



HIV COUNSELOR PERSPECTIVES

Serosorting

“Serosorting” is the practice of having sex (or certain kinds of sex) only with people of the same HIV status. This includes both people who have anal or vaginal sex only with people of the same HIV status and people who have *unprotected* anal or vaginal sex only with others of the same HIV status, but who use condoms with other partners. One of the key reasons that people serosort is so that they can reduce some of the risk of HIV transmission without using condoms.

Since HIV can spread only when an HIV-negative person has contact with the blood, breast milk, or sexual fluids of an HIV-positive person, serosorting should, in theory, be a highly effective HIV prevention strategy. But in the real world, how well does serosorting work to prevent new HIV infections? This issue of *PERSPECTIVES* explores this question, the effectiveness of serosorting as a strategy for HIV-positive versus HIV-negative people, and the ways counselors can help clients make informed decisions about serosorting.

What Is Serosorting?

Because people practice serosorting differently, it can be complicated for counselors to talk about this

strategy. For example, a client who believes he is HIV-negative might say, “The people I have sex with are negative,” or “I usually just do oral—but if the guy is negative, I’ll have anal sex,” or “I use condoms for anal sex unless the other guy is negative too.” All of these would be examples of serosorting choices—people making decisions about what to do or not do sexually based on the HIV status of their partners. Likewise, a person who knows he is HIV-positive might seek out other HIV-positive partners either for all sex, for anal sex, or for unprotected anal sex. While some people who serosort also use condoms with their partners, many people use serosorting as an alternative to using condoms. In this way, it is one kind of sexual harm reduction—a way to reduce, but not eliminate, the risks that can come with sexual contact.

Since people practice serosorting in different ways, counselors need to know what it means to any client who talks about it. Further, many clients practice some form of “serosorting” without actually using that term. A counselor might clarify what a client means by asking, “When you say that you ‘have sex only with guys who are

healthy,’ what does that mean?” If the client says that he has anal sex only with other HIV-negative men, the counselor could follow up by asking whether the client uses condoms, how the client assesses his partner’s HIV status, and what the client does when he wants to have sex with someone who is HIV-positive or whose status he doesn’t know. This assessment can help reveal the mix of strategies the client uses to reduce risk and how he decides among them.

Making decisions about sex based on HIV status is nothing new—and it’s not something that only men who have sex with men do. Most of the research evidence about serosorting, however, comes from studies of U.S., British, and Australian gay and bisexual men, so most of the discussion here focuses on those groups. There is some evidence that the practice of serosorting is increasing among gay and bisexual men in places such as San Francisco,¹ Seattle,² London,^{3,4} and Sydney.⁵

In California, a 2006 population-based survey found that 41 percent of HIV-positive men and 62 percent of HIV-negative men engaged in serosorting—which they defined as unprotected anal sex with same-status partners—with their primary

partners. In the same study, 33 percent of HIV-positive men and 20 percent of HIV-negative men had unprotected anal sex with their most recent non-primary same-status partners. These findings led the researchers to suggest that future studies examine and report information about same-status and mixed-status anal intercourse separately.⁶

Why Serosort?

There are many reasons why people choose sexual partners of their own HIV status. Reducing the risk of HIV transmission is a key motivation, but even this reason entwines with others. For example, some people say that having sex with same-status partners

Many people decide their partners' status based on looks or behavior, rather than an actual discussion.

relieves them of anxiety about HIV transmission, which then allows them to enjoy sex more fully.⁷

Some people who serosort in addition to using condoms report that this reduces their concerns about condom failure. One review of the literature, however, found that the most important motivation is the intention “to maintain a sense of personal safety while avoiding condom use.”⁸ For the majority who serosort without condoms, the intimacy and physical pleasure of unprotected sex are a powerful draw. It is important for counselors to remember that this desire for a sense of closeness is often a significant part of the context in which people make sexual choices.⁹⁻¹⁰ According to the review cited above, other reasons for serosorting include: altruism, “safer-

sex fatigue,” and concerns about the criminalization of HIV transmission.⁸ Other studies have found additional reasons some people dislike condoms: inconvenience, awkwardness, discomfort, or because condom use interrupts sexual spontaneity or inhibits sexual performance.

