II | Mental Health Issues of HIV-Negative Gay Men

Ariel Shidlo

I wish I just became HIV-positive and got it over with.

These words were spoken in a therapy session by a high-functioning, intelligent, and successful gay man. This patient was suffering from the physical pain of a shingles episode and he was anxious about whether this meant he was HIV-positive. He was obsessively reviewing his sexual past to make sure that he had not done anything “risky,” questioning whether the shingles inflammation was a sign from God to stop having sex with other men, and revisiting internalized homophobia that associated being gay with disease and punishment.

This HIV-negative gay man was angry. His recent experience of dating a man, falling in love and becoming sexual had been spoiled by the fear that he had become infected with HIV and that he had done something wrong. He complained of feeling that intimacy and love were contaminated for him by the fear of HIV and the wait to become infected.

This seronegative gay patient had never engaged in unprotected sex. He felt confident that he was not about to engage in risky sex. And yet he still had a nagging feeling that it was only a matter of time before he seroconverted. Being a gay man meant for him that eventually he too would get AIDS, no matter how careful he was (see Frederick & Glassman, 1996).

I myself am an HIV-negative gay man who came out in 1980, just one
year before AIDS was identified. When I first tested for HIV antibodies in 1987, I expected to test seropositive. Even though I had practiced safer sex since the mid-1980s, I assumed that I had become infected with HIV before that. When I got my seronegative results, instead of feeling relieved and happy, I found myself depressed and mournful. It seemed inconceivable to me that I could be HIV-negative.

I frequently asked myself, "Why me?" How could it be that I hadn't been infected? I would envision a plane crash, the people next to me lying dead while I walked away unhurt. In light of the suffering of my peers, I felt guilty about being HIV-negative. I went through years of disbelief, suspicious that one day my real HIV results—positive—would finally emerge. My feelings of guilt and disbelief were compounded when, in the late 1980s, I learned that a man whom I had dated in 1980 had seroconverted and another man with whom I had been involved had died.

When they were published, I read Johnston's (1995) and Odets's (1995) writings on HIV-negative gay men. They described feelings that I had not been able to articulate previously—that HIV-negative gay men suffer considerably from the shadow of HIV, that we should allow ourselves to contemplate a personal future without illness, that we can survive this epidemic.

It has taken me nine years since I first tested seronegative to develop a stable belief that I am and will remain HIV-negative.

**HIV-Negative Men in the Gay Community**

About the middle of the 1990s, we witnessed a new movement in the gay community. We started to acknowledge and articulate the stresses that many HIV-negative gay men are experiencing. Community forums in major U.S. cities, support and therapy groups, books, newspaper articles, videos, and counseling programs are addressing the concerns of HIV-negative gay men.

This activity has been spurred in part by our admitting aloud our worry at the resurgence of HIV seroconversion rates in gay men since the early 1990s (Gay Men's Health Crisis, 1995a). From one third to half of gay men in certain major U.S. urban centers are estimated to be infected with HIV (Morris & Dean, 1994). At the current rate of seroconversion, a twenty-year-old gay man has less than a 50 percent probability of remaining HIV-negative during his lifetime (Hoover et al., 1991).

Already many gay men in cities such as Los Angeles, San Francisco,
and New York, where the gay community is dense and enmeshed, have experienced a multitude of deaths and ill friends. As many as 274,192 gay and bisexual men have been diagnosed with AIDS in the United States; tens of thousands have died (Centers for Disease Control and Prevention, 1996).

Odets (1995) has described many urban gay HIV-negative men as living in a world of shadows, survivors, and ghosts. As a result of so many losses, some HIV-negative gay men may experience significant survivor guilt. This guilt may be especially powerful when a partner or close friends are HIV-positive.

Many HIV-negative gay men find it difficult to discuss their feelings about how the specter of AIDS has affected their relationships, love, sex, their identities and their futures. Many HIV-negative gay men feel secretive and shameful about their serostatuses. They are afraid to tell their HIV-positive friends for fear of hurting them, making them envious, or burdening them with perceived trivialities. Some HIV-negative men even lie to others, pretending to be HIV-positive. They do not talk about their serostatuses with HIV-negative friends because it is supposed to be a nonissue, a lab result that one should accept quietly and gratefully. In a climate where the meanings of HIV serostatus are not openly explored and discussed, HIV-negative gay men's identities can become fragmented and confused (Ball, 1995).

Many gay men find it exceedingly difficult to discuss their feelings about protected and unprotected anal intercourse with prospective sexual partners or even with established life-partners. This lack of open communication about unprotected anal intercourse occurs in a climate where 20 to 43 percent of gay men aged 18 to 25 in large urban centers report having engaged in it over the previous year or two (see Dean & Meyer, 1995; Hays, Kegeles, & Coates, 1990). Similarly, more than 50 percent of a sample of gay and bisexual African American men in the San Francisco Bay Area reported having unprotected anal intercourse in the previous six months (Peterson et al., 1992), and 41 percent of a predominantly white Seattle community sample reported unprotected anal intercourse over the previous year (GayMap survey results, 1994). Recent figures from Project ACHIEVE in New York City reveal that 31 percent of men under age 30 and 25 percent of men age 30 and above in a cohort of 600 HIV-negative gay men reported insertive unprotected anal intercourse in the previous three months with an HIV-positive or unknown serostatus partner (Achievements, 1995). Figures for receptive unprotected anal intercourse in
this sample were 25 percent for men under age 30 and 17 percent for men age 30 and above.

My clinical practice suggests that many HIV-negative gay men are mistrustful and fearful of being lied to about serostatus by their sexual partners. Intimacy and trust have paid a high price in this climate of suspicion and fear (Odets, 1995; Rofes, 1996). Prevention material exhortations to “use a condom with every partner” have been interpreted by many men to mean “trust no one, not even your lover” and “every man for himself.” A young man in his twenties who seroconverted recently told me that his boyfriend had known for several years that he was HIV-positive and had withheld that information, yet had had unprotected anal intercourse with him. Only after my patient seroconverted and confronted his boyfriend, the only sexual partner with whom he ever had unprotected anal intercourse, did the boyfriend admit that he had been too afraid to tell him.

The majority of HIV-positive gay men may never have unprotected anal intercourse with an HIV-negative partner. Still, it is our responsibility to disillusion those HIV-negative men who assume that their sexual partners’ or lovers’ willingness to engage in unprotected anal intercourse signifies that their partners are seronegative (Gold, 1995). We have to help our HIV-negative clients learn to ask partners about their serostatus before deciding to engage in unprotected anal intercourse. Couples may view unprotected anal intercourse as a sign of commitment and trust in each other (Schoofs, 1995). They need to be supported in sharing the responsibility of staying uninfected through an open dialogue that values maintaining seronegativity as an expression of love and caring for each other.

Gold (1995) has written that asserting that the gay community is a safer-sex culture may make it very difficult for gay men who practice unprotected anal intercourse to discuss their behavior with friends. This conspiracy of silence has facilitated development of shame and secretiveness in those struggling with the riskiness of this behavior when partners are seropositive or of unknown status. Those who practice unprotected anal intercourse with a monogamous seronegative partner also do not feel readily able to talk about it because it is contrary to the “use a condom every time with every partner” exhortation of prevention campaigns. This scarcity of dialogue about risky sex has deprived gay men of the chance to provide emotional support and guidance to each other on these issues. Grass-roots groups such as the New York-based Community AIDS Prevention Activists are creating new and exciting forums for such dialogues.
Rofes (1996) has asked whether a gay culture filled with warnings about the hazards of anal sex has had the paradoxical effect of channeling gay men's erotic desires more strongly toward anal intercourse. As many gay men have staked out a terrain as "sexual outlaws" who are viewed as deviant or sinful by homophobes, Rofes poses the challenging question of whether unsafe sex has become the defining act of a renegade status. In my clinical work, one patient reported finding and enjoying comradeship with his partners in unprotected anal intercourse. He enjoyed the thrill of discovering whether a prospective sexual partner would (silently) consent to or signal interest in having intercourse without a condom. On a related note, Ostrow, DiFranceisco, & Kalichman (1996) investigated whether some men have a "risk-taking" personality trait that leads them to enjoy the dangers of unprotected anal intercourse with partners of unknown HIV status.

**Odets's Conceptual Groundwork**

Odets (1994, 1995) has created a conceptual groundwork for understanding the lives of HIV-negative gay men.

First, he writes that there has been an obfuscation of an essential difference between the lives and the fates of HIV-negative and HIV-positive gay men. It is painful to acknowledge a qualitative difference between those who are uninfected and can look forward to longevity and those who face a chronic and often terminal illness. Uninfected gay men, HIV-positive men, and persons with AIDS are not on a continuum, as some prevention campaigns have claimed. The promotion of the continuum idea, while having positive connotations of unity between HIV-negative and -positive gay men, also contains the damaging implication that a progression along the continuum is inevitable. (One slogan of 1980s gay AIDS activism was "We are all people with AIDS.") As a community under siege from the right wing and from religious homophobes, gay men have not felt the luxury of articulating this potentially divisive fissure in the gay community. Instead, HIV-negative men have felt protective of their HIV-positive friends and lovers and fearful of any public articulation of the painful difference between negatives and positives.

Second, according to Odets, many HIV primary prevention efforts have confused outcome and target groups. Stating the obvious, only HIV-negative men can be helped to stay uninfected: They are therefore the only outcome group of primary prevention. HIV-negative and
-positive men should be viewed as distinct target groups for prevention activities, each with its own concerns and motivations. Educational material and counseling should acknowledge these realities rather than obfuscate them.

Third, the meaning and the importance of anal intercourse and the exchange of semen (orally or anally) for many gay men have been ignored. Anal intercourse has been trivialized as dispensable, and the desire for and the practice of unprotected anal intercourse have been pathologized. Odets attributes this trivialization and devaluing of the importance of anal intercourse between men to homophobia; it is expressed in the prevention message that this is an expendable activity that is interchangeable with other sexual behaviors. He has observed that, in contrast, married heterosexual couples who test seronegative for HIV are generally not told to use a condom every time they have vaginal intercourse or asked to view intercourse as a dispensable aspect of their sexual lives.

Another contribution of Odets’s (1995) analysis is the recognition that HIV-related survivor guilt may activate earlier developmental guilt. In addition to whatever historical guilt issues both gay and nongay individuals may deal with, Odets points out that many gay men have a unique developmental history of guilt based on their experience of taking from their parents the “normal” heterosexual son that they expected. Many families experience their sons’ homosexuality as an abandonment and their sons may thus emotionally equate survival as gay men with the abandonment of others.

An important generalization in understanding the interaction between preexisting characterological and developmental issues and being HIV-negative is that any developmental conflict may interact with the psychological experience of HIV-negative gay men living in the AIDS epidemic (Odets, 1995). A history of difficult conflict about homosexuality, serious depression, long-standing personal isolation and similar difficulties may interact destructively with AIDS.

**HIV-Negative Identity**

The idea that being HIV-negative should be or even can be viewed as an identity or as a component of identity is being debated in the gay community (Johnston, 1995; Odets, 1995; Rofes, 1996). Arguments against its being viewed as an identity have included fears that it would promote what has been called “viral apartheid” and facilitate a dangerous demarca-
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Promoting an HIV-negative identity is an important means to help keep gay men from seroconverting (Dalit, 1996; Odets, 1995). An HIV-negative identity has several important characteristics:

- It is defined by the absence of a viral infection rather than by the presence of a defining feature.
- It is associated with a precarious sense of grace from which one can fall anytime. Seroconversion frequently appears as an omnipresent threat.
- It is a status that is seldom talked about with others.
- It is frequently unintegrated with other aspects of gay men’s identity.

HIV-negative men who have not had the opportunity to talk openly about their serostatuses frequently describe their experience of being in an HIV-negative group as a “coming out” process that is reminiscent of having coming out as gay men. Odets (1995) posits that not coming out as HIV-negative compromises gay men’s commitment to that identity and to their actual physical condition. HIV-negative gay men require social structures within the gay community that support their feelings and their identities and that are invested in maintaining their seronegative statuses. The preservation of an HIV-negative serostatus has to continue shifting from a solely individual responsibility to a communal effort. In this process, an open dialogue between HIV-negative and HIV-positive gay men is an essential component. Groups such as Community AIDS Prevention Activists and Gay Men’s Health Crisis in New York have done important work in this direction by sponsoring CrossTalk community forums that bring together seronegative, seropositive, and untested men for the purpose of talking to each other.

My Clinical Work

The program I direct, TalkSafe, is a peer counseling program for gay and bisexual men who self-identify as HIV-negative. The program provides time-limited individual, couple, and group peer counseling. TalkSafe is founded on the following principles:

- HIV-negative men need a safe space to talk openly about their feelings without fear of neglecting, offending, or hurting HIV-
positive men or incurring their resentment or anger (Odets, 1995).

- Staying HIV-negative is an ongoing process that is impacted by psychological, interpersonal, and community factors.
- Gay men need help in the process of staying HIV-negative.
- Gay men who view HIV-negative serostatus solely as a lab result need to be supported in developing an identity as HIV-negative men and in integrating this identity into their multiple identities.
- No one factor explains why an individual would engage in unprotected anal intercourse, but a unique constellation of factors affects each individual.
- Gay men need help to talk about how they determine the situational riskiness of unprotected anal intercourse (see Lowy & Ross, 1994).
- HIV-negative couples need help to examine their decision-making around unprotected anal intercourse.
- Couples with mixed HIV statuses need help to examine each partner's feeling toward the other's serostatus.
- Clients who are candidates for peer counseling need a mental health assessment by a professional provider to link those with a significant psychological or substance abuse disorder with appropriate mental health services.
- Counseling for relatively intact clients can be successfully provided by peers who are trained and supervised by a professional mental health provider.
- Peer counselors can use disciplined self-disclosure and model for clients their own coping with the anxieties of an HIV-negative status.
- Gay men sometimes need help in developing nonsexual intimacy; they may need help to learn how to talk with each other.
- Since it is not clear what interventions are useful in helping HIV-negative gay men remain seronegative, we need ongoing program evaluation to determine what works (Choi & Coates, 1994).

**Barriers to Services**

When I was asked in 1995 to design a peer counseling program for HIV-negative gay men at St. Vincent's Hospital and Medical Center in New
York, I was initially fearful of negative reactions from the gay community. Would we be vilified for creating a program that excluded HIV-positive men or accused of diverting limited resources from services for HIV-positive people? Providers considering HIV-negative services may be faced with hostility from within the AIDS health care community (Johnston, 1995; Odets, 1995; Rofes, 1996). Within our AIDS Center I overheard a (joking) remark about my project staff: "They're only the prevention program people. They're not important."

Both providers and clients may need consciousness raising to recognize that many HIV-negative gay men experience significant psychological distress associated with their serostatuses. Clients and providers may collude in avoiding difficult feelings or therapeutic issues by focusing instead on AIDS information and safer-sex guidelines. Many HIV-negative gay men are habituated to focusing on worries about the health concerns of HIV-positive partners and friends. Dalit (1996) reports on a member of an HIV-negative gay men's group who brought to a meeting copies of the latest research on protease inhibitors. The members were easily drawn into a discussion on these new anti-HIV medicines; they were startled that the group leader interpreted this group behavior as symptomatic of the difficulty many HIV-negative gay men have in focusing on issues related to their own serostatuses. The tendency to focus on HIV health issues should be similarly attended to when treating a couple with a mixed HIV serostatus.

Tools for Clinical Practice

Clinicians working with HIV-negative men should consider these points:

• *Assess your clients' attitudes regarding their HIV-negative serostatus.*

Gay men who are HIV-negative may experience a multitude of conflicting feelings about their serostatus. The following dimensions bear assessment: level of guilt, shame, and secrecy about being seronegative; level of precariousness about HIV-negative serostatus; and level of sense of legitimacy at viewing HIV-negativity as a problem compared to the concerns of friends and lovers who are HIV-positive. Clients who have not discussed their HIV-negative statuses with other HIV-negative gay men may benefit from viewing a short video that presents the isolation that some gay men feel about their seronegative statuses (Gay Men's Health Crisis, 1995b).
- **HIV-negative gay men need to be helped to develop an identity that integrates being uninfected into other aspects of their lives.**

They need to be given permission to feel that being HIV-negative is something that they can feel good about and tell others about. Encourage your clients to articulate negative and positive feelings about being seronegative and to tolerate the confusion of contradictory sentiments. Adaptive identity integration of seronegative status can be accomplished only after exploring negative feelings.

Facilitate the process of grieving the intrusiveness and contamination of AIDS on love, dating, relationships, sex, and sense of self as gay men. Help your clients examine to what extent they have constructed their identities and plans for the future around AIDS (Dalit, 1996). Some HIV-negative gay men may experience a tremendous burden at finding out they are seronegative. These are men who did not expect to grow old and therefore avoided dealing with issues of planning for a future, professionally and financially. One of Dalit’s clients (Personal Communication, March 1996) who had recently tested negative reported never having paid taxes because he did not expect to have a long life.

- **Educate your clients regarding errors in assumptions.**

Many HIV-negative gay men interpret the willingness of a sexual partner to have unprotected anal intercourse with them as evidence that their partner is also seronegative (Gold, 1995). Some men may not readily believe that a seropositive man would offer to have anal intercourse without a condom. They assume that their sexual partners are the same as they are—seronegative. Your clients need to be educated that their seropositive partners may themselves make an assumption of *sameness of serostatus*, thinking, “You’re willing to have unprotected anal intercourse? This must mean *you are the same as me*; we are both HIV-positive so it’s okay to do it without a condom.” Help your clients to feel comfortable discussing serostatus issues with men they are dating, their lovers or life-partners and their sexual partners.

- **Help your clients articulate the meanings of specific sexual behavior.**

Your clients may appear comfortable talking about sex but have difficulty exploring the meanings that sexual acts hold for them. Each gay man may have a unique constellation of meanings attached to sex and AIDS. Help your clients articulate aloud what
anal intercourse with and without a condom means to them, what oral sex with and without a condom means to them, what having a man ejaculate inside them means to them, what ejaculating inside another man means to them, what kissing another man means to them, and what being sexually desired by another man means to them. Ask them what it means to them to have sex or make love with an HIV-negative partner, an HIV-positive partner, and a partner of unknown serostatus (see Elovich, 1995).

- Examine the specific psychological impact that your clients experience as a result of the ambiguity over oral sex transmission data and prevention guidelines.

Many gay men have considerable anxiety about unprotected oral sex because the evidence about transmission is ambiguous. The most recent findings suggest that unprotected oral sex is classifiable as safer sex or as safe compared to safest (Nimmons & Meyer, 1996). The de facto standard of safer sex among many gay men includes unprotected oral sex. Examine whether anxiety and anger about the ambiguity of the riskiness of oral sex leads your clients to engage in unprotected anal intercourse (“No one knows what’s really safe anyway; I might as well have anal intercourse without a condom.”)

I believe that providers should consider that there may be a danger of overfocusing or labeling oral sex as “high risk.” This may lead clients to view the risk of unprotected oral sex as equivalent to that posed by unprotected anal intercourse. Remember: Only a handful of transmissions due to oral sex between gay men have been documented (Nimmons & Meyer, 1996). All other sexual transmission between men has occurred through unprotected anal intercourse. Recognize that a majority of gay men who engage in oral sex do so without a condom. Use of a condom in oral sex may not be a realistic goal for many clients. Do not collude with your clients in having them state that they intend to use condoms with oral sex unless they have a strong commitment to doing so. Instead, review the ways of reducing the risk of unprotected oral sex (Nimmons & Meyer, 1996): Keep the mouth, teeth, and gums healthy; do not floss before receptive oral sex; avoid using stimulant drugs that dull sensation, which may be associated with permitting trauma to the mouth and throat, thereby increasing susceptibility to infection;
do not have a large numbers of partners within a short period of time, since doing so can also cause trauma to protective tissue; avoid ejaculation in the mouth, which can lower the risk of transmission of HIV and other STDs.

- Help your clients assess the unique factors that might lead them to engage in unprotected anal intercourse with partners of unknown status or with seropositive partners.

Each individual differs in the relative importance of the following factors that in my clinical experience may be associated with unprotected anal intercourse:

— Internalized homonegativity (Shidlo, 1994) — negative attitudes toward one’s homosexual feelings, behavior, relationships, and identity.
— Shame about sex with other men.
— Hopelessness and indifference about the future and one’s personal well-being; fatigue of living in an epidemic without an apparent end: “We’ll all get it sooner or later; it’s just a question of time”; and “All my friends are sick or dead; I don’t have much to look forward to.”
— Identity issues as a seronegative gay man: shame, secrecy, guilt, isolation, alienation, lack of visible role models.
— Difficulty saying no to an attractive or sexually desirable partner who requests unprotected anal intercourse.
— Experience of rejection by other gay men and associated negative mood states (Gold, 1995; Odets, 1995).
— Impact of body image; poor self-esteem around body image may increase vulnerability to risky unprotected anal intercourse.
— Risk-seeking trait; pleasure at placing oneself at risk (Ostrow, DiFranceisco, & Kalichman, 1996).
— Poor communication and assertiveness skills; difficulty asking partner’s serostatus, telling partner one’s status, initiating condom use, insisting on condom use.
— Informational fallacies, erroneous beliefs that insertive partners (“tops”) can’t get infected in unprotected anal intercourse, unprotected anal intercourse without ejaculation is safe, unprotected anal intercourse limited to insertion of tip of penis is okay.
— Distrust of safer sex credo; the role of the ambiguous data on oral sex as leading to unprotected anal intercourse.

— Sense of invulnerability; a feeling of personal immunity sometimes confirmed by a history of repeated HIV-negative test results in spite of history of risky unprotected anal intercourse.

— Untreated affective disorder.

— Untreated substance and alcohol abuse or dependence (Ostrow, DiFranceisco, & Kalichman, 1996; Ostrow et al., 1993).

— Need for intimacy; closeness and feeling of trust provided by unprotected anal intercourse may take on paramount significance over longevity and health (Odets, 1995). For some men, exchange of semen may be deeply valued and meaningful.

— Unacceptable negative meanings associated with condom use. Some men may view condoms as signifying “promiscuity,” lack of trust, betrayal, and evidence of unacknowledged seropositivity in partner (see Schoofs, 1995).

— Condom-associated sexual dysfunction; erectile difficulties in insertive partner.

— Interethnic negative attitudes; differential perception of seroprevalence in particular ethnic groups; sadistic or masochistic impulses toward partner of different ethnicity.

• **Monogamous couples where both partners have tested HIV-negative sometimes opt to have unprotected anal intercourse. To minimize the risks of this decision, they need to be encouraged to think through and talk openly about their choice.**

The Victorian AIDS Council/Gay Men’s Health Centre in Australia (1994) has helpful education for couples considering unprotected anal intercourse. It recognizes that issues of trust and communication are crucial in the decisions. I have adapted their guidelines as follows:

1. The couple discusses the importance and meanings of unprotected anal intercourse for each partner.

2. If they both strongly want to engage in unprotected anal intercourse, both partners have an HIV test (preferably together) and commit to be completely honest with each other about the results.

3. The couple continues to use condoms every time they have anal intercourse for six months.
4. The couple then has another HIV test together.
5. If both test seronegative, the couple agrees that neither partner will engage in unprotected anal intercourse outside the relationship. The couple commits and promises to tell each other immediately if this agreement is broken. If the agreement is broken, they restart condoms for anal sex and go through all the preceding steps again.

If both partners test HIV-positive, they should consider the effects of reinfection when deciding whether to have unprotected anal intercourse with each other. If one of the partners is HIV-seropositive, they should continue to use condoms every time they have anal intercourse. Couples of mixed HIV status need help in talking to each other about the complex feelings each partner may have about the meanings of the difference between them in serostatus.

• Conceptualize how characterological and developmental issues may be exacerbated by AIDS-related issues.
  Help clients identify which aspects of their psychological distress or maladaptive behavior are in direct response to the stresses of the AIDS epidemic versus those aspects that are reactivations of earlier wounds and vulnerabilities. Assess whether earlier developmental issues related to internalized homophobia and gay identity formation need to be revisited by the clients. For some clients, AIDS may serve as a repository of toxic material. Ball (1995) reports having seen clients whose previous therapists interpreted anxiety, panic, and depression as solely characterological in origin, failing to contextualize them as normal reactions to the ongoing traumatization of the AIDS epidemic.

• Actively support your clients when they report dating, falling in love, being in relationships, and having sex.
  Gay men need to hear that loving other men is a good thing and that sex with other men is a healthy and desirable thing. In the context of the “AIDSification of gay identity” and the “homosexualization of AIDS” (Odets, 1995), it is an essential function for the provider to act as a counterforce that helps clients celebrate being gay. Challenge the tendency of clients to pathologize inappropriately their relationships and their sexual behavior. Help them examine what they actually mean when they report that they are “addicted” to sex. Is this an accurate descrip-
tion of dyscontrol and compulsion, or is it an AIDS-phobic and gay-phobic misinterpretation of high levels of sexual desire?

• **Clients may have different needs for individual, couple, and group modalities.**

Clients who are early in the process of examining issues about being seronegative may require individual intervention. If appropriate, offer couple counseling for seronegative and negative/positive couples. The obvious but sometimes forgotten clinical wisdom is that not all HIV-negative gay men are appropriate for a group intervention. Screening for membership in group should be conducted according to established principles (Yalom, 1995).

• **Primary prevention programs and counseling materials need to recognize explicitly HIV-negative gay men and HIV-positive gay men and target each population distinctly** (Odets, 1995).

When creating educational material, avoid obfuscating the differences between the concerns and the feelings of HIV-negative and HIV-positive gay men. HIV-negative men need to be helped to value self-preservation in addition to supporting their HIV-positive peers. HIV-positive men need to be helped to value avoiding reinfection in addition to maintaining the health of their HIV-negative peers. Both groups need help in valuing the continuity of the gay community and in keeping the next generation of gay men alive and healthy.

**REFERENCES**

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