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Aids Prevention through Printed Media: Knowledge and Communication Behaviors of Gay College-Aged Males

Cheryl L. Knight
Western Michigan University

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AIDS PREVENTION THROUGH PRINTED MEDIA: KNOWLEDGE AND
COMMUNICATION BEHAVIORS OF GAY COLLEGE-AGED MALES

by

Cheryl L. Knight

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Master of Arts
Department of Psychology

Western Michigan University
Kalamazoo, Michigan
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AIDS PREVENTION THROUGH PRINTED MEDIA: KNOWLEDGE AND
COMMUNICATION BEHAVIORS OF GAY COLLEGE-AGED MALES

Cheryl L. Knight, M.A.

Western Michigan University, 1989

AIDS prevention research has established the effectiveness of multiple component group interventions. It has not identified whether the effectiveness is due to the format of the intervention (i.e., rehearsal, feedback, etc.) or its instructional content. This study investigates the impact of instructional content delivered in the inexpensive and readily obtained printed medium. Thirteen gay or bisexual college-aged men received an information pamphlet and an AIDS-related communication skills training booklet. Subjects were evaluated on measures of knowledge, safe and risky behaviors, and communication behaviors in each of three assessment sessions. Visual analyses and repeated measures analyses of variance did not support evidence of change on any measures. Rank order of behaviors at pre- and postintervention demonstrated little change. Implications for future investigations relevant to the printed medium and AIDS prevention behavior change programs are discussed.

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CHAPTER I

INTRODUCTION

Acquired Immune Deficiency Syndrome (AIDS) is a devastating disease that impairs the functioning of the body's immune system, leaving an individual vulnerable to a variety of "opportunistic" diseases. At present, there is no known cure or vaccine for AIDS, making prevention the only viable public health alternative (Kelly & St. Lawrence, 1987).

A number of risk factors (i.e., behaviors) for AIDS infection have been identified. Among them are any form of intercourse (i.e., anal, oral, or vaginal) without use of condoms (Calabrese & Gopalakrishna, 1986; Kelly & St. Lawrence, 1988; Lederman, 1986) and frequent sexual encounters with different partners (Francis & Chin, 1987). The transmission of AIDS has also been correlated with intravenous drug use (DesJarlis, Friedman, & Hopkins, 1985).

Research in AIDS prevention has focused on change of these behavioral risk factors. McKusick, Horstman, and Coates (1985) investigated change in the sexual behavior of gay men in a community that implemented a number of education interventions for AIDS prevention. Interventions available to the community at the time of the

study included the distribution of educational material and condoms, and educational workshops in bars, community meetings, and private homes (Kelly, St. Lawrence, Brasfield, & Hood, 1988). Based on self-report of retrospective and current sexual behavior, MuKusick, et al. (1985) found evidence of some behavioral change in risk factors and a high level of knowledge about AIDS and HIV transmission. However, a sizeable number of men who exhibited knowledge of risk behaviors continued to engage in those same behaviors which placed them at risk of HIV transmission.

Researchers (Kelly & St. Lawrence, 1987; Kelly & St. Lawrence, 1988; McKusick et al., 1985) responded to discrepancies between reported knowledge of risk behaviors and continued practice of risky sexual behaviors by recommending the use of interventions in health related behavior change (i.e., cigarette smoking; excessive eating; alcohol abuse; seatbelt use; etc.) to reach that part of the population which does not respond to knowledge alone. A study by Kelly, St. Lawrence, Brasfield, and Hood (1989) examined the application of these methodologies to AIDS prevention.

Kelly et al. (1989) developed a group intervention for gay men consisting of education, cognitive and behavioral training, assertion training, and personal development of social support systems. In comparison

with a waiting-list control group, the intervention group exhibited higher levels of knowledge, ability to refuse sexual propositions, and "safer sex" activities, and lower levels of risky sexual practices.

While participation in multifaceted behavioral intervention groups is effective, it requires individuals willing to identify themselves as likely to engage in risky behaviors and communities willing to finance such interventions (Siegel et al., 1986). In cases where these two conditions are not being met, another alternative may be required.

The majority of AIDS prevention efforts have focused on the provision of printed AIDS information to at-risk individuals (Siegel et al., 1986). Existing printed materials on AIDS prevention typically involve descriptions of the virus, methods of transmission, alternative behaviors, symptoms of the disease, and information on being tested for the virus (Seigel et al., 1986).

Unfortunately, little is known about whether the provision of AIDS prevention information in printed form produces any change in risky behaviors. The McKusick et al. (1985) study described above constitutes the best investigation of AIDS information interventions. It provided an excellent sampling of descriptive information at a time when AIDS prevention efforts were being conceived. However, it's reliance on retrospective self-

report and the chance provision of information in education programs of varying media (i.e., printed materials, workshops, etc.) does not render the results interpretable with regard to the effectiveness of printed information as AIDS prevention. Therefore, a systematic evaluation of the effects of printed information as an AIDS prevention intervention is indicated.

Research (Kelly et al., 1989) demonstrating the effectiveness of a multiple component intervention suggests the need for more than simple provision of information about AIDS and HIV. However, it is unclear whether the Kelly et al. (1989) intervention was effective because it contained instruction about a variety of AIDS prevention skills or because of its format--a format that included programmed rehearsal, instructor feedback, etc.

One way to resolve the confound between instructional content and instructional format is to present information about AIDS prevention skills without the use of programmed rehearsal or feedback to help determine the extent to which skill instruction alone can impact on AIDS-related behaviors. This can be accomplished by presenting communication skills instruction in a printed format without programmed behavior (i.e., rehearsal and feedback).

Assertiveness training, a central skill of the Kelly, et al. (1989) intervention package, can be presented in the printed medium. Elements of assertiveness training amenable to a printed format include basic instruction and written modelling of communication relevant to AIDS prevention. A booklet containing these elements of assertiveness training was developed for this study. Because the written modelling of communication responses required examples of very detailed and specific messages, the booklet was developed for a target audience. The target audience chosen for the study was gay men of college age.

This target population was selected for two reasons. Despite a growing incidence of HIV infection among intravenous drug users, heterosexual males and females, and children born to mothers with AIDS, the majority of AIDS cases continues to be concentrated among gay men (Kelly & St. Lawrence, 1986). Secondly, men of college age may be at additional risk for the contraction of HIV. Male college students, irrespective of sexual orientation, are reported to have both relatively high levels of sexual activity, including intercourse, and a high potential for multiple partners (e.g., Keller, Elliot and Gunberg, 1982). Therefore, gay or bisexual male college students potentially comprise a population in need of AIDS prevention intervention.

This study will assess the impact of written materials containing AIDS information and AIDS-related communication skills on AIDS relevant knowledge, attitudes, and behaviors of gay or bisexual males. The results are important in determining whether the promising results reported by Kelly et al. (1989) can be produced by an intervention using a similar communication/assertiveness skills component delivered within a more economical, written format.

CHAPTER II

METHOD

Subjects

Thirteen gay or bisexual males were recruited through advertisements in a university newspaper and a city newspaper. With the assistance of local Gay Community leaders, flyers describing the study were included in a mailing of a local gay/lesbian newsletter, and were distributed at three local meeting places of the gay community.

After reading and signing an Informed Consent (see Appendix A), and providing demographic information, subjects were blindly assigned to one of two groups matched for sexual orientation, education, and relationship status. Three subjects identified themselves as bisexual and ten as gay or homosexual.

Ages ranged from 18 to 36 and all were white. Subjects reported a range of education from high school graduation to postgraduate study. At the initial interview, 2 subjects described themselves as abstinent, 4 were in mutually monogamous relationships, 3 conducted serial mutually monogamous relationships, and 4 were sexually active with multiple partners. During the final

assessment sessions, 2 subjects spontaneously reported changes in these descriptions. One reported a change from abstinence to a mutually monogamous relationship and another subject reported a decision to engage in exclusively heterosexual activities.

Subjects who completed four sessions were paid \$15.00. Two subjects, who were assigned to different groups, did not complete the final evaluation. They were not available to provide comment.

Setting

All subjects were assessed in a university-affiliated psychology laboratory, with one exception. One subject unable to remain in the area for follow-up assessment was visited at another university-affiliated psychology laboratory in close proximity to his temporary residence.

The room used for assessment sessions was well-lighted, private, and contained a variety of office furniture. A desk and chair were used by subjects when writing was required. Two tape recorders were arranged beside an upholstered chair, where subjects sat for communication skills assessments.

Materials

A Craig audio cassette tape recorder, model J102, was used to present all role play stimuli. An Audio-tronics audio cassette tape recorder, Classette 152, was used to record the entire contents of each communication assessment session, i.e., the role play stimuli as presented to the subject followed by subject responses to the stimuli. All role play stimuli were also recorded on the Classette 152.

Procedure

Dependent measures consisted of two types of evaluation measures: self-report measures of AIDS-related knowledge, perceived risk for AIDS, and behavior; and role play assessments of communication skills relevant to AIDS prevention.

AIDS Questionnaire

A questionnaire (See Appendix B) assessed subjects on their knowledge about AIDS and "safe sex", and AIDS-related behaviors.

Thirty-two questions assessed knowledge of current facts about AIDS and HIV and its transmission. A "Knowledge" score was determined by calculating the number of questions answered correctly. A five-point

Likert scale endorsement of three items identified perceived risk for contracting AIDS/HIV. The "Risk" score was calculated by adding point values assigned to individual items and corresponding scale points, with a higher, positive number indicating a higher degree of perceived risk, and a lower, negative number indicating a lower degree of risk. Subjects were also asked to report number of previous sexually transmitted diseases, number of persons known by them who have AIDS, and number of persons subjects knew who have died as a result of complications from AIDS. These items were scored as "STD's", "PWA's", and "Deaths of PWA's", respectively, with raw data constituting the individual scores.

A behavior checklist presented 28 items and an "Other" category all related to AIDS and HIV transmission (i.e., anal receptive intercourse without a condom; oral insertive intercourse with a condom; using clean needles to inject drugs; etc). Seventeen items were "safe" behaviors and 11 were "risky". Items reported as "Other" were considered on an individual basis and placed in either the "safe" or "risky" category. These items were presented in an order so that the "safe" or "risky" status of the behavior was not immediately apparent.

These behaviors were reported as frequency-per-week, either through in-session assessment or by mailing the checklists to the researcher on a weekly basis. At

initial assessment, behaviors were reported as frequency-per-four-weeks and later converted to frequency-per-week (i.e., divided by four).

A "Safe Sex" score and a "Risky Sex" score was calculated for the endorsement of the respective items. A percentage of activities was determined by dividing the number of "safe" or "risky" activities per week by number of "safe" plus "risky" behaviors per week (see Appendix B for sample scoring protocol).

Communication Skills Assessment

Subjects' abilities to communicate with peers and prospective sex partners about AIDS and "safe sex" behaviors were directly assessed in role plays of typical situations where such discussion should or could occur. During each of three assessment sessions, each subject was presented three tape-recorded role plays.

The role play situations were developed to fall into one of two categories: refusal of an unwanted or risky sexual proposition; and verbal initiation of "safe sex" discussion or "safe sex" activity. A local writer/actor, who was involved in a local organization providing services to Persons With AIDS (PWA's), developed and assisted in writing these role plays. He read and tape-recorded all of the scenarios.

Three "standard" role plays were developed and recorded for initial assessment purposes. These scenarios were constructed to be somewhat generic in appeal to a wide audience of gay men, as all subjects received these three role plays, and one was later chosen to be presented at all subsequent sessions.

Following initial assessment and feedback from the subjects on the role plays, the actor and researcher developed and recorded four additional role plays for each subject. These four individualized role plays constituted the "novel" role play situations and, like the standard role plays, represented a variety of refusal and initiation situations. These novel scenarios were introduced to prevent habituation and rehearsal effects from repeated exposure. Because subjects came from a variety of social settings and represented a full range of lifestyles, these individualized situations were also constructed to improve the validity of subject response in an analogue setting. If subjects could not "relate" to the scenarios, it was anticipated that their responses would be even less typical than the in vivo situation. Therefore, attempts were made to create an "appealing" situation, based on subject feedback on the kinds of men they find attractive, places where they typically meet men, and approaches used by men that would interest the subjects.

To assess repeated exposure to the stimulus situation, one of the three standard role plays was selected to be consistently repeated across subjects, along with the two novel role plays presented at the second and third assessment sessions. The specific standard role play, an initiation situation, was chosen due to acceptance from subjects, based on informal report and feedback forms.

For role play assessment purposes, the actor recorded detailed descriptions of proposed physical settings, and provided a "motivation" statement for each setting (i.e., "You are interested in pursuing something more intimate with this man, but only if it includes 'safe sex'", or, "You are attracted to this man, but are not interested in anything more intimate even if it includes 'safe sex'.") In each setting, a man was present with whom the subject was "interacting". After describing these elements, the actor prompted the subject to respond verbally to the situation. The prompt consistently came in the form of, "you look at him and say"

Prior to each communication assessment, subjects were instructed to accept the setting and motivation as given to them, even though it may not have been typical for them. They were also told to respond directly to the man being described in the situation, as if they were actually experiencing the situation.

An overall communication score for each session (i.e., combined score on three role plays) was obtained by adding one point for the presence of the following items in each subject role play response: Audibility (scored in session); Noncompliance (resistance or disagreement with "risky" or unwanted proposition); Statement of Safe Sex Preference (statement of adherence to or belief in exclusively "safe sex" practices); Request "Safe" Behavior (subject asks person to engage in a specifically "safe sex" behavior); Request or State Preference for Alternate Nonsexual Activity (subject asks or states preference of an activity that is specifically free of any highly sexual content, such as dancing, dinner, etc); and Use of AIDS-Related Words (AIDS-related words: condoms; lubricant with nonoxynol-9; play safe; safe; safe sex; safety; safe lubricant; safe lube; spermicide). One point was subtracted for Compliance (agreement of acceptance of a situation identified as unwanted or risky) and for every three speech dysfluencies per role play. Latency and duration of response was recorded in cumulative seconds per session. Inter-observer agreement with an independent rater was 91.66% ($\text{Number Correct} / (\text{Number Correct} + \text{Number Incorrect})$) on a random sample of 22% of the total role play responses (24 of 108) (see Appendix B for sample scoring protocol and response definitions).

The independent variables were an AIDS information pamphlet, titled, "AIDS in Black and White" and a communication training booklet, titled, "TalkTalkTalk".

Development and Description of "AIDS in Black and White"

A review of over forty AIDS-related information pamphlets and Siegel et al. (1986) component analysis of AIDS pamphlets, resulted in the construction of a pamphlet: "AIDS in Black and White". The pamphlet presented facts on transmission of HIV, the symptoms of AIDS, a list of behaviors categorized according to risk for transmission of HIV, and a section on a range of lifestyle changes available to people interested in AIDS prevention (see Appendix C for text of the pamphlet).

Development and Description of "TalkTalkTalk"

This booklet established the importance of communicating AIDS prevention choices and then presented a range of those choices (i.e., refusing a sexual proposition; proposing an alternative nonsexual activity; proposing safe sex; initiating a mutually monogamous relationship; proposing HIV antibody testing; and limiting intake of drugs prior to sexual activity). Each of these categories was presented along with a rationale for making the associated decision, a setting for a situation in

which this decision might be required, and several sample verbal responses to the situation.

Because AIDS prevention can encompass a range of approaches (i.e., abstinence, mutual monogamy, or "safe sex" with multiple partners) the provision of alternative choices and prospective communication skills attempted to encompass major belief/value systems. Emphasis was placed on the provision of a range of acceptable choices and communication skills rather than promotion of one specific value (e.g., abstinence versus sexually active; heterosexuality versus homosexuality; etc.) (see Appendix C for text of booklet).

Social Validation of Communication Booklet

Sexual behaviors and communication about sexual behaviors are typically more private and vary according to the individual and his beliefs and values. Therefore, a social validation of the range of relevant communication skills (i.e., refusing an unwanted sexual proposition; suggest an alternate "safe sex" behavior; refuse a request by ignoring that it occurred; propose mutual HIV testing; initiate discussion of mutually monogamous relationship; initiate discussion of sexual histories; express concern and fear of AIDS; and refuse offers of drugs prior as a means of AIDS prevention) and samples of communication used to model those communication skills

was developed. An attempt was made to present a range of "good" to "bad" items so not to bias responses in any direction. The surveys were distributed by mail to 16 local "experts" after an initial telephone contact. These individuals represented the fields of human sexual behavior and communication/education, or represented the leadership of local gay organizations. "Experts" were asked to endorse each of 116 items on a five point Likert scale. Ten of these surveys were returned by mail, anonymously. Items meeting criteria (an average rating of 4.0 or above on a 5 point scale, where 5 = very important and 1 = not important at all) were used as a guide in constructing the booklet. Thirty-three percent of these items met criteria (see Appendix D for the survey and a summary of its results).

Experimental Design

Members of both groups completed three assessment phases. Upon completion of the first assessment, all members received a packet containing reading material. Subjects in Group A received the pamphlet, "AIDS in Black and White" and the booklet, "TalkTalkTalk". Subjects in Group B received an article entitled, "Living the Tradition: Gay American Indians" (Roscoe, 1987) which contained no information about AIDS or communication. Both groups completed a second assessment. One week

prior to a third assessment, subjects in Group B received the same intervention as Group A as seen in Table 1.

Table 1
Outline of Assessment Conditions

Group A

Assessment #1: Assessment (Pre-intervention) and
Receipt of Intervention

Assessment #2: Assessment (Postintervention)

Assessment #3: Assessment (4-Week Follow-Up)

Group B

Assessment #1: Assessment (Pre-intervention)

Assessment #2: Assessment (Pre-intervention) and
Receipt of Intervention 1 Week Prior to
Assessment #3

Assessment #3: Assessment (Postintervention)

Following an initial telephone contact, subjects met individually with the researcher. The first session consisted of a one hour interview. After signing an informed consent, subjects recorded demographic information and provided details to assist in the construction of individualized role plays.

All of the following sessions began with subjects completing the AIDS Questionnaire and the Communication Skills Assessment. At the close of every session,

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Group B

This group was initially given no special training intervention but experienced the same sequence of repeated assessment measures (e.g., AIDS Questionnaire and Communication Skills Assessment) as the treatment group. Subjects in Group B were assessed for knowledge, attitude and behavior change attributable to exposure to mass media coverage of AIDS and to participation in the assessment procedures of this study. One week prior to the third assessment, these subjects received the intervention given to Group A at the completion of the first assessment.

The resulting data were subjected to a repeated measures analysis of variance to determine if any change in the dependent variables across time occurred and to determine if any group differences exist. A correlational analysis between knowledge and attitudes about AIDS and relevant behavior as measured by self-report and direct observation during role plays was also conducted.

Knowledge scores, Risky Behavior and Safe Behavior scores as percentages of total behaviors were analyzed through visual display and rank orders of Safe and Risky Behavior frequencies across groups and assessments were also created.

A crosstabulation was conducted to examine the relationship between knowledge of unprotected oral sex and risky and practice of this behavior.

CHAPTER III

RESULTS

Five subjects in each group completed all three assessments. Two subjects failed to attend scheduled meetings despite repeated telephone contacts, and one set of communication data from a third subject was lost due to a technical failure of the recording equipment. Only subjects with complete data sets were included in the following data analyses.

The reading comprehension words were reported with 100% accuracy by all subjects.

Prior to any intervention (i.e, following Assessment #1), two-sample T-tests indicated no statistically significant differences between Group A and Group B on any dependent measures, $t(8) = -0.94$ to 0.99 . Therefore, there was no evidence for any differences existing between the two groups on Knowledge, Safe Behaviors, Risky Behaviors, all Communication, all Latency, and all Duration measures prior to any intervention. It was noted that Knowledge scores (maximum score = 32) were quite high for all subjects, with a range of 27 to 32 and a mean of 29.76 across all subjects. With the exception of one subject in Group B, Safe behaviors (in percentage of Safe behaviors divided by number of Risky plus Safe

behaviors) comprised over half of all behaviors (Range = 73% to 100%).

Visual inspection of all dependent measures indicated some change within groups across time on measures of percent Safe Behaviors, percent Risky Behaviors, cumulative Communication Scores (Combined, Standard And Novel), average Latency in seconds, and average Duration in seconds. Knowledge scores, however, when reported in means rounded to the nearest whole number, remained constant across groups and across time (Figure 1). A repeated measures Analysis of Variance (ANOVA) did not provide any evidence to indicate significant change either between or within groups on Knowledge scores, $F(2,13)=0.47$, $p=.63$.

The average percent of Safe Behaviors (Figure 2) decreased slightly within groups over time. These decreases were also evident at pre- and postintervention, but as part of the larger trends toward decreasing, were not as remarkable. A repeated measures Analysis of Variance (ANOVA) of groups, $F(2,13)=0.04$, $p=.96$, however, did not support the visual change between or within groups as statistically significant.

Risky Behaviors (Figure 3) increased in mean percentages within groups across time, again evident at pre- to postintervention, as part of general trends. A repeated measures ANOVA of average percent Risky Behaviors in Fig

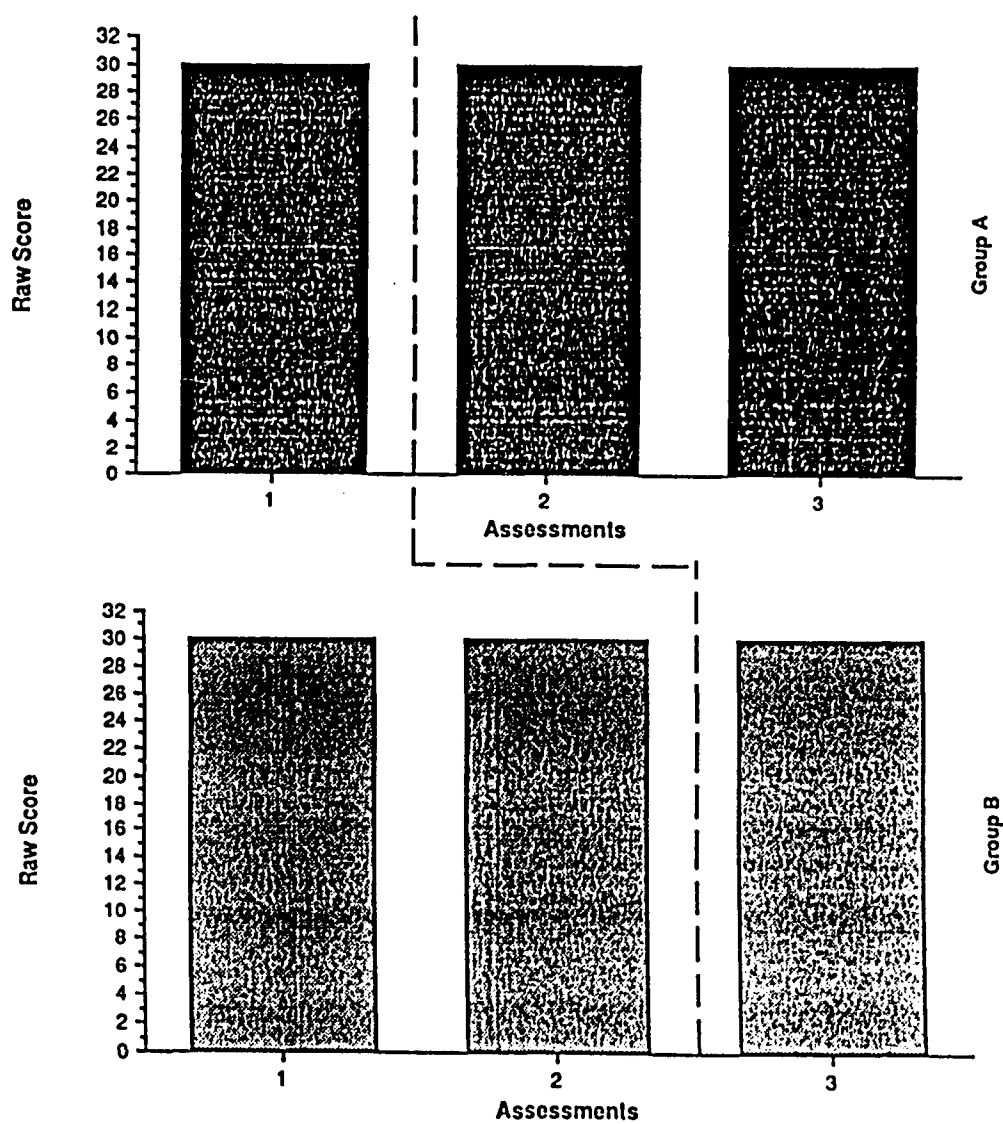


Figure 1. Mean Knowledge Score Expressed in Whole Numbers.

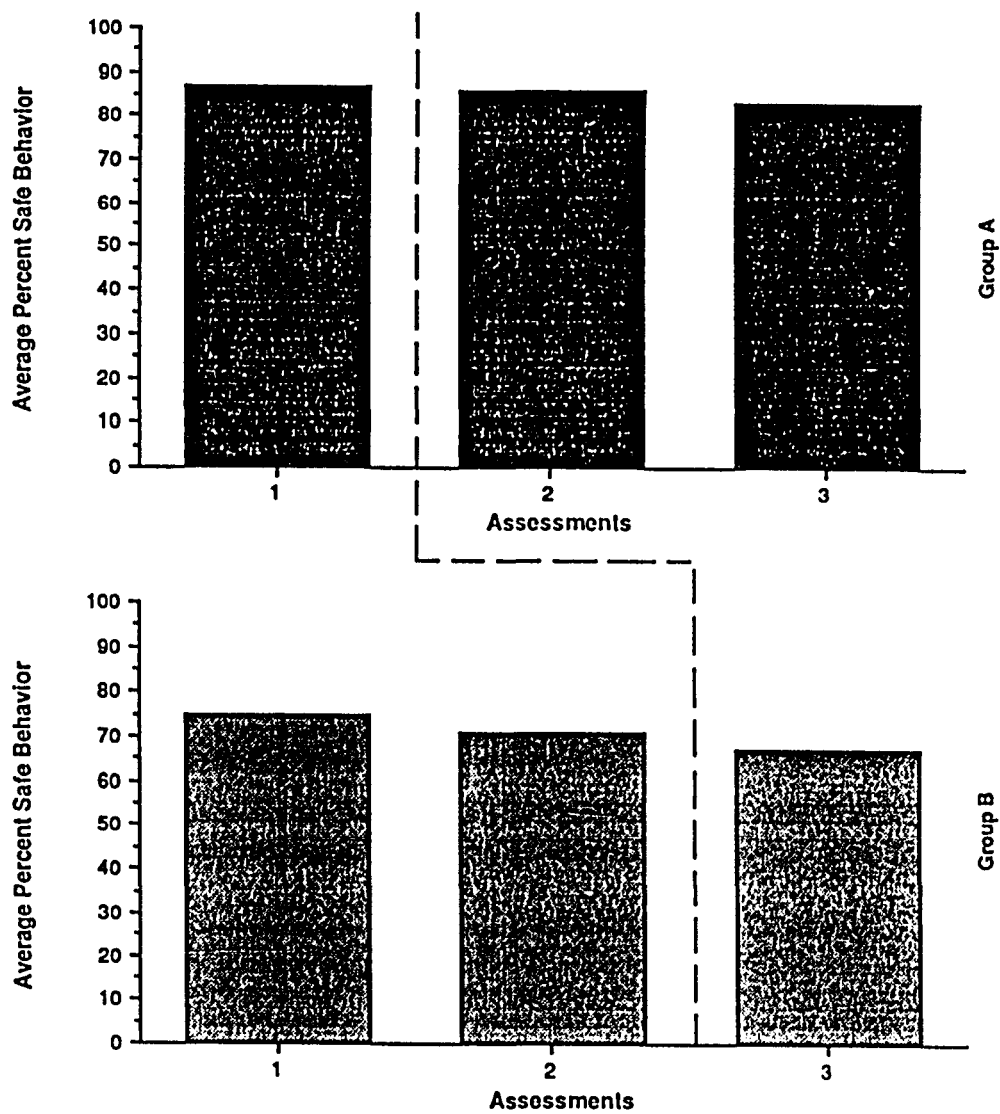


Figure 2. Mean Percent of "Safe" Behaviors.

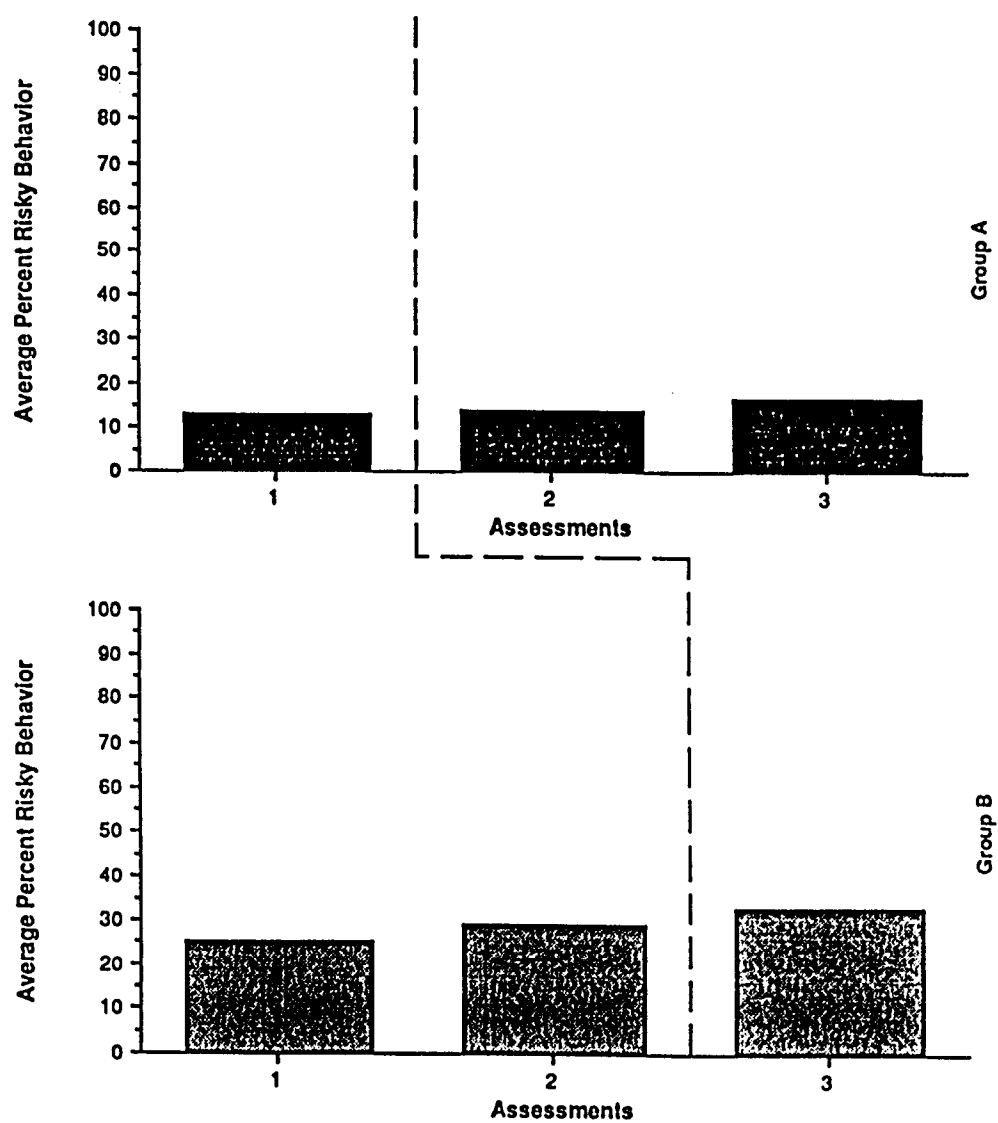


Figure 3. Mean Percent of "Risky" Behaviors.

groups across time did not attain statistical significance, $F(2,13)=0.01$, $p=.99$. Therefore, these visual trends within groups were not supported by statistical analysis of change either within or between groups.

Cumulative raw (i.e., addition of scores of all subjects within groups, per assessment) Communication scores (Combined, Novel, and Standard role plays) demonstrated only minor changes across time, with a higher score indicating the incorporation of more communication elements. Combined Communication scores (Figure 4) of both groups increased slightly during Assessment #2 and then decreased at Assessment #3, with the general pattern exhibited across time rather than according to intervention. The group receiving the intervention at a later date, unlike the group which received the intervention at an earlier date, however, decreased at Assessment #3 to a level below that of Assessment #1. A repeated measures ANOVA between and within groups across time, however, could not support the visual analysis with statistical significance, $F(2,13)=0.31$, $p=.74$.

Novel Communication role play scores exhibited a similar trend as Combined Communication scores (i.e., increase at Assessment #2 followed by a decrease at Assessment #3), across time rather than across treatments. The Standard Communication scores exhibited a slightly different pattern than their Combined and Novel

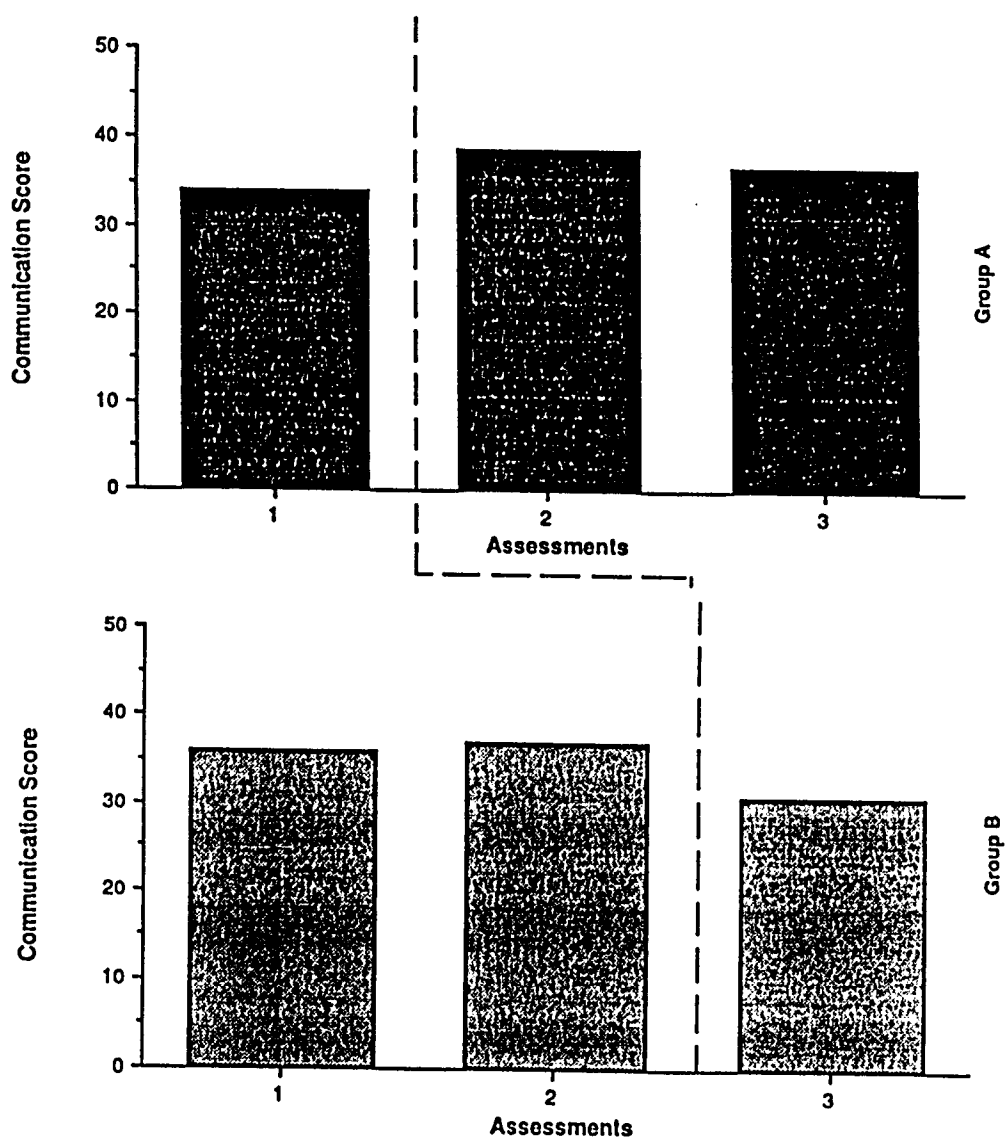


Figure 4. Communication Scores of all Responses for all Role Plays, Totalled per Assessment Session.

counterparts. Group A remained stable from Assessment #1 to Assessment #2, the post-intervention measure, but then increased by 3 points at Assessment #3. Group B, which also remained stable from Assessment #1 to Assessment #2 (the two baseline assessments), dropped 1 point at Assessment #3. All of these changes, however, when statistically analyzed with a repeated measures ANOVA, were not supported as significant (i.e., Novel: $F(2,13) = 0.09$, $p = .91$; Standard: $F(2,13) = 0.36$, $p = .70$).

The general trend of all average Latency scores (in seconds) on Combined role plays (Figure 5), Novel role plays, and Standard role plays, was a general decrease across time in groups regardless of receipt of intervention. The single exception was a slight increase of less than 3 seconds on Novel role plays in Group A at postintervention. Repeated measures ANOVA's conducted across all groups on all three types of Latency measures, did not provide evidence to support the significance of these changes, within or between groups, $F(2,13) = 0.02$, $p = .98$ (Combined); $F(2,13) = 0.09$, $p = .91$ (Novel); and $F(2,13) = 0.47$, $p = .63$ (Standard).

Measures of average Duration in seconds (Combined role play, Novel role plays, and Standard role plays) did not exhibit any singular pattern. Combined role play Duration (Figure 6) increased across time within both groups, unrelated to intervention. Standard Duration

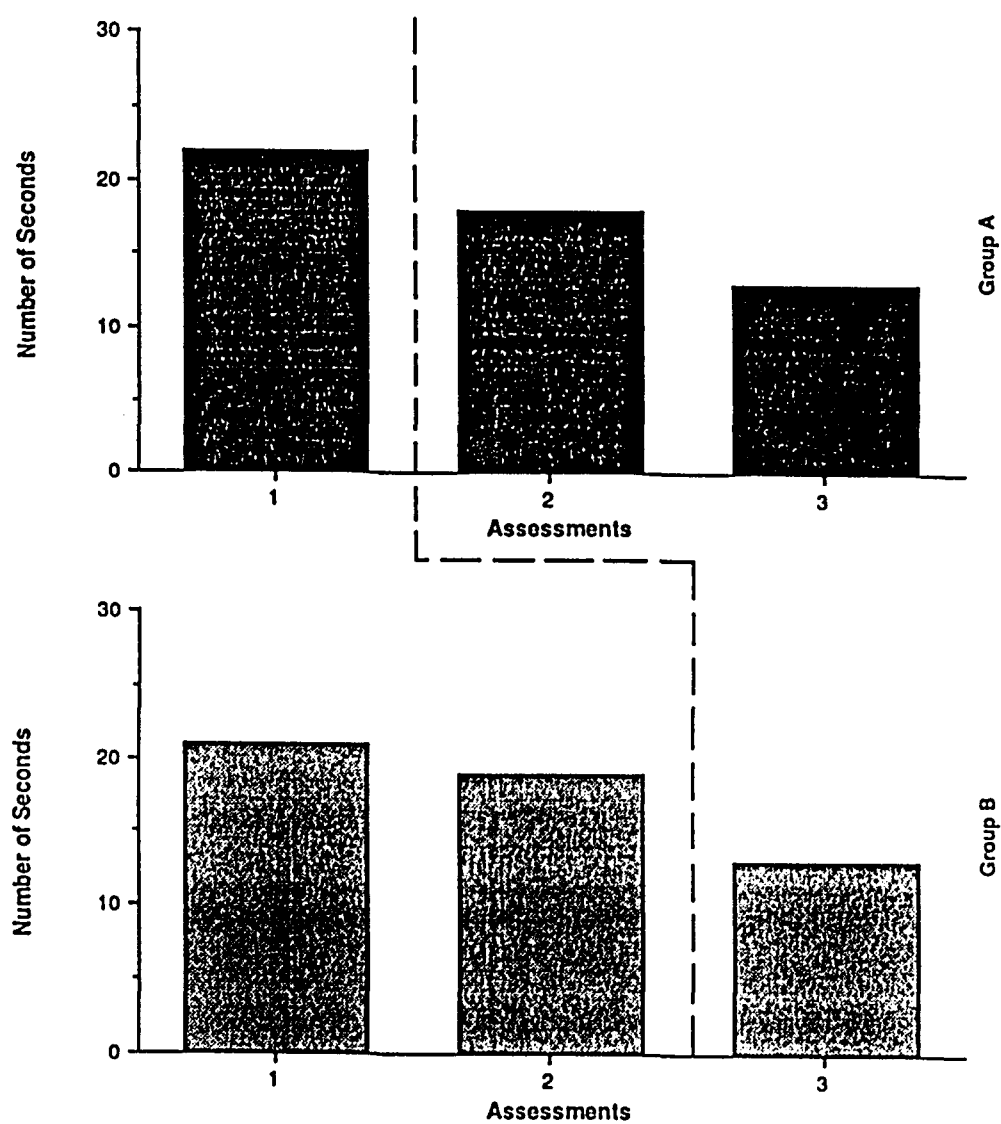


Figure 5. Mean Latency in Seconds of all Responses for all Role Plays Totaled per Group Within Assessment Session.