Seroguessing

If condom use is challenging, so is talking explicitly about HIV status and possible HIV exposure. Many people decide that their partners are of the same HIV status as they are based on the partner's looks or behavior, or on what is not said: “He'd tell me if he was positive,” or “He'd want to use a condom if he was negative,” or “I told

him I was negative; he would have told me if he wasn't.” Some researchers call this “seroguessing.” They suggest that studies need to better distinguish between serosorting based on explicit disclosure and that which is based on assumption.¹¹

One Australian study of 2,000 men who have sex with men found that approximately one-third of both HIV-negative and HIV-positive participants were actually guessing at their partner's status the last time they had “seroconcordant” anal sex. Approximately two-thirds of both groups had directly discussed HIV status. Among HIV-negative men, as might be expected, unprotected anal sex was even more likely than protected sex when men guessed their partners' HIV-negative status

than when they discussed HIV status directly. The researchers expressed concern that seroguessing might undercut the protective effect of true serosorting based on explicit conversations about status. The authors also acknowledge, however, that the dangerous consequences of seroguessing may be more significant for HIV-negative than for HIV-positive men.¹¹

Serosorting for Positives

HIV-positive people report their own reasons for serosorting. Many HIV-positive gay men have had painful encounters with potential sexual partners who ask, “Are you healthy?” or “Are you clean?” Some online ads state “I'm disease free—you be too,” or that “negatives only” should respond. It's not hard to see why some say that choosing HIV-positive partners helps them avoid the rejection and stigma they sometimes feel when they disclose their status to HIV-negative people.¹² Some also want partners who understand the experience of living with HIV, and many want to avoid infecting an HIV-negative person.⁹

Serosorting among HIV-positive people has its complications. One concern that comes up for some clients and service providers is the possibility of superinfection (or reinfection): getting a second (and perhaps more damaging) strain of HIV from unprotected sex with another HIV-positive partner. Despite much research attention, the extent and consequences of superinfection remain unclear.¹³

A greater concern for many is that unprotected sex, including oral sex, can lead to transmission of STDs other than HIV. A 2009 Berlin study found that HIV-positive gay and

bisexual men who used serosorting as their risk-reduction method were 4.3 times more likely to have a bacterial STD than those who used condoms or monogamy as their strategy and 3.7 times more likely to have a bacterial STD than those who used other strategies or no strategy to reduce risk at all.¹⁴ In fact, one of the signs that led researchers to suspect that serosorting was going on among men who have sex with men was that flat HIV infection rates in some places such as San Francisco occurred at the same time as dramatic increases in rates of other STDs such as syphilis.¹ Counselors talking with clients about serosorting can help both HIV-positive and HIV-negative clients think through the possible health consequences of STD exposure and how to avoid it. For example, a good regimen for serosorters is to undergo regular STD screenings (and treatment, when necessary) to minimize damage to their health.

Serosorting for Negatives

Serosorting among people who believe that they are HIV-negative is much more complicated than it is among people who know that they are HIV-positive, for reasons that are explored below. Further, the data about whether HIV-negative serosorting works are mixed. One 2009 Seattle study, using mathematical modeling, found that serosorting could be an effective harm reduction strategy, potentially reducing serodiscordant sex acts from 50 percent of contacts to 22 percent of contacts.¹⁵ A 2009 University of Connecticut review of 51 serosorting-related studies, however, suggested that attempted serosorting often fails. According to the authors, HIV-negative men who rely on sero-

sorting alone “are inadvertently placing themselves at risk for HIV.”⁸

A 2008 study of Seattle men who have sex with men who attended an STD clinic found that serosorting among HIV-negatives had some limited protective value. Men who had unprotected anal intercourse only with other men they believed to be HIV-negative were less likely to seroconvert (2.6 percent) than men who had unprotected anal intercourse with partners they knew to be HIV-positive (4.1 percent), but the serosorting men were more likely to seroconvert than men who tried to use condoms consistently for anal sex (1.5 percent).²

For HIV test counselors, this suggests that, as always, context is key. HIV-negative clients who replace consistent condom use with condomless serosorting for anal sex are likely to increase their risk of contracting HIV. HIV-negative clients who go from having unprotected anal intercourse with HIV-positive partners to unprotected anal intercourse with partners believed to be HIV-negative are likely to decrease their HIV exposure.^{2,16}

