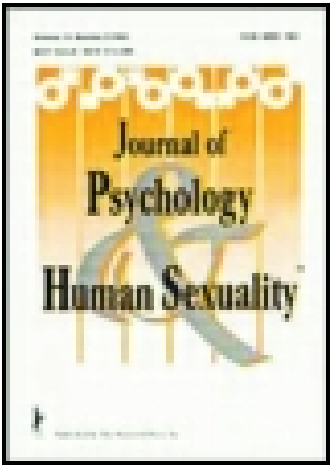

Journal of Psychology & Human Sexuality
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/wzph20

Sexual Attitudinal Conflict and Sexual Behavior Changes Among Homosexual HIV-Positive Men

Lena Nilsson Schonnesson PhD [a] & Ulrich Clement PhD [b]

[a] Psychosocial Center for Gay and Bisexual Men, Stockholm City Council, Stockholm, Sweden

[b] Psychosomatic Clinic, University of Heidelberg, Thibautstrasse, Germany

Published online: 23 Oct 2008.

Sexual Attitudinal Conflict and Sexual Behavior Changes Among Homosexual HIV-Positive Men

Lena Nilsson Schönnesson, PhD
Ulrich Clement, PhD

SUMMARY. In a German-Swedish cooperative study the HIV-adaptation process, its psychological sequelae and the psychosexual dilemma of homosexual HIV-positive men were investigated. The focus of this article is to highlight conflict solutions of attitudinal conflict related to sexual behavior changes. The findings indicate that unprotected sex as well as giving up sexual behaviors that are still positively loaded are two examples of conflict solutions. It should also be noted that the conflict is at work even when the individual practices are protected or "safer" sexual behaviors. The results indicate that only referring to sexual behavior data would underestimate the potential of so-called "relapses" to unprotected sexual behaviors. *[Single or multiple copies of this article are available from The Haworth Document Delivery Service: 1-800-342-9678, 9:00 a.m. - 5:00 p.m. (EST).]*

Being diagnosed with an HIV-infection involves among other things that the individual is confronted with psychological, social, and medical

Dr. Lena Nilsson Schönnesson is affiliated with the Psychosocial Center for Gay and Bisexual Men, Stockholm City Council, Box 17531, S-11891 Stockholm, Sweden. Dr. Ulrich Clement is affiliated with the Psychosomatic Clinic, University of Heidelberg, Thibautstrasse 2, 69115 Heidelberg, Germany.

[Haworth co-indexing entry note]: "Sexual Attitudinal Conflict and Sexual Behavior Changes Among Homosexual HIV-Positive Men." Schönnesson, Lena Nilsson, and Ulrich Clement. Co-published simultaneously in *Journal of Psychology & Human Sexuality* (The Haworth Press, Inc.) Vol. 7, No. 1/2, 1995, pp. 41-58; and: *HIV/AIDS and Sexuality* (ed: Michael W. Ross) The Haworth Press, Inc., 1995, pp. 41-58; and: *HIV/AIDS and Sexuality* (ed: Michael W. Ross) Harrington Park Press, an imprint of The Haworth Press, Inc., 1995, pp. 41-58. *[Single or multiple copies of this article are available from The Haworth Document Delivery Service: 1-800-342-9678, 9:00 a.m. - 5:00 p.m. (EST).]*

threats towards his sexual existence. The sexual scenario is characterized by the expectations of the HIV-positive person to change his sexual risky behaviors into less risky ones and to maintain these changes during the rest of his life in order to minimize transmission of the virus. In addition to this responsibility there are worries related to societal control and potential prosecution. Among Swedish people with HIV there is also a legal threat. The Swedish Communicable Diseases Act requires disclosure of one's HIV-seropositivity as well as condom use when practicing anal, oral, or vaginal intercourse. The individual's sexual existence is also threatened by the HIV-infection itself and its potential impact on sexual desire and/or sexual functioning. The core of the sexual scenario is the sexual dilemma between on the one hand not to transmit the HIV to other persons and on the other hand to remain sexual.

Major sexual behavior changes as to reduced number of sexual partners and increased use of condoms in particular in casual sexual encounters have been observed within the American (Multicenter AIDS Cohort Study, San Francisco Gay Men's Health Study, Vancouver Lymphadenophati Study, New York Community Impact Project) as well as the European (Dannecker, 1990; Pollak, 1990; Bochow, 1988) gay community. Studies also show that men who are involved in a steady relationship are less inclined to change their sexual risky behaviors including using condoms (Tillmann et al., 1990; Connell et al., 1989; Martin, 1987). Many of these studies do not, however, refer particularly to the HIV-status of the respondents.

Data are limited and contradictory with respect to the relationship between knowledge of HIV-status and changes of sexual riskful behaviors. Some studies (Catania et al., 1991; Schechter, 1988; Coates et al., 1987; Fox et al., 1987; Niemeck & Schumann, 1986; Zones et al., 1986) have found that HIV-seropositive men refrain from unprotected anal sex to a larger extent than HIV-negative men or untested people. Joseph et al. (1987) found the opposite, i.e., the HIV-negative gay men more often practiced protected anal sex than did HIV-positive men.

Still other studies have not found any differences between those who are tested and those who are not (Detels et al., 1989; Ginzburg et al., 1989; Doll, 1988; Calabrese et al., 1986). A more diversified picture that may partly explain the contradictory results emerged in studies conducted by McCusker (1988) and van Griensven (1987). Those gay men who were HIV-positive displayed not only greater changes as to number of partners and sexual behaviors than did the HIV-negative ones. They also reported having had more numerous sexual partners and having practiced anal sex more often pre-HIV diagnosis. Subsequently, sexual behavior changes among HIV-positive men became more salient than those of the HIV-negative men.

Within the context of HIV-prevention the importance of attitudes towards changing risky sexual behaviors is often emphasized as a pre-requisite for taking action towards protected sex. However, there are to our knowledge no studies among men who have sex with men examining the relationship between attitudes and sexual behavior changes.

Every person develops a map of sexual behavioral predilections and aversions that may differ from situation to situation, from partner to partner. The characteristics of this map are of importance to the sexual "re-learning" that many HIV-positive men have to do. The individual arena of sexual behavior changes encompasses behaviors that are very much liked (positive loading) and therefore difficult to change or to give up. But there are also behaviors that are disliked or indifferent (negative loading) and consequently easier to change or to give up. It is surprising that almost no scientific attention has been paid to these dimensions of sexuality. However, in the San Francisco AIDS Foundation studies the gay and bisexual respondents were asked to rate among many other variables the enjoyability of a list of sexual behaviors. One made comparisons between ratings at three junctures (1984, 1986, and 1987). In the 1987 study French kissing was the highest rated, followed by mutual masturbation, oral sex, anal intercourse, oral/anal contact, and fisting. The enjoyment of unprotected anal and oral sex as well as oral/anal contact had decreased most dramatically since 1984.

Sexual behavior changes are often pictured as a conscious and rational decision. Dannecker (1990) on the other hand emphasizes anxiety as the motive. Anxiety can, according to Dannecker, contribute to an increased conflict between sexual behavior predilections and practiced sexual behaviors, since the individual wishes more than can be realized. On the other hand, it is possible that the HIV-climate to some gay men has led to a better congruency between predilection and behavior. The sexual liberation movement sometimes forced gay men to have sex in a way that was not always in line with their own wishes and preferences. HIV may under such conditions help the person to justify behavior changes to himself and to the gay community why he gives up certain sexual behaviors (Dannecker, 1990).

When Dannecker's arguments are applied to the life situation of HIV-positive gay men four different theoretical possibilities can be identified as to congruency between sexual behavior psychological loadings and their practice:

1. positive congruency between positive loading of a given sexual behavior and its realization;
2. negative congruency between negative loading of a given sexual behavior and its giving up;

3. discrepancy between positive loading of a given sexual behavior and its giving up; and
4. discrepancy between negative loading of a given sexual behavior and its realization.

The purpose of this descriptive article is to illuminate among a sample of self-identified gay men who are HIV-positive the following questions: (1) What are the attitudes towards changing sexual behaviors? (2) To what extent are sexual behavior changes occurring? (3) Which sexual behaviors are positively and negatively loaded? and (4) To what extent is there a conflict between sexual behavior loadings and practiced sexual behaviors?

METHOD

Subjects

In a German-Swedish cooperative study[1] the HIV-adaptation process, its psychological sequelae and the psychosexual dilemma of HIV-positive men were investigated. The sample consisted of fifty-nine self-identified homosexual men who were diagnosed with HIV and asymptomatic. The respondents were recruited from two sites. Twenty-nine of the participants were recruited through gay volunteer organizations in Stockholm, Sweden. The German subsample consisted of thirty men from the Heidelberg area of whom most were outpatients from two HIV-clinics of the Medical School, University of Heidelberg.

The mean age was 38.8 years (range 18-65 yrs.). Twenty-four percent of the men were notified about their HIV-diagnoses less than one year ago, 26% between one and two years, and 51% more than two years ago (mean: 22.6 months).

The respondents were in-depth interviewed and additionally they completed a set of questionnaires. The relevant questionnaires for the purpose of this article are those measuring attitudes towards sexual behavior changes, actual sexual behavior changes, and sexual behavior loadings.

Assessment

Attitudes towards sexual behavior changes. We developed a 16-item-scale measuring perceived degree of difficulties related to sexual behavioral changes ranging from "great difficulties" to "positive reinterpretation of difficulties."

Every item was answered either "yes," "no" or "partly." Examples of items: "It is necessary to change my sex life but it is not easy"; "I go on as before"; "It is no problem for me to give up certain sexual behaviors."

Sexual behavior changes after the HIV-diagnoses were assessed by means of 15 sexual behaviors. In addition the Swedish sample responded to another six behaviors covering protected oral sex and protected anal sex with/without ejaculation. The categories of each behavior were: "have never practiced it," "don't practice it any more," "rarely practice it today," "continue to practice it as before," and "practice it more often now."

In order to assess sexual behavior loadings a questionnaire was designed including 12 different sexual behaviors (Clement, 1992). In the Swedish sample the participants were asked to respond to additionally 10 behaviors (oral and anal sex with condoms, with/without ejaculation as well as active and passive rimming). The respondent was asked to mark degree of associated difficulties in giving up each of the 12/22 behaviors. The categories were: "I can't give it up"; "It is difficult for me to give it up"; "I can easily give it up"; and "I don't like to practice it."

A given sexual behavior was assessed as being of a positive loading when categories of "I can't give it up" or "It is difficult for me to give it up" were marked. A sexual behavior was assessed as negatively loaded when "I can easily give it up" and "I don't like to practice it" were marked.

Congruency/incongruency between sexual behavior loadings and practiced sexual behaviors was measured by means of combining data as to sexual behavior of today and sexual behavior loadings.

RESULTS

Attitudes Towards Sexual Behavior Changes

The vast majority of the men (93%) acknowledged the sadness of their sexual limitations (Table 1). This item followed by another five items all assented to items that explicitly or implicitly pointed to the necessity to change risky sexual behaviors despite its related difficulties. However, 79% of the men agreed that they were not always successful in restricting their sexual behaviors. Almost half of the sample (49%) partly acknowledged that they could not change or give up their sexual life.

A minority–at the most only one fourth–of the respondents affirmed to items that reflected more of an egoistic attitude or indecision as to chang-

TABLE 1. Distribution Frequency of Attitudes Towards Sexual Behavior Changes (N = 59)

I often find it so sad with these restrictions	Yes	42%
	Partly	51%
	No	7%
First of all I've to be concerned about my partner	Yes	46%
	Partly	46%
	No	8%
It's necessary to change my sex life, but it is not easy	Yes	49%
	Partly	41%
	No	10%
As a result of my HIV-infection, I've become so aware about my sex life	Yes	29%
	Partly	54%
	No	17%
I'm not always successful in restricting my sex life	Yes	9%
	Partly	70%
	No	21%
I take it for granted to restrict my sex life	Yes	31%
	Partly	42%
	No	27%
I've always been responsible when it comes to sex	Yes	15%
	Partly	54%
	No	31%
I can't change my sex life, it's a part of me that I can't give up	Yes	7%
	Partly	49%
	No	44%
To give up is no problem	Yes	7%
	Partly	34%
	No	59%
I've not made up my mind yet	Yes	2%
	Partly	22%
	No	76%

I experience my sexuality as more intense after I've made sexual behavior changes	Yes	5%
	Partly	17%
	No	78%
I go on as before	Yes	2%
	Partly	15%
	No	83%
I'm completely indifferent whether I expose myself to additional risks or not	Yes	0%
	Partly	14%
	No	86%
Generally speaking, my sex life has been enriched through the HIV-infection	Yes	3%
	Partly	9%
	No	88%
So far I've not thought of changing my sex life	Yes	0%
	Partly	10%
	No	90%
Since I'm already infected it's quite indifferent to me whether I infect another person	Yes	0%
	Partly	5%
	No	95%

ing sexual behavioral patterns. Only one of the participants reported that he could not make a decision. The same holds for "Since I am already infected I don't care if I infect someone else."

Between 12%-22% of the participants acknowledged to the more positive oriented items or an unproblematic attitude towards changes. Forty-one percent declared that there was no problem to them to change.

In summary it could be said that among the HIV-positive gay men there was an awareness of the associated difficulties to sexual behavior changes but at the same time the changes were recommended and emphasized. Egoistic/careless and indecisive attitudes as well as more positive loaded attitudes were only partly approved of and by the most by one fourth of the men.

Sexual Behavior Changes

The results are shown in Table 2. It becomes very clear that major sexual behavior changes have occurred within the German-Swedish sample. Mutual masturbation was more often practiced than before HIV-diagnosis. About three quarters of the respondents had in casual sexual en-

TABLE 2. Changes in Sexual Behaviors Since the HIV-Diagnosis

	Steady partner	Casual sexual partner
Mutual Masturbation		
Have never practiced it	0%	2%
Don't practice it anymore	4%	2%
Rarely practice it	19%	23%
Cont. to practice it as before	23%	33%
Practice it more often now	54%	40%
	(N = 26)	(N = 43)
Receptive Oral-Genital Sex with Ejaculation		
Have never practiced it	27%	10%
Don't practice it anymore	35%	63%
Rarely practice it	23%	20%
Cont. to practice it as before	15%	8%
Practice it more often now	0%	0%
	(N = 26)	(N = 40)
Receptive Oral-Genital Sex without Ejaculation		
Have never practiced it	15%	5%
Don't practice it anymore	19%	26%
Rarely practice it	39%	31%
Cont. to practice it as before	23%	38%
Practice it more often now	4%	0%
	(N = 26)	(N = 42)
Insertive Oral-Genital Sex with Ejaculation		
Have never practiced it	16%	8%
Don't practice it anymore	68%	75%
Rarely practice it	0%	10%
Cont. to practice it as before	16%	8%
Practice it more often now	0%	0%
	(N = 25)	(N = 40)
Insertive Oral-Genital Sex without Ejaculation		
Have never practiced it	12%	2%
Don't practice it anymore	40%	31%
Rarely practice it	20%	33%
Cont. to practice it as before	28%	33%
Practice it more often now	0%	0%
	(N = 25)	(N = 42)

	Steady partner	Casual sexual partner
Receptive Anal Sex without Condom with Ejaculation		
Have never practiced it	16%	8%
Don't practice it anymore	68%	74%
Rarely practice it	12%	13%
Cont. to practice it as before	4%	5%
Practice it more often now	0%	0%
	(N = 25)	(N = 39)
Receptive Anal Sex without Condom without Ejaculation		
Have never practiced it	20%	8%
Don't practice it anymore	52%	58%
Rarely practice it	12%	23%
Cont. to practice it as before	16%	13%
Practice it more often now	0%	0%
	(N = 25)	(N = 40)
Insertive Anal Sex without Condom with Ejaculation		
Have never practiced it	32%	20%
Don't practice it anymore	64%	70%
Rarely practice it	0%	3%
Cont. to practice it as before	4%	8%
Practice it more often now	0%	0%
	(N = 25)	(N = 40)
Insertive Anal Sex without Condom without Ejaculation		
Have never practiced it	36%	15%
Don't practice it anymore	48%	60%
Rarely practice it	0%	13%
Cont. to practice it as before	16%	13%
Practice it more often now	0%	0%
	(N = 24)	(N = 41)
Receptive Anal Sex with Condom		
Have never practiced it	21%	7%
Don't practice it anymore	17%	12%
Rarely practice it	25%	32%
Cont. to practice it as before	25%	32%
Practice it more often now	12%	17%
	(N = 24)	(N = 41)

TABLE 2 (continued)

	Steady partner	Casual sexual partner
Insertive Anal Sex with Condom		
Have never practiced it	33%	12%
Don't practice it anymore	17%	10%
Rarely practice it	17%	29%
Cont. to practice it as before	21%	37%
Practice it more often now	12%	12%
	(N = 24)	(N = 41)
Receptive Rimming		
Have never practiced it	29%	12%
Don't practice it anymore	50%	60%
Rarely practice it	8%	19%
Cont. to practice it as before	13%	7%
Practice it more often now	0%	2%
	(N = 24)	(N = 42)
Active Rimming		
Have never practiced it	39%	21%
Don't practice it anymore	35%	48%
Rarely practice it	4%	14%
Cont. to practice it as before	22%	14%
Practice it more often now	0%	2%
	(N = 23)	(N = 42)
Receptive Fisting		
Have never practiced it	83%	71%
Don't practice it anymore	13%	19%
Rarely practice it	0%	5%
Cont. to practice it as before	4%	2%
Practice it more often now	0%	2%
	(N = 23)	(N = 42)
Insertive Fisting		
Have never practiced it	74%	67%
Don't practice it anymore	17%	21%
Rarely practice it	0%	2%
Cont. to practice it as before	9%	7%
Practice it more often now	0%	2%
	(N = 23)	(N = 42)

counters given up unprotected oral and anal intercourse with ejaculation. Those men who continued to practice these behaviors had reduced their frequencies.

The vast majority of the men (78-81%) used condoms when practicing anal sex with casual partners. The equivalent figures with a steady partner were 50-62%. A small group of 7-12% reported that they had never had protected anal sex with casual partners and the equivalent figures for regular partners were 21-33%. The most clear trend in these data is the giving up of unprotected oral and anal intercourse, whereas there was an increase in mutual masturbation (40-54%). Condom use when practicing anal sex was quite high, but it is noteworthy that 10-17% of the participants had given up protected anal sex after the diagnosis. Just as noteworthy is that about 19-23% of the men had reduced mutual masturbation.

Within the Swedish sample it was a trend to make use of double protection (condom use and no ejaculation) when practicing active anal sex (58%) and passive oral sex (63%).

Among the 59 respondents, 15 of them reported that they had had unprotected oral and/or anal sex to ejaculation with a casual partner at least once after notification of their HIV-diagnosis.

Sexual Behavior Loadings

Table 3 indicates that masturbation was the highest positively rated sexual behavior (88%) followed by mutual masturbation (65%). The active role in unprotected anal and oral intercourse without ejaculation was positively loaded (56% and 56% respectively). These data indicate that the positive loadings of anal and oral sex appeared to be more associated with penetration than ejaculation. This finding was more salient for oral sex (difference between positive loading of oral sex with versus without ejaculation: 35% receptive and 26% insertive) than for anal sex (difference: 14% receptive and 18% insertive). Only two of the participants rated insertive and receptive fisting as positive whereas 76% reported negative loadings. A minority disliked ejaculation from the partner in receptive oral sex (28%), receptive anal sex (20-24%) and insertive anal sex (12-24%).

Among the Swedish gay men the majority reported active protected anal sex to be positively loaded (without ejaculation: 83%; with ejaculation: 63%). In contrast, passive protected anal sex had a negative loading, and so had passive and active protected oral sex (in particular with ejaculation, 79% and 83% respectively).

TABLE 3. Positive and Negative Sexual Behavior Loadings (47 < = N < = 50)

Masturbation	
I can't give it up	72%
It is difficult for me to give it up	16%
I can easily give it up	8%
I don't like to practice it	4%
Mutual Masturbation	
I can't give it up	38%
It is difficult for me to give it up	27%
I can easily give it up	31%
I don't like to practice it	4%
Receptive Oral Genital Sex with Ejaculation	
I can't give it up	0%
It is difficult for me to give it up	21%
I can easily give it up	51%
I don't like to practice it	28%
Receptive Oral Genital Sex without Ejaculation	
I can't give it up	8%
It is difficult for me to give it up	48%
I can easily give it up	37%
I don't like to practice it	6%
Insertive Oral Genital Sex with Ejaculation	
I can't give it up	2%
It is difficult for me to give it up	22%
I can easily give it up	55%
I don't like to practice it	20%
Insertive Oral Genital Sex without Ejaculation	
I can't give it up	6%
It is difficult for me to give it up	44%
I can easily give it up	44%
I don't like to practice it	6%
Receptive Anal Sex without Condom with Ejaculation	
I can't give it up	6%
It is difficult for me to give it up	22%
I can easily give it up	48%
I don't like to practice it	24%
Receptive Anal Sex without Condom without Ejaculation	
I can't give it up	12%
It is difficult for me to give it up	30%
I can easily give it up	38%
I don't like to practice it	20%

Insertive Anal Sex without Condom with Ejaculation	
I can't give it up	6%
It is difficult for me to give it up	32%
I can easily give it up	38%
I don't like to practice it	24%
Insertive Anal Sex without Condom without Ejaculation	
I can't give it up	12%
It is difficult for me to give it up	44%
I can easily give it up	31%
I don't like to practice it	12%
Receptive Fisting	
I can't give it up	0%
It is difficult for me to give it up	4%
I can easily give it up	20%
I don't like to practice it	76%
Insertive Fisting	
I can't give it up	0%
It is difficult for me to give it up	4%
I can easily give it up	20%
I don't like to practice it	76%

Congruency/Incongruency Between Sexual Behavior Loadings and Practiced Sexual Behaviors

Table 4 shows the congruence/incongruency between sexual behavior psychological loadings and practiced sexual behavior. Masturbation and mutual masturbation were practiced in concordance with a positive, or at least a neutral, loading.[2]

There was less congruency between loadings and practices when it came to oral and anal sex; a larger group of respondents had given up positively loaded sexual behaviors ranging from 8% (receptive unprotected anal sex) to 34% (insertive unprotected oral sex). It was much less common to go on practicing behaviors that were negatively loaded (anal sex 8% and oral sex 2%).

Over fifty percent of the Swedish sample practiced protected passive anal sex despite its negative loading.

DISCUSSION

The data presented in this article display two patterns of sexual behavior among a German-Swedish sample of HIV-positive gay men. The large

TABLE 4. Congruency Between Sexual Behavior Loadings and Sexual Behaviors (N = 48)

Masturbation	
Positive congruency	98%
Negative congruency	2%
Positive loading/giving up	0%
Negative loading/practiced	0%
Mutual Masturbation	
Positive congruency	94%
Negative congruency	2%
Positive loading/giving up	2%
Negative loading/practiced	2%
Insertive Oral Genital Sex	
Positive congruency	62%
Negative congruency	2%
Positive loading/giving up	34%
Negative loading/practiced	2%
Receptive Oral Genital Sex	
Positive congruency	74%
Negative congruency	7%
Positive loading/giving up	20%
Negative loading/practiced	0%
Insertive Anal Sex	
Positive congruency	71%
Negative congruency	4%
Positive loading/giving up	17%
Negative loading/practiced	8%
Receptive Anal Sex	
Positive congruency	75%
Negative congruency	8%
Positive loading/giving up	8%
Negative loading/practiced	8%

majority avoid infecting others by using condoms or by giving up oral and/or anal sex. An important change is the shift from oral and anal sex to masturbation. On the other hand, risks of HIV-transmission are not totally excluded. A minority of the respondents (N = 15) still practice unprotected sexual behaviors (see Clement, 1992 for a detailed analysis). These sexual behavior patterns are both accompanied by attitudes that support the necessity to change risky sexual behaviors and those that formulate difficulties in doing so.

The findings are interpreted in terms of an attitudinal conflict as to sexual behavior changes that can be solved in different ways. Unprotected sex as well as giving up sexual behaviors that are still positively loaded are two examples of conflict solutions. It should also be noted that the conflict is at work even when the individual practices protected or "safer" sexual behaviors. The results indicate that only referring to sexual behavior data would underestimate the potential of so-called "relapses" to unprotected sexual behaviors.

The sexual dilemma of HIV-positive gay men is very often looked upon from solely a cognitive and rational perspective. But in order to give justice to its complexity, psychological aspects of sexualities have to be addressed. The dilemma may cause frustration and stress as the hedonistic dimension of sexuality is reduced. The psychological pain is, however, not only related to behavioral changes and/or behavioral giving up but also to the regressive dimension of sexuality; i.e., to give in physically and psychologically to another person. The HIV-positive person is, due to the infectiousness of HIV, partly debarred from this dimension.

Another potential contributing factor to the pain is the psychological representation of a given sexual behavior. If unprotected anal intercourse, for example, represents a merger with one's partner it is the behavior as such in combination with this symbol that the HIV-positive person has to give up. The psychic equilibrium of the HIV-positive person is very much threatened by various HIV-related strains and stressors. The individual sexuality plays an important role as a compensation strategy of the more or less instable equilibrium. Schorsch (1989) has identified three aspects of sexualities: the narcissistic, the relational, and the psychological reproductive aspects.

The narcissistic aspect refers to the role of sex as a psychic stabilizer (or a distracting mechanism) by for example soothing depression and anxiety, reducing tension, increasing (but also masking) low self-esteem.

The relational aspect. The HIV-positive person's sexual life can be less frustrating when his partner is HIV-positive as well rather than HIV-negative or untested. But the intimacy sphere can be troublesome related to worries about who will be the first to develop HIV-related symptoms/diseases and/or die, etc. The HIV-positive person can also experience worries about being abandoned regardless of the partner's status. Single men may worry about not finding a partner.

The psychological reproductive aspect alludes to irrational fantasies about "life reproduction." Sexuality is here viewed as the counterweight for death. Subsequently sex gets an existential value, symbolizing partici-

pation in life and its continuity. The need to be sexual and to act upon it is associated with a hope of future and a longing for not being extinguished.

The narcissistic, the relational and the psychological reproductive aspects may in other words serve as a protective shield (or a distracting, defensive mechanism) towards strains and distress. The sexual encounter can, provided the individual experiences feelings of being attractive, affirmed, liked, or loved, become a counterbalance to feared or real devaluation of himself and alienation.

The sexual dilemma may be "solved" in different ways. One solution is to go on living in sexual abstinence. Another solution is to try to find one's partner(s) within the Body Positive group. The individual may also develop sexual depression in terms of reduced sexual desire and/or erectile dysfunctions as a response to anxiety of infecting another person. In future research it is of greatest importance to pay attention to these above mentioned psychological aspects of sexualities, including sexual behavior psychological loadings, in order to broaden and deepen our understanding of the sexual dilemma. Another important research issue is to examine the ways in which HIV-positive people psychologically try to deal with the conflict of giving up sexual behaviors that are positively loaded in particular.

Whereas HIV-related psycho-sexuo-social research has mainly focused on sexual risk-reduction and its contributing factors, our empirical knowledge is almost non-existent with respect to what extent HIV-positive gay men may experience psychological and/or sexual distress as a consequence of their sexual behavior changes. Clinical experiences indicate for example that sexual risk reduction distress may be reinforced for those men who, prior to the HIV-diagnosis, to a large extent made use of their sexuality as a defense mechanism towards mental suffering. It is suggested that whether sexual risk reduction distress ultimately manifest itself in various psychological and/or sexual symptoms is dependent upon intervening psychological mechanisms. Examples of such mechanisms or buffers are personality dimensions, coping styles, coping strategies and attitudes towards sexual behavior changes.

Finally, both scientists and clinicians are in an urgent need to develop theoretical models in order to illuminate the complex web of psycho-dynamic, cognitive, and social aspects of the sexual dilemma of HIV-positive persons. These models could serve as guidelines for future research and to the clinicians as instruments in facilitating individual endeavour to achieve a psychic equilibrium between HIV-infection, sexual dilemma, and sexual well-being. By promoting sexual well-being, we will also contribute to prevention of HIV transmission.

NOTES

1. Principal investigator of the Swedish project was Lena Nilsson Schönnesson and the project was financially supported by the Swedish Council for Social Research, the Swedish Medical Research Council, and the Swedish Red Cross. Principal investigator of the German project was Ulrich Clement and the project was financially supported by the Ministry of Science and Art, Baden-Wuerttemberg.

2. It should be noted that "positive congruency" of oral and oral sex includes unprotected, protected, with and without ejaculation. The focus is which *behavior* as such is preferred and also practiced.

REFERENCES

Bochow, M. (1988). Wie leben schwule Männer heute? Bericht uber eine Befragung im Auftrag der Deutschen AIDS-Hilfe. Berlin: AIDS-Forum D.A:H., Band II.

Calabrese, L.H., Buck, H., Easley, K.A., & Proffitt, M.R. (1986). Persistence of high risk sexual activity among homosexual men in an area of low incidence for acquired immunodeficiency syndrome. AIDS Research 2:357-361.

Catania, J.A., Coates, T. J., Stall, R., Bye, L., Kegeles, S.M. m fl. (1991). Changes in condom use among homosexual men in San Francisco. Health Psychology, 10(3):190-199.

Clement, U. (1992). HIV-positiv. Psychische Verarbeitung, subjektive Infektionstheorien und psychosexuelle Konflikte HIV-Infizierter. Eine komparativ-kasuistische Studie. Stuttgart: Ferdinand Enke Verlag.

Coates, T.J., Morin, S.F., & McKusick, L. (1987). Behavioral consequences of AIDS antibody testing among gay men. Journal of the American Medical Association, 258:1889.

Connell, R.W., Crawford, J., Kippax, S., Dowsett, G.W., Baxter, D., & Watson, L. (1989). Facing the epidemic: Changes in the sexual lives of gay and bisexual men in Australia and their implications for AIDS prevention strategies. Social Problems, 36:384-402.

Dannecker, M. (1990). Homosexuelle Männer und AIDS–Eine Sexualwissenschaftliche Studie zu Sexualverhalten und Lebensstil. Schriftenreihe des Bundesministers für Jugend, Familie, Frauen und Gesundheit, Band 252. Stuttgart: Kohlhammer.

Detels, R., English, P., Visscher, B., Jacobson, L., Kingsley, L., Chmiel, J., Dudley, J., Eldred, L., & Ginzburg K. (1989). Seroconversion, sexual activity, and condom use among 2915 HIV seronegative men followed for up to 2 years. Journal of Acquired Immune Deficiency Syndromes, 2:77-83.

Doll, L.S., O'Malley, P., Pershing, A., Hessol, N., Darrow, W., Lifson, A., & Cannon, L. (1988). High-risk behavior and knowledge of HIV-antibody status in the San Francisco City Clinic Cohort. IV International Conference on AIDS, Stockholm, Sverige.

Fox, R., Odaka, N.J., Brookmeyer, R., & Polk, B.F. (1987). Effect of antibody test disclosure on subsequent sexual activity in homosexual men. AIDS, 1:241-246.

Ginzburg, H., Fleming, P., & Miller, K. (1988). Selected public health observations derived from the Multicenter AIDS Cohort Study. Journal of Acquired Immune Deficiency Syndromes, 1:2-7.

Joseph, J.G., Montgomery, S.B., Kessler, R.C., Ostrow, D.G., Wortman, C.B. (1987). Behavioral risk-reduction in a cohort of homosexual men: Two year follow-up. III International Conference on AIDS, Washington DC, USA.

Martin, J. (1987). The Impact of AIDS on Gay Male Sexual Behavior Patterns in New York City. American Journal of Public Health, 77:578-581.

McCusker, J., Stoddard, A.M., Mayer, K.H., Zapka, J., Morrison, J., & Saltzman, S.P. (1988). Effects of HIV antibody test knowledge on subsequent sexual behaviors in a cohort of homosexually active men. American Journal of Public Health 78:462-467.

Niemeck, U., & Schumann, J. (1986). Psychosoziale Auswirkungen von AIDS am Beispiel homosexueller Männer mit und ohne HIV-Antikörper-positiven Befund. Diplomarbeit (Psychologie) Albert-Ludwigs-Universität Freiburg.

Pollak, M. (1990). Homosexuelle Lebenswelten in Zeichnen von AIDS. Soziologie der Epidemie in Frankreich. Ergebnisse Sozialwissenshaftlicher AIDS-Forschubg 4. Berlin: Edition sigma.

Research and Decision Corporation: A report on designing an effective AIDS prevention campaign strategy for San Francisco (1987). Results from the fourth probability sample of an urban gay male community. San Francisco: The San Francisco AIDS Foundation.

Schechter, M., Craib, K., Willoughby, B., Douglas, B., McLeod, A., Maynard, M., Constance, P., & O'Shaughnessy, M. (1988). Patterns of sexual behavior and condom use in a cohort of homosexual men. American Journal of Public Health, 78:1535-1538.

Tillmann, K., Braun, R., Clement, U. (1990). Veränderungen des sexuellen Verhaltens durch die Angst vor AIDS–eine empirische Untersuchung an hetero und homosexuellen Studenten. Öffentliches Gesundheitswesen, 52:323-329.

Van Griensven, G.J.P., Tielman, R.A.P., Goudsmit, J., van der Noordaa, F., de Wolf, F., & Coutinho, R.A. (1987). Effect of HIV-Ab serodiagnosis on sexual behavior in homosexual men in The Netherlands. III. International Conference on AIDS, Washington DC.

Zones, J.S., Beeson, D.R., Echenberg, D.F., Frigo, M.A., O'Malley, P.M., & Rutherford, G.W. (1986). Personal and social consequences of AIDS Antibody testing and notification in a cohort of gay and bisexual man. II. International Conference on AIDS, Paris, Frankrike.