Review

Intimacy and HIV/Aids

Kasiram M, D Phil
Dano B, BA(SW)
Partab R, MMed Sc(SW)
Department of Social Sciences, Social Work-Westville Campus, University of Kwazulu-Natal

Correspondence: Professor Madhu Kasiram
E-mail: kasiramm@ukzn.ac.za

Abstract

This paper addresses intimacy in relationships where HIV/AIDS exists. The authors explore what strengthens and strains relationships and review insights on promoting communication about intimacy. Therapist discomfort and attitudes that prevent effective therapeutic intervention are addressed to allow for the co-existence of HIV/AIDS and intimacy.

(SA Fam Pract 2006;48(2): 54-55)

Dealing with Interaction and Intimacy

Professionals dealing with persons with HIV/AIDS (PWA's) lack knowledge and skill in broaching the topic of intimacy as it is "intrusive" and complex.[1] Even in healthy relationships, sexuality and intimacy are considered multi-dimensional and dynamic and thus difficult to probe.[2] Discussions on sexuality and intimacy should interrogate whom one has sex with, in what ways, why, under what circumstances and with what outcomes. Further, a culture of "pluralism with multiple perspectives" (McDowell et al[3] p.180) needs to be cultivated to generate "thick" conclusions and unique outcomes.[4]

Complicating communication about sex are misconceptions about the contagiousness and management of HIV/AIDS resulting in psychological distress.[5] Knowledge that partners are turning to sex workers or that there is forced sex to infect others, widens the gap between partners.

What Strengthens/Strains Couple Relationships?

Factors that strengthen intimacy in couple relationships include: honesty, sensitivity, taking responsibility for sexual gratification, communicating needs, identifying and negotiating new ways of achieving intimacy and growing through adversity.[1,6] Strong relationships are underscored by openness. Open communication leads to taking sexual responsibility that can prevent infection and re-infection and negotiating creative ways of re-kindling intimacy. Closeness and intimacy may be achieved through re-discovering nature as nurturer and through spirituality. When faced with trauma, it is common to question values, beliefs and spiritual bases to find meaning to life.[7] Answers may be found in wilderness trails to re-discover and re-connect with what is/was important.[8] Hence, growth may result from "adversity" and trauma.

Factors that strain couple relationships include: suspicion, fear, making difficult reproductive decisions, guilt, impotence and partners who refuse to use condoms. Pessimism, fear, and guilt have a vice grip control preventing positive living or enjoying fulfilling relationships. When sex is seen as producing the problem of HIV/AIDS in the first place, it is difficult for the couple to resume intimate contact. Reproductive decision-making is complicated when intimacy issues are not addressed. In African communities, bearing a child is seen as an essential part of being a woman and achieving success. Hence women who are infected and who decide against having children may be viewed as unsuccessful, unfulfilled and incomplete.[9]

Unequal power in relationships prevents the negotiation of safe sexual practices to reduce the impact of HIV infection and re-infection.[10] Inequality results from social conditioning of males carrying a "macho" image, of having numerous sexual exploits and being unconcerned about consequences of their behaviour.[11] Sexual risk is taken even when knowledge of HIV exists, needing macrosystemic interventions to change notions of dominance in sexual relationships. Gender inequality in relationships is no longer just "costly but fatal" especially where HIV/AIDS exists.[2] Females must re-claim locus of control in the sexual encounter and insist on safe sex.[10] Unequal power in sexual relationships also finds expression in revenge infecting to "cure" oneself of the virus. The misconception is that virgins/children have good immunity against sexually transmitted diseases because of a dry vaginal tract which allows an infusion of "purifying blood" from the encounter.[12] Maintaining neutrality when moral conduct is thus breached is difficult especially when burdened by limited resources, skills and knowledge.[13]

Sexual Dysfunction and HIV/AIDS

Sexual dysfunctions/disorders frequently characterize relationships with HIV/AIDS. These include: inhibited sexual desire, sexual aversion disorder, sexual arousal disorder, male erectile disorder, male/female orgasmic disorder, sexual pain disorder, premature ejaculation and vaginismus.[14]

The challenge is to keep abreast of an ever-evolving pool of knowledge and remain unbalanced when intruding into the private space of intimacy. The counselor often faces the additional challenge of societal pressure not to intervene e.g. in a depressed economy that prioritizes basic needs. Under these circumstances sexual health exploration is considered socially and politically irrelevant. How does the counselor give credence to intimacy issues in the absence of basic infrastructural support? Possessing skills to intervene meaningfully goes a long way in addressing this concern.

