UNSAFE SEX

Unsafe sex refers to unprotected sexual activities that put people at risk for HIV infection. It consists of activities that involve the exchange of body fluids, including blood, semen, vaginal secretions or breast milk. Researchers believe HIV can be transmitted through pre-ejaculate, the fluid released from the penis before ejaculation. While other fluids, such as saliva, urine and tears may contain HIV, it is generally believed that the quantity of HIV in these body fluids is not sufficient to transmit the virus.

RESEARCH UPDATE

Unprotected anal sex, particularly receptive anal intercourse whether male-to-male or male-to-female, has consistently been identified as the sexual behavior that poses the greatest HIV transmission risk. Vaginal sex is believed to be the next highest risk, especially for the female partner. Other sexual behaviors that may pose an HIV-related risk include oral sex; anal activities such as “fisting” and “rimming”; rectal douches and enemas; sharing of anal insertable “sex toys”; and activities that involve urine or feces when blood is present in them.

This Research Update reviews sexual behaviors that have been studied for their HIV infection risk.

Anal Sex

Over the past several years, receptive anal intercourse, which is practiced by people of all sexual orientations, has been identified as the most effective sexual route of HIV transmission. Although research related to anal sex exists, it has been hampered by the social taboo surrounding the behavior.

The relationship between unprotected receptive anal sex and HIV infection has been widely publicized and surveys have found high levels of awareness of its risks, particularly in the gay community.

While many gay men have responded to this risk by ceasing to have anal sex or lowering risk by using condoms, surveys have found that others still engage in unprotected anal sex. A survey of 823 gay and bisexual men in Los Angeles found that 21% reported episodes of unprotected receptive anal intercourse with ejaculation during the previous 30 days. In a survey of Latino and Filipino gay and bisexual men in San Francisco, 34% of Filipino and 47% of Latino men reported having unprotected anal sex in the previous year despite knowing about the HIV transmission risk of the behavior.

While receptive anal intercourse poses the greatest sexual risk for HIV infection, insertive anal intercourse is also a high-risk sexual behavior. Because rectal tissue is susceptible to damage during anal intercourse, researchers believe that HIV-infected blood or secretions from the traumatized rectal tissue of the receptive partner may be transmitted to the insertive partner through small abrasions on the penis.

Although anal sex has traditionally been considered uncommon among heterosexuals, a recent review estimated that at least 10% of heterosexuals in the United States regularly engage in anal sex. In various surveys, nearly 20% of heterosexual men and 40% of women have reported engaging in anal sex during their lives. Surveys of teenage women have found that more than one in five report having had anal sex. Several recent studies of heterosexuals have found higher rates of HIV infection among those who engage in unprotected anal sex.

A survey of lesbians who had engaged in sex with men found that less than 25% engaged in anal intercourse if their partner was heterosexual, but nearly half engaged in anal sex if their partner was a bisexual man.

Vaginal Sex

About 5% of all AIDS cases in the United States have been attributed to transmission through unprotected heterosexual intercourse, and epidemiologists project that the rate of
infection among non-drug using heterosexuals will double over the next five years. According to a national survey of sexual behavior, heterosexuals appear more often than not to engage in sex without condoms.

Unprotected vaginal intercourse places both partners at risk. Risk of transmission is considered higher from the man to the woman than from the woman to the man. Researchers believe HIV passes more easily into the bloodstream through the walls of the vagina and rectum than into the shaft of the penis. While unprotected vaginal sex is a high-risk behavior, the risk of infection from vaginal sex is less than the risk of infection from anal sex. This is true partly because vaginal walls, unlike the rectum, expand to allow for the entry of a penis, thereby leading to less trauma. The risk of vaginal trauma increases as intercourse becomes more vigorous or when performed without consent.

It is not only self-identified heterosexuals who engage in vaginal intercourse. Surveys have found that some men who identify as gay and some women who identify as lesbian also engage in vaginal intercourse. In one study, 72% of men who identified as gay had, at some time in their lives, engaged in sex with female partners. A national survey of lesbians found that nearly half had engaged in sex with men, both heterosexual and bisexual, in the previous 10 years.