There are several reasons why HIV-negative serosorting is more challenging than it is for HIV-positive people:

People who have tested HIV-positive have tested. Sometimes people who have never tested for HIV assume that they are HIV-negative, when in fact they are HIV-positive. Such people are more likely to have a viral load that is not suppressed by medication, which could make them more infectious than people on effective HIV antiviral treatments.^{17,18} It is also true that some people who assume that they are HIV-positive have never tested, which underscores the importance

of testing for any serosorting plan. In fact, researchers note that one of the most crucial factors determining how well serosorting can work in a given population is the estimated number of people who might have undiagnosed HIV. This estimate, in turn, depends on how widespread and frequent HIV testing is in that population.¹⁶ The greater the number of people in a community who know their status, the better the chances that serosorting will be an effective intervention.

Remember the window period? A person could receive an HIV-negative antibody test result and still be in “the window period.” The window period is the time before the person’s body has had a chance to develop antibodies that fight off HIV infection. If a person who tested HIV-negative during the window period was actually HIV-positive, he or she would be in the highly infectious period known as “acute infection.” During this time immediately after infection, the virus multiplies rapidly and is especially easy to transmit to others.^{19,20} This means that a person might honestly believe that he is HIV-negative, and might disclose his “negative” status to partners, but be even more infectious than someone who has been HIV-infected for longer.²¹ This is a key reason why it is so important for counselors to clearly and correctly explain the window period to clients. Some researchers suggest that serosorters test frequently using HIV RNA testing, but this test is not available in many places.

HIV-positive status doesn’t change, but HIV-negative people have to keep testing. Even if a person has tested HIV-negative many times, they may still be HIV-positive if they have been exposed to HIV since their last test.

In order to get a sense of the accuracy of a partner's last negative test result, a person would need to know the last time his partner tested, if he was still in the window period when he tested, and if he might have been exposed to HIV since that last test. A 2009 literature review suggests that many men who have sex with men do not test frequently enough to be sure of their HIV-negative status, instead relying on test results from more than a year

2007 Seattle study found that 20 percent of HIV-positive subjects reported telling at least one sexual partner that they were HIV-negative after they had already received an HIV-positive diagnosis.²⁴

It's hard to wait for a final answer, especially when you're in a relationship. Often, people who enter relationships decide to stop using condoms as a sign of trust and intimacy, and a way to enhance sexual pleasure.

A recent Seattle study found serosorting to be more effective at preventing HIV seroconversion than using no strategy at all, but less effective than consistent condom use.

in the past, despite potential HIV exposure since that time.⁸

The stigma of saying "I'm positive" can make disclosure difficult. Rather than asking questions that might lead to disclosure, some HIV-negative men rely on HIV-positive men to volunteer their status. But the stigma associated with identifying as HIV-positive may make such disclosures difficult—especially when it is clear that the price of disclosing HIV-positive status is no sex.²² A 2003 survey of British gay men found that more than one-third of HIV-negative respondents “both expected a positive partner to disclose their status prior to sex and would not want to then have sex if they did.”²³

Relying on the other person to disclose status may not work: A 2009 literature review found that as many as one in three HIV-positive men who have sex with men have had unprotected anal sex without disclosing their HIV status to their partners. A

But to truly serosort in a relationship between HIV-negative people, all of the concerns discussed above must be addressed: both partners must test and feel comfortable honestly disclosing their status to each other; neither partner was still in the window period at the time of the last test, nor has either partner been exposed to HIV since the last test. They must also decide how to handle the possibility of HIV exposure from outside partners during the relationship.

Helping the Client Decide

Controversy has surrounded the question of whether or not public health service providers should “recommend” or “promote” serosorting as a viable HIV risk-reduction technique. In the counseling session, the question isn't so much about promoting a particular strategy as it is about helping the client make conscious choices about behavior.