Skills, Processes and Techniques

Counselors should explore the "p's" of sexuality. These are: practices, partners,

pleasures, pressure, pain, procreation and power.[2] Power underscores every sexual encounter and was discussed earlier under what strengthens/strains relationships. The interview must also be deliberately planned and special techniques used as discussed hereunder.[15,16]

Opening the Interview and Goal Setting: Clients should be made aware of why they are interviewed especially the one who did not initiate contact. The origin and development of the disorder and current medication must be understood early as it impacts on sexual (dys)functioning.

Establishing rapport: Clients must feel understood and assured of not being judged. Jargon should be avoided and euphemisms clarified. Rapport tends to increase when people feel in control, so it is helpful to assure clients that they do not have to answer every question and that they can stop the interview if uncomfortable.

Identification of problems: It is helpful to identify problems that are resolvable to generate hope into what appears a desperate and embarrassing situation. Clients should be discouraged from offering justifications; rather they need to provide factual information. It is also useful not to settle for the first sexual problem mentioned as initial awkwardness renders clients garrulous or monosyllabic, giving a false impression of the range and magnitude of the problem.

Background information: It is useful to proceed chronologically e.g. from the present backward or from the past forward. People generally provide more complete information if they are able to place it in the context of other important life events. A map with a time line outlining toxic issues and nodal events may add further clarity.

Completing the interview: It is important to establish what will happen without treatment and "why now?" to provide direction and impetus towards change. Leaving the door open for further elaboration is necessary as clients are rarely able to tell the whole story in a single interview.

The interview may be easier to conduct if specific interviewing techniques are employed.[16] These include the *sportscaster technique* to ask the person to describe an event as a sportscaster with the event happening right now. The time sequence avoids speculation, hypothesizing and rationalizing about the problem. The time line discussed earlier is a similar concept. Using the *sexual fantasy letter*, the PWA is invited to write a letter to a magazine describing "unusual/best sexual experiences" to elicit information to identify sexual problems and their solutions. The technique of *future projection* as discussed in "completing the interview" again helps to question the future, with and without treatment. The authors note that this is in accord with hypothetical questioning used in Milan Family to project the future, set goals and deal with impasses in the face of hopelessness.

Both HIV and intimacy are topics shrouded in secrecy and silence. By employing the above processes and techniques, counselors normalize HIV and intimacy and nurture their co-existence. A *normative support group environment* also helps move beyond illness and stigma to receive compassionate care.[5,13,17,18] Groups provide for "weakened or absent social support".[19] In addition they facilitate the development of alliances, representing PWA's to the outside world, making possible collective responses and generating hope while institutionalizing problems.[13] Group interaction encourages the exploration of what matters most such as reproductive options, future planning, seeking forgiveness and re-connecting with spirituality.[1] Changes could then be reinforced by the group.[13]

Conclusions and Recommendations

The conspiracy of silence and shame surrounding both HIV and intimacy render the co-existence of both a serious challenge and carries hidden costs, mostly in human "wreckage".[21] Proactive empowerment and life-long learning at multi-systemic levels is vital. This may be accomplished through the employment of narrative theatre to promote community education[22] allowing PWA's who have endured histories of stigma to tell their stories without prior interpretation and receive respect and community support.[19] In a similar vein, "edutainment" to educate the masses is suggested, noting that HIV/AIDS has been the target of much attention, and therefore has to be relayed differently but culturally appropriately to educate and entertain for mass benefit.[10] Peer education is a valuable means of participatory practice that may promote the negotiation of safer sexual practices where perceived power differences dominate in the relationship.[19,20] Supporting peer education with role plays would facilitate sexual decision making to distinguish gaps between cognitive knowledge and behavioural outcomes. In addition, macrosystemic approaches that change beliefs about male domination and myths around revenge infection require national co-ordination such as affirming the female through "women's day" celebrations.