Oral Sex

Oral sex is referred to as fellatio when performed from mouth to penis and as cunnilingus when performed from mouth to vulva. Studies have shown that most gays, lesbians and heterosexuals make oral sex a regular part of their sexual behavior. Fellatio is believed to be the most widely preferred form of sex among gay men. And, a survey found that nearly three quarters of those in heterosexual marriages have engaged in oral sex with their partners. Among young people, oral sex has occurred with increasing frequency and, in recent years, at younger ages. Among lesbians, a survey from 1983, the most recent study available, reported that 39% of lesbians usually or always engaged in cunnilingus during sex.

Researchers have found it difficult to isolate oral sex for study as a risk behavior for HIV because sexual activity usually involves other behaviors that are considered more likely to transmit HIV. However, several reports over the past two years have confirmed cases in which infection has occurred with unprotected male-to-female oral sex as the only known risk behavior.

Several factors increase the risk of infection during unprotected oral sex:
- Poor oral hygiene or bleeding after tooth brushing.
- Allergies or inflammation in the mouth or nasal cavities that may result in breaks in mucous membranes.
- Use of alcohol and other drugs such as “crack,” which may lead to particularly long oral sex sessions that may cause abrasions in the mouth.
- More physical and penetrative oral sex, which can occur with greater frequency as people replace other forms of unsafe sex with oral sex.

Rimming

Rimming is oral contact with the anus and rectum. It often precedes anal intercourse and is correlated with other anal sex behaviors. One study of gay and bisexual men found that about 20% had rimmed their partners.

One study reported a relationship between rimming, oral contact with a partner’s feces and the development of Kaposi’s sarcoma (KS) among gay and bisexual men.
infected with HIV. KS, which is an AIDS-defining disease, developed in 75% of those with HIV who rimmed weekly compared to 18% of those who had never engaged in rimming. While the relationship between rimming and KS has been disputed, rimming has been strongly associated with the development of other sexually transmitted diseases (STDs), including hepatitis B and parasites.

**Fisting**

Fisting, also known as handballing, refers to inserting the arm or at least three fingers into the anus or vagina. In studies of sexually active gay men, higher rates of HIV infection have occurred among those who engaged in receptive fisting compared to those who had not engaged in this activity. This higher rate is believed to be due to expansion or stretching of the anus and sphincter, which can cause injuries, including tears and bleeding. These injuries can allow HIV to enter the blood during fisting through cuts on the hand, or, more likely, during unprotected anal sex, which often follows fisting.

In a study of gay and bisexual men, HIV infection rates were slightly higher among those who fisted without using protective gloves compared to those who used gloves. Those infected with HIV were more likely than those who were not infected to have engaged in fisting, although there was no evidence that this behavior was directly related to HIV infection. Studies have found rates of fisting between 2% and 12% among gay men. Heterosexual fisting has not been studied.

**Enemas, Rectal Douches and Anal Insertables**

Use of enemas, rectal douches and other anal insertable devices poses a risk for HIV infection. Enemas and rectal douches are sometimes given to cleanse the bowel before anal intercourse or fisting. These behaviors are considered by some to be erotic unto themselves. In one study, more than half the men infected with HIV, and more than one-quarter of those not infected, had douched before receptive anal intercourse. Enemas may cause perforation and inflammation, which allows entry of HIV-infected semen. Rectal mucosa can also be injured when insertable objects such as “anal plugs” and dildos are used.

**Kissing**

Kissing is not considered a risk behavior for HIV, and there have been no reported cases of HIV transmission during kissing. It is believed to pose a possible risk for HIV if tissue of the mouth is broken and blood is present in saliva. A study of 45 heterosexual couples found blood present in the saliva of half the group. It was present in higher levels after tooth brushing and passionate kissing, which was defined as kissing that lasts for several minutes with vigorous rubbing of the inside of the mouth.

**Other Behaviors**

“Watersports” refers to activities that involve urinating on the skin or into the mouth, and “scat” is defecating on someone or playing with or eating feces during sex. It is believed that HIV may be present in urine or feces only when blood is present in them. Even in the absence of blood, feces can transmit STDs and parasites.

