-using behavior because of the ease of maintaining needle-cleaning practices and adapting the practice as a permanent behavior change. While a change from unsafe sexual behavior means the elimination of certain practices or the use of condoms, the use of a clean needle does not have a direct effect on the practice of shooting drugs.

However, for various other reasons, individuals who adapt clean needle-using behaviors may still be vulnerable to relapse. An individual must have a convenient supply of bleach in order to ensure that needles are cleaned. And individuals may face peer pressure to use a needle that has not been cleaned. For example, a needle-sharing partner may pressure an individual into using an unclean needle by saying that cleaning a needle implies a lack of trust. In addition, sharing needles has a ritualistic importance among some I.V. drug users, and refusal to share or insistence to use only clean needles may alienate a person from a community.

I.V. drug users also are susceptible to relapse in safe needle-using behaviors after learning their antibody status, regardless of whether they are antibody positive. They may “celebrate” the news of not being infected and become unconcerned about protection, or they may feel suddenly invincible to infection. Individuals who test positive may conclude that they have little reason to clean their needles.

I.V. drug users are highly susceptible to relapse in sexual behaviors, and studies have shown that drug users have a high rate of relapse.

is met with social support, and those who cited anal sex as their favorite sexual activity. Relapsers who have seroconverted tend to be young, frequent drinkers and those who believe that insertive anal sex is safe.

Knowledge of HIV antibody status may not have a significant effect on deterring unsafe behavior. And, some individuals may be more susceptible to sexual relapse after learning their antibody status.

In the case of a positive antibody result, individuals may believe their attempts to prevent infection may have been unsuccessful and there is no reason to continue to practice safer forms of sex. Individuals who test negative may feel that because they have been given what they consider a “healthy” report, they may be more lenient in their adherence to safer-sex guidelines.

Methods of Reducing Relapse

Researchers have suggested that relapse to unsafe sex can best be understood when unsafe sex is studied as a permanent behavior change, similar to the way other unhealthy behaviors, such as smoking, alcohol use, diet and a sedentary lifestyle, are examined (Stall et al., 1988).

Research suggests it is relatively easy to halt a behavior for a limited time, but quite difficult to permanently eradicate that behavior. At the start of the epidemic, individuals resolved to alter their practices but believed they needed to do so only temporarily rather than make long-term changes.

Many individuals still expect that they will soon be able to safely engage in any sexual practice. And some do not fully understand or believe that, unlike a person who occasionally slips into other unhealthful behaviors, a slip into even one episode of unsafe sex can mean infection with HIV.

Continuing education and reinforcement are also important to preventing relapse. When not continually presented with safer sex messages, some individuals lose their awareness of the importance of safer sex or believe that practicing safer sex is no longer necessary. Health educators have also suggested that discussion of the relapse issue should be a primary role of education efforts.

References


St. Lawrence JT, Brasfield TL, Kelly JA. Factors which predict relapse to unsafe sex by gay men. Poster presentation from the Sixth International Conference on AIDS. June 19-24, 1990, San Francisco.


**IMPLICATIONS FOR COUNSELING**

Often, many clients will commit in front of counselors to practice safer sex, only to lose their resolve in a sexual setting, while some clients will make promises to counselors that they never intend to keep. Other clients tell counselors they have no intention of permanently restricting their sexual practices.

For all of these clients, risk-reduction guidelines have limited use. Counseling for these individuals, and for others who have relapsed into unsafe activities, may require an examination of the client's background and other psychosocial factors. For instance, a troubled client may consider precautions for safer sex to be a low priority. And an individual with a low sense of worth may believe risk to be acceptable.

Because many individuals who vow to practice safer sex lose their resolve when under the influence of alcohol or other drugs, acknowledgement and help with a substance abuse problem may be needed. This may include a careful assessment of drug and alcohol use, current and historic, and in some cases referral to an alcohol substance abuse program, or to a self-help, 12-step or similar intervention.

Some alcohol and drug users who relapse may not understand the connection that drug and alcohol use has to relapse, and these individuals may not understand the relevance of referrals to them. For these clients, it is important to explain that being under the influence of alcohol or other drugs does have an effect on their resolve to practice safer sex, and they should try to understand this relationship.

Other individuals may lose their resolve to give up unsafe sex because of a lack of self-esteem, which makes them unable to assert their desires for safer sex to a partner. For these individuals, acknowledging this difficulty may be a part of the counseling session.

It may be useful to offer specific teaching skills to help clients anticipate and successfully deal with the temptation to relapse, and to negotiate safer sex with partners.

**A COUNSELOR'S PERSPECTIVE**

"With clients who have problems with relapse, I explore what's happening in their lives. These people may be having unsafe sex because there is no other sustenance in life. I acknowledge their frustrations; sometimes I can offer support. Other times demand confrontation of unsafe behaviors."

This may be done by discussing a client's level of confidence and ability to assert feelings and intentions to a partner. In addition, counselors might engage clients in a role play involving partner negotiation.

Learning about a client's behaviors and background can be useful in some cases to determine if that person is more likely to relapse. For instance, individuals who are more likely to relapse tend to engage in unprotected receptive anal intercourse more frequently than others and they generally have a greater number of overall sexual partners. Because men in relationships may have different reasons for relapse from men who are single, counselors need to know about an individual's current and past relationships.