For example, the counselor can ask a client who reports same-status partners how he finds out his partners' status. For example, a counselor might say: “Sometimes people tell me that they talk everything out. They talk about their own testing, and they ask the other person about theirs. Other people tell me that they can figure out someone's status in other ways. How do you decide?” Or a counselor might say: “Sometimes people have a hard time talking about HIV status with their partners. It sounds like that in the club you're going to, there's not a lot of conversation. How would someone let you know that he was positive?” Or a counselor might ask: “How do you handle it when you meet someone who's positive and you want to have sex with him?” Counselors can also ask clients if they have a backup strategy such as condoms or oral sex, if the guy they want to have sex with turns out to be the opposite status.

Counselors can also help clients explore how testing fits into the client's serosorting strategy and how confident the client is that he will remain HIV-negative using this strategy. As the research cited above suggests, whether or not serosorting is a beneficial strategy for an individual client depends on what the client would do if he were not serosorting. Is serosorting replacing a higher-risk or a lower-risk behavior? Equally important, the success of this harm reduction strategy is dependent not only on ongoing testing and honest communication, but also on whether or not the discovery of a potential partner's status is based on a conversation or on only an assumption. ■

A Counselor's Perspective



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I haven't heard people use the term "serosorting" much, but the idea goes back to the beginning of the epidemic, when some HIV-negative guys said that

they wouldn't have sex with HIV-positive guys, because they were so afraid of the virus, and there wasn't any treatment. Later, positive men wanted to have sex with other positive men—they didn't want their own or other guys' anxiety about infection to ruin sex, and they didn't want it on their conscience that they could be infecting someone.

Now, in the session, when HIV-negative guys say that they wouldn't want to have sex with someone positive, I explore that—I ask them, "How do you decide that a guy is negative?" A lot of times, people aren't going into much detail—they're afraid of turning a date or a sexual encounter into an interview. It's a

difficult conversation to have—but if you don't do it, how would you really know your partner's status?

Here in San Francisco, there's a big push to talk about status, and that's important—but when people are making decisions about sex, it's more complicated than just talking about status. Just because you say you are both negative, does that mean throw away the condoms right away? Sometimes clients will say that it's important to have a sense of trust with your partners, and that opens up a conversation about how you get to trust somebody—for example, is that something that you can do right away, or something that happens over time? ■

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Test Yourself

Review Questions

1. True or False: One of the key reasons that people choose to serosort is so that they can reduce the risk of HIV transmission without using condoms.
2. Many people decide that their partners are of the same HIV status as they are based on how the partners look or act, rather than an actual conversation. This process is called: a) serosorting; b) serocategorizing; c) seroguessing; d) serodisclosing.
3. True or False: HIV-positive people have a more difficult time serosorting accurately than HIV-negative people do.
4. True or False: Serosorting is one kind of sexual harm reduction.
5. Some of the complications of serosorting for people who believe they are HIV-negative include: a) when they and their partners last tested; b) whether they or their partners could have been in the window period at the last test; c) whether their partners would feel comfortable telling them if they were HIV-positive; d) all of the above.
6. Even if they serosort accurately, HIV-positive people still may be exposed to some health risks through unprotected sex. According to the article, perhaps the greatest of these concerns is: a) HIV superinfection; b) sexually transmitted infections other than HIV; c) transmitting HIV to HIV-negative people; d) none of the above.

Discussion Questions

1. Do you hear clients talking about only or primarily having sex with people who are also HIV-negative in an effort to stay HIV-negative? If so, how do these clients determine the status of their partners? Would you describe their strategies as being more like “serosorting” or “seroguessing”?
2. How do you talk with clients about their “risk tolerance”—that is, what level of risk they are comfortable taking when they engage in behaviors that might expose them to HIV?
3. Some people believe that, because of the difficulties involved in serosorting for HIV-negatives, HIV-positive people are the only ones who can truly serosort. What do you think? How can counselors present information about serosorting in a way that acknowledges its complexities, and still stays client-centered?
4. How might you talk with a client who is excited about having started a new relationship with a partner who is also HIV-negative, and who is ready to stop using condoms?

Answers to Review Questions

1. *True.*
2. *c.*
3. *False. While HIV-positive serosorting can have complications, it is much more difficult for HIV-negative people to serosort accurately than for HIV-positive people to do so.*
4. *True.*
5. *d.*
6. *b.*



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