Intimacy and sexuality are integral to the human experience. However, intimacy is elusive when accompanied by hopelessness and negativity. Re-connecting with nature and spirit has been suggested to re-experience hope and positivity. The metaphors of nature could be likened to metaphors of life to face adversity with hope[8,23] and religion/spirituality could affirm tired spirits to promote forgiving, all of which are essential to re-kindling intimacy in relationships.[7]

Intimacy and HIV/AIDS need to coexist as we move from shame to empowerment of the individual, couple, counselor and the community.

References

1. Kasiram M, Partab R, Dano B, van Greunen J. *Managing HIV/AIDS: Guidelines for Counsellors, Caregivers and Faith-Based Practitioners.*, Durban: Print Connection; 2003
2. Gupta G R. Gender, Sexuality, and HIV/AIDS: The What, the Why, and the How. [on line] 2000. Available from [accessed September 1 2005]
3. McDowell T, Fang S-R, Brownlee K, Young C G & Khanna. Transforming and MFT Program: A Model for Enhancing Diversity. *Journal of Marital and Family Therapy* 2002 28(2):179-191
4. Epston D and White M. *Experience, Contradiction, Narrative and Imagination.* Australia: Dulwich Centre Publications 1992
5. Van Devanter N, Thacker AS, Bass G, Arnold M. Heterosexual Couples Confronting the Challenges of HIV Infection. *AIDS Care* 1999 11(2): 181-193
6. DeMatteo D, Wells LM, Goldie RS, King SM. The Family Context of HIV: A Need for Comprehensive Health and Social Policies. *AIDS Care* 2002 14(2): 261-278
7. Kasiram M. Winning the War against HIV/AIDS. Conference Proceedings of the IFTA World Congress, 2003 May 8-10; Slovenia; 2004 p.168-174
8. MacDowell M. The Spirit of Wilderness-The Benefits of a Wilderness Trail for Child-Headed Families. Paper presentation at the 9th SAAMFT International Conference, Durban; 2004
9. Sewpaul V. Models of Intervention for Children in Difficult Circumstances in South Africa. *Child Welfare League of America.* 2001 LXXX(15): 571-586
10. Naidoo P. An Investigation into the Factors contributing to unplanned pregnancy at UKZN, Westville Campus. [Masters dissertation] UKZN; 2004
11. Moore S, Rosenthall D. *Sexuality In Adolescence.* London: Routeledge; 1993
12. Rutenberg N, Kaufman CE, Macintyre K, Brown L, & Karim A. "Pregnant Or Positive: Adolescent Childbearing and HIV Risk in South Africa [on line] 2001 Available from: URL: [accessed May 15 2004].
13. Corey MS and Corey G. *Groups Process and Practice.* 4th ed. California: Brooks/Cole; 1997
14. Sexual Dysfunctioning. Fact Sheet [on line] Jan 2003. Available from: URL:http:// [accessed May 15 2004]
15. Johnson SL. Therapist's Guide to Clinical intervention. USA: Academic Press; 1997
16. Federoff J. Interview techniques to assess sexual disorders. Families in society: *The Journal of Contemporary Human Services* 1991; 72(3):140-145
17. Allan J, Pease B and Briskman L. ed *Critical Social Work: An Introduction to Theories and Practices.* Australia: Allen and Unwin. Australia; 2003
18. Jacobs EE, Masson RL and Harvill RL. *Group Counselling: Strategies and Skills.* 4th ed. Australia: Brooks/Cole; 2003
19. Greif G L and Ephross P H. *Group Work with Populations at Risk.* New York: Oxford University Press; 1997
20. Gage A. Female Empowerment and Adolescent Behaviour [on line] 1997 Available from: URL: http:// [accessed May 15 2004]
21. Anderson G. *Courage to care: Responding to the Crisis of Children with AIDS.* Washington DC: Child Welfare League of America; 1990
22. Sliep Y. An Interview. Workshop presented at the 8th International Conference of SAAMFT, Cape Town;2000
23. Brink J. Take a Walk on the Wild Side. Workshop presented at the 8th International Conference of SAAMFT, Cape Town; 2000