Peer support is important in maintaining behavior change and combatting the multiplying effect of relapse. Many individuals perceive that their peers are not practicing safer sex and they feel pressured to conform to what is being practiced.

Because a trend toward relapse
**A Case Study**

Michael, a gay white man in his 30s, has told his antibody test counselor that he sincerely wants to avoid unsafe sex, but he has felt increasingly pressured by his partners to engage in unprotected anal sex. Michael, who is antibody negative, has one regular sex partner and other occasional partners who tell him they are tired of condoms and safer sex. For six years, he has regularly used condoms for insertive and receptive anal sex. However, he said that on one recent occasion, when he was moderately intoxicated, he did slip and engaged in anal sex with his regular partner without wearing a condom. He is not a heavy drinker, but he said he has always preferred to have two or three drinks before sex. Michael said that because of the behavior of others, he fears he may permanently lose his resolve, and even his commitment, to avoiding unsafe sex.

**Counseling Intervention**

A counselor should be supportive of Michael's commitment over the past six years to follow risk reduction guidelines. Then, without making judgment, the counselor should learn about Michael's drinking habits, the relationship of his drinking to his sexuality, and his understanding of his habits. Michael might be asked how long he has felt a need to drink before engaging in sexual activities, and how he has maintained his commitment to following risk reduction guidelines over the past six years while under the influence of alcohol. The counselor should get as much specific information as possible to make an accurate assessment for referrals, and to make Michael aware that his drinking is dangerous to his risk of becoming infected with HIV.

The counselor should also learn more about the effect of peer pressure on Michael and what he considers to be "pressure." The counselor may choose to analyze Michael's slip into unsafe behavior and examine the reasons for this relapse and any others Michael may be reluctant to discuss. This analysis should make Michael more aware of possible reasons for his vulnerability to pressure, such as a low self image or a lack of assertiveness.

After empathically confronting Michael's dangerous use of alcohol and susceptibility to be negatively influenced by peer pressure, specific referrals should be offered for support groups, Alcoholics Anonymous meetings and for individual counseling with someone trained in substance abuse counseling.

**A Counselor's Perspective**

"I have clients who say they have never relapsed, but who are worried that they will. I have to reinforce them in general and I have to reinforce the motivations that have kept them from relapsing so far."

Can have a multiplying effect within a community, clients may need reinforcement to help them maintain safer sexual behavior and assert their desires for safer sex to partners.

Antibody test counselors can reiterate the importance of safer sex and provide positive support for those practicing safer sex. And counselors can encourage clients to enter support groups to maintain their resolve to practice safer sex. Peer-led support in a relaxed group may be the most useful way to acknowledge concerns about relapse, and may lead to a reduction in the tendency to relapse.

Counselors must remember that knowledge of risk does not necessarily lead to a decrease in risk behaviors. Most gay men in large cities who are practicing unsafe sex are well-informed about the dangers of their activities. Knowledge is important in making an individual aware of risks, but prevention of relapse involves a more comprehensive study of the reasons a person practices unsafe sex and the specific factors that motivate behavior change for the individual.

Counselors also need to be aware that individuals who receive a positive test result are vulnerable to relapse, and that individuals may return to unsafe sex regardless of their test result. Clients may not even realize that they are susceptible to relapse at this time. It may be helpful for some clients to be aware of this tendency so that they can better anticipate some of the feelings or impulses that may arise after receiving a negative or a positive test result, and prepare to deal with them constructively.
**DISCUSSION QUESTIONS**

- Do you think relapse is a problem among the clients you’ve been seeing for HIV antibody testing? Why or why not?

  - What would your strategy be if you were working with a client who reported recent slips into unsafe behavior? What information would you need to gather? What suggestions and general counseling would you offer?

  - What are some possible referrals that might help the client reporting relapse?

- Do you think a discussion of relapse should be a standard part of antibody test counseling? Why or why not? If so, when would you have this discussion? In the pre-test session? In the post-test session?

  - Are there clients for whom the issue of relapse is not relevant? If so, who would they be?

**Answers to “Test Yourself”**

1. False. Vows to eliminate unsafe sex can be broken by many factors, including use of alcohol and other drugs, low self-esteem or self-assertion, depression, stress or falling in love.

2. B. Researchers estimate that in San Francisco as much as 75 percent of all unsafe sex could be attributed to relapse, with only 25 percent of those performing unsafe sex having always practiced unsafe sex.

3. False. To eradicate unsafe sex, individuals must view it as a permanent behavior change. The tendency to view it as a short-term change makes an individual more susceptible to relapse.

4. B. Younger men are most likely to relapse into unsafe sex.

5. D. Alcohol can have all of these effects.

6. True. Individuals often cite emotions of being “in love,” an “overwhelming sexual desire” or stress as reasons for relapsing into unsafe sex.

7. False. Rates of STD infection among gay men are increasing in many parts of the country, and a report in the Seattle, Wash., area showed a dramatic increase in cases of gonorrhea for 1989.

8. C. 16% of the individuals who made a commitment to avoid unsafe sex had broken this commitment.