Researchers believe relatively few heterosexuals or homosexuals engage in behaviors involving urine or feces. Surveys have generally found that fewer than 2% of all people engage in activities involving direct contact with feces.

**References**

People have difficulty engaging in safer sex even after they are aware of the risks of HIV transmission through unsafe sex and the benefits of safer sex. Research indicates that the reasons for continued risky sexual behavior are complex. They are related to factors such as personal values and emotional needs as well as intellectual decision-making and risk-taking. 18 Nowhere is the complexity of reasons for having unsafe sex displayed more vividly than in the gay community.

While gay men more than any other group have responded to the need to change behaviors, and most gay men continue to avoid unsafe sex, some continue to engage in unsafe sex and others have expressed fears about doing so. Social researchers and front-line counselors speculate that after a decade of loss and grief, many in the gay community are emotionally exhausted. As a result, personal resolve to avoid unsafe sex has wavered for some people and a sense of fatalism prevails for them. With so many already infected or dead, trying to fend off the epidemic by avoiding unsafe sex can sometimes seem futile. Gay men who are uninfected express guilt at surviving while their friends and lovers become ill or die. 19

Some gay men with a long-standing preference for anal intercourse or a history of high-risk sexual behavior have had difficulty permanently changing behaviors. Risk behaviors such as anal sex and exchanging semen can have significant personal meaning. These intimate behaviors are a historic and fundamental part of gay sexuality and of communicating love and emotional vulnerability. Yet these values are difficult to discuss openly because of societal taboos, homophobia and personal shame about desiring to engage in unsafe behaviors.

Many gay men who engage in unsafe sex lack a strong social network in the gay community and their interaction with gay life is primarily through their sexual contacts. These men may struggle with negative attitudes about being gay. Low self-esteem related to these attitudes can translate into a passive attitude toward one's sexuality and foster unsafe sex. 20

Other factors that lead to risk-taking include involvement in primary relationships where partners come to believe they have established a safe place in which to have unsafe sex. Drug and alcohol use can also lead to unsafe behaviors. Making changes in sexual behaviors sometimes means confronting a pattern of addictive behavior that includes compulsive sex. 21

Most recently, research has shown that some of the highest rates of unsafe sex are found among young gay and bisexual men, a group to whom few prevention messages are targeted. Young gay and bisexual men frequently feel less in control of their behaviors and believe they are at less risk than older men. In addition, their sexual and social contact is often with peers who have similar feelings and a similar lack of experience or motivation in asserting a need for safer sex. Whether with other young partners or older partners, they often lack skills or experience for negotiating safer sex.

often looked at as fun, playful and even humorous and is treated this way when talked about among friends and sex partners.

Begin a discussion of sex by learning about the role of sex in a client's life. By having clients describe their sexual lives and ways of sexual expression, counselors may be better able to dispel their own stereotypes and understand clients' thoughts and feelings. In addition, this discussion may be a way for clients to begin talking about specific behaviors without feeling that counselors are being invasive. Understanding the role of sex in a person's life can help counselors better understand why people engage in certain behaviors, what they gain from them, and what risks they consider to be acceptable.

Unresolved issues related to sexuality and sexual history can block people from focusing on the value of safer sex. For instance, a male client may engage exclusively in sex with other men but may not identify himself as homosexual. Because of this self-perception, he may have not received messages targeted to gay men regarding high-risk sexual behavior.

Issues of sexuality that can affect clients' thoughts, feelings and behaviors include rape, incest, abandonment, and other abuse. Clients may lack awareness or be in denial about the significance of such issues in their lives. If this is the case, it is unlikely these will arise in the test counseling session. However, with further counseling, such concerns may emerge. Be aware of referrals for clients who might face these issues.

**Talking About Behaviors**

Ask clients to describe their sexual behaviors. If they appear unwilling to discuss specific behaviors, attempt to learn the reasons for this and, if appropriate, explain that the counselor's role is to offer information and support, in either a confidential or anonymous setting. Acknowledge that, for some people, talking about sexual behaviors can be embarrassing. If the client remains unwilling to talk about sex, respect this reticence and present a general overview of HIV-related risks.

Clients may feel freer when they can talk about sexual behaviors in the context of other behaviors. For instance, a counselor can explain that many people have engaged in unsafe behaviors after becoming intoxicated and then ask the client if this has ever happened to friends or to him or her.

Similarly, linking unsafe sex to emotions that commonly precede it, such as boredom, anxiety or loneliness, may evoke a less defensive response than direct questions about whether the client has engaged in unsafe sex. In addition, people who have engaged in unsafe sexual behaviors do not always see their behaviors as unsafe. They may have never before examined the risk of their own behaviors.

Support clients by stating that many people engage in safer sex. Explain that peer support groups are helpful because they allow people to hear about the experiences and feelings of others. It is easy for someone to feel isolated in his or her sexual experiences and views of sexuality.

Learn how comfortable clients feel about the safety of the sexual behaviors they practice. Present the idea of a continuum of risk, and ask clients to place their behaviors at various points on a continuum, regardless of whether the behaviors are high-risk or pose no risk. Help clients with this process.

**Behavior Risks**

The following are approaches for dealing with specific behaviors:

**Anal sex.** State that anal sex is considered the riskiest sexual behavior for HIV transmission. Anal intercourse creates significant trauma to the rectum, resulting in breaks in the rectal lining, and this allows HIV to pass from the insertive partner's semen into the receptive partner's bloodstream. It is important to note that damage to the rectal lining generally occurs without detection or notice, it may cause little if any pain and it cannot be visibly detected. Proper use of a latex condom greatly decreases the high level of HIV-related risk from anal sex.

To those who wish to engage in anal sex, as well as those who engage in vaginal sex, assert the need to use a latex condom and water-based lubricant to reduce the risk of infection with HIV or another sexually transmitted disease (STD). Review proper condom and lubricant use, including the use of spermicides. [For information on the use of condoms, latex dams, spermicides and other barriers, please refer to the “Use of Prophylactics” issue of PERSPECTIVES, Vol. 1, No. 4; August 1991.]

Some people begin anal sex without a condom with the intention of using one nearer the time of ejaculation. The passion of sex can make it difficult to follow through on this intention. In addition, research suggests HIV may be transmitted through pre-ejaculate, the fluid released before full ejaculation. Therefore, emphasize the importance of applying a condom before starting intercourse and not after it begins. For clients who assert their discomfort in using condoms, discuss the reasons for their discomfort, and explore whether other factors have contributed to these feelings.
Do not assume that a client does not participate in a behavior, such as heterosexual anal sex, simply because he or she does not readily identify having engaged in it.

**Vaginal Sex.** While the risk of HIV transmission during vaginal sex is believed to be somewhat lower than during anal sex, unprotected vaginal sex is an unsafe behavior. The risk of infection appears to be greater for the female partner, but female-to-male transmission does occur. Discuss condom use as outlined above.

**Oral Sex.** Clients need to be aware that HIV can be transmitted during oral sex. Because there have been relatively few confirmed cases of HIV transmission through oral sex, the need for behavior change has been seen as a gray area, and people are often ambivalent or uncertain about what changes are necessary.

Promote the use of condoms and other latex barriers for use during oral sex, address client resistance to using these barriers and suggest ways their use can become more attractive. For instance, point out that, to improve sensitivity, clients can place water-based lubricant inside the condom before applying it.

Instruct clients about the importance of good oral health and hygiene, including regular dental visits, especially for someone who may be susceptible to gum disease or gums that bleed. Counselors often recommend that clients avoid brushing within one hour before or after having oral sex, and flossing within 12 hours before or after oral sex. Mouthwash, such as Listerine, and hydrogen peroxide solutions, are sometimes recommended as disinfectants following oral sex. However, such methods have not been proven to be effective at reducing the HIV risk. [For information on oral sex, please refer to the "Risks of Oral Sex" issue of PERSPECTIVES. Vol. 1, No. 2; March 1991.]

**Fisting and rimming.** In addition to its HIV-related risk, rimming, which is oral-anal contact, puts a person at high risk for other STDs, including hepatitis B, and for parasite transmission. Counselors often recommend that people who engage in rimming use barrier protection, such as a condom that has been "cut down," a latex dam, or plastic wrap, though studies have not been performed on the effectiveness of these methods.

For people who wish to engage in fisting, assert the need for the insertive partner to wear a surgical or other type of protective latex glove. State that fisting, like anal sex, creates ruptures and tears in the skin, and that a receptive partner who engages in both fisting and anal sex is placing himself or herself at high risk of HIV infection.

**Non-penetrative sexual behavior.** Some sexual behaviors may pose little or no risk for HIV, but clients may have questions or anxiety about them. Answer such questions. However, be aware that by dwelling on behaviors that do not pose a risk for HIV, clients may fail to clarify which behaviors are risky.

Answer questions about kissing. Explain that kissing is considered safe and that there are no known cases of HIV transmission through kissing. State that because of the theoretical risk of transmission some people have changed behaviors regarding "deep" kissing, in which saliva or blood in the mouth of one partner can potentially come in contact with open sores of another partner, especially when one or both partners have gums that bleed.

**Harm Reduction**

Clients may be unwilling to eliminate risks entirely and may respond to risk reduction efforts only when they can do so by making gradual changes. Halting too many behaviors at once may be overwhelming or discouraging.

With some clients, it may be useful to discuss the risks they are willing to accept. Counselors may see this approach as conflicting with the goal of stopping transmission. However, for some clients, "harm reduction" may be the only approach that will achieve change.

Harm reduction is often accomplished by eliminating or reducing the frequency of a person's highest risk behavior first, and then doing the same with other behaviors. This is accomplished over time, and can continue with follow-up counseling by other health care providers.
Case Study

Susan is a 33-year-old heterosexual. For several years, she has generally insisted that her partners use condoms during sex. On three occasions in the past year, however, one partner has asked Susan if he could put the condom on after sex had begun but before he ejaculated. Susan said she felt a little uneasy about this initially but viewed his request as a "compromise" and accepted it. Recently, she says she has been more concerned about what happened.

Counseling Intervention

Begin by supporting Susan for her willingness to describe these occasions of unsafe sex. State that having an awareness and then sharing it is valuable to making behavior changes in the future. Also state that Susan is not alone and that, unfortunately, many people have placed themselves in situations similar to hers.

Describe to her that having intercourse without a condom at any point, regardless of whether it is before ejaculation, is an unsafe behavior that puts a person at HIV risk. Describe that prior to ejaculation, pre-ejaculate is released, often without the man being aware that this is happening or is going to happen. It is generally believed that HIV can be transmitted through this fluid. In addition, the man who begins intercourse without a condom may fail to keep his commitment to stop before ejaculation. Because of this, help Susan see that the decision to use a condom after intercourse had started was not a "compromise" that would reduce her risk for HIV infection.

State that it is important for Susan to be aware of her health needs because her partners may not. If Susan does not see that her partners have disregarded her health, avoid direct criticism. Susan may respond to criticism by defending her partners, feeling shame, and alienating herself from her counselor.

Discuss ways this situation can be avoided in the future by asking Susan how she thinks she can avoid situations in which she might be at risk for HIV. Ask Susan to describe her negotiation with her partners on occasions she has avoided unsafe sex. Through this, affirm her ability to follow safer sex guidelines on most occasions in the past. Relying on her style in successful negotiations, perform a role play of a negotiation session in which the male partner is resistant to condom use. Emphasize the importance of beginning this negotiation before engaging in any form of sex.

After assessing Susan's power to negotiate, refer her, if appropriate, for counseling so that she can discuss and improve boundary-setting and negotiation skills.

As added protection, suggest that she consider using spermicides. But stress that such methods are considered only additional protection and they can produce an allergic reaction.

Commitment to Safety

Determine the motivation or reasons clients may have for desiring to engage in safer sex. With these in mind, ask clients if they are willing to make a commitment to behavior change. The commitment can be focused on avoiding unsafe behaviors or reducing the frequency of specific behaviors. State that expressing this commitment to the counselor and to a sexual partner can strengthen resolve.

Discuss the option of abstinence. Clients may go through periods of considering abstinence, and may waver on the virtues of both abstinence and engaging in sex. At times, some clients may see abstinence as the only way they can be safe, and they may maintain this approach for extended periods. Even for clients who abstain, it is important to review HIV-related risks during pre-test and post-test counseling.

Referrals

Where available, make referrals to peer support groups. Such groups may create the mood of a social occasion in which people feel they can casually discuss sexual behavior with friends or others like themselves. In a directed group setting, clients are often willing to openly discuss their behaviors, including acknowledging having had unsafe sex.

Also, offer referrals for individual counseling regarding HIV-related risks, other sexual issues, and topics such as substance abuse. Provide the phone numbers of HIV/AIDS hotlines where clients can receive continuing education.
**TEST YOURSELF**

1. Approximately what percentage of all AIDS cases have been attributed to transmission through heterosexual sex? a) 5%, b) 30%, c) 50%, d) less than 1%.

2. True or False: Research suggests that HIV may be transmitted through pre-ejaculate.

3. True or False: Unprotected vaginal intercourse places both partners at risk, but transmission from the man to the woman is more likely than transmission from the woman to the man.

4. There have been no reported cases of HIV transmission from which of the following behaviors? a) kissing, b) oral sex, c) both a and b are correct, d) none of the above.

5. True or False: Reviews have shown that at least 10% of Americans and their sex partners regularly engage in anal sex.

6. True or False: Rimming has clearly been related to transmission of both hepatitis B and parasites.

7. Which of the following is generally considered to pose the highest HIV infection risk? a) oral sex, b) unprotected anal intercourse, c) vaginal intercourse, d) fisting.

8. Which of the following is considered the most popular form of sex among gay men? a) anal sex, b) fisting, c) oral sex, d) none of the above.

**DISCUSSION QUESTIONS**

- Many counselors and clients are uncomfortable talking about sex. How can counselors feel more comfortable? And, how can counselors help clients feel more comfortable discussing sexual histories and behaviors, especially unsafe behaviors?
  - How can counselors respond when clients resist talking about sex?
  - How can counselors assess clients' knowledge of HIV-related risks and willingness to avoid unsafe sex?
  - How can counselors help clients link unsafe sex behaviors to such issues as their reasons for having sex and their feelings for themselves? How can they relate unsafe sex to substance using behaviors?
  - How can counselors respond when clients are willing only to reduce some of their unsafe sex, while still engaging in other HIV-related risk behaviors?
  - How can counselors help clients who have been unable to adopt safer sex behaviors to see that it is possible to do so?
  - Is it useful to work with clients to present the HIV-related risk of various behaviors on a continuum? What other methods are useful for helping the client measure the relative risk of behaviors?

**Answers to "Test Yourself"**

1. A. About 5% of all cases of HIV infection have been attributed to heterosexual intercourse.

2. True. Research suggests that HIV may be transmitted through pre-ejaculate, the fluid released by the penis before ejaculation.

3. True. Both partners are at risk in vaginal intercourse, although the risk to the female partner is greater.

4. A. There have been no reported cases of HIV infection from kissing. There have been reports of transmission through oral sex.

5. True.

6. True.

7. B. Unprotected anal intercourse is the sexual behavior that poses the greatest risk for HIV infection. Most cases of HIV infection through sexual behavior have been attributed to unprotected anal sex.

8. C. Oral sex is considered the most popular sexual behavior among gay men.

How to Use PERSPECTIVES:

PERSPECTIVES is designed as an easy-to-read educational resource for HIV test counselors and other health professionals. Each issue explores a single topic with a "Research Update" and an "Implications for Counseling" section. The Research Update reviews recent research related to the topic. Implications for Counseling poses the research is applied to the counseling session, and a case study is presented. PERSPECTIVES also includes two sets of questions to consider yourself or discuss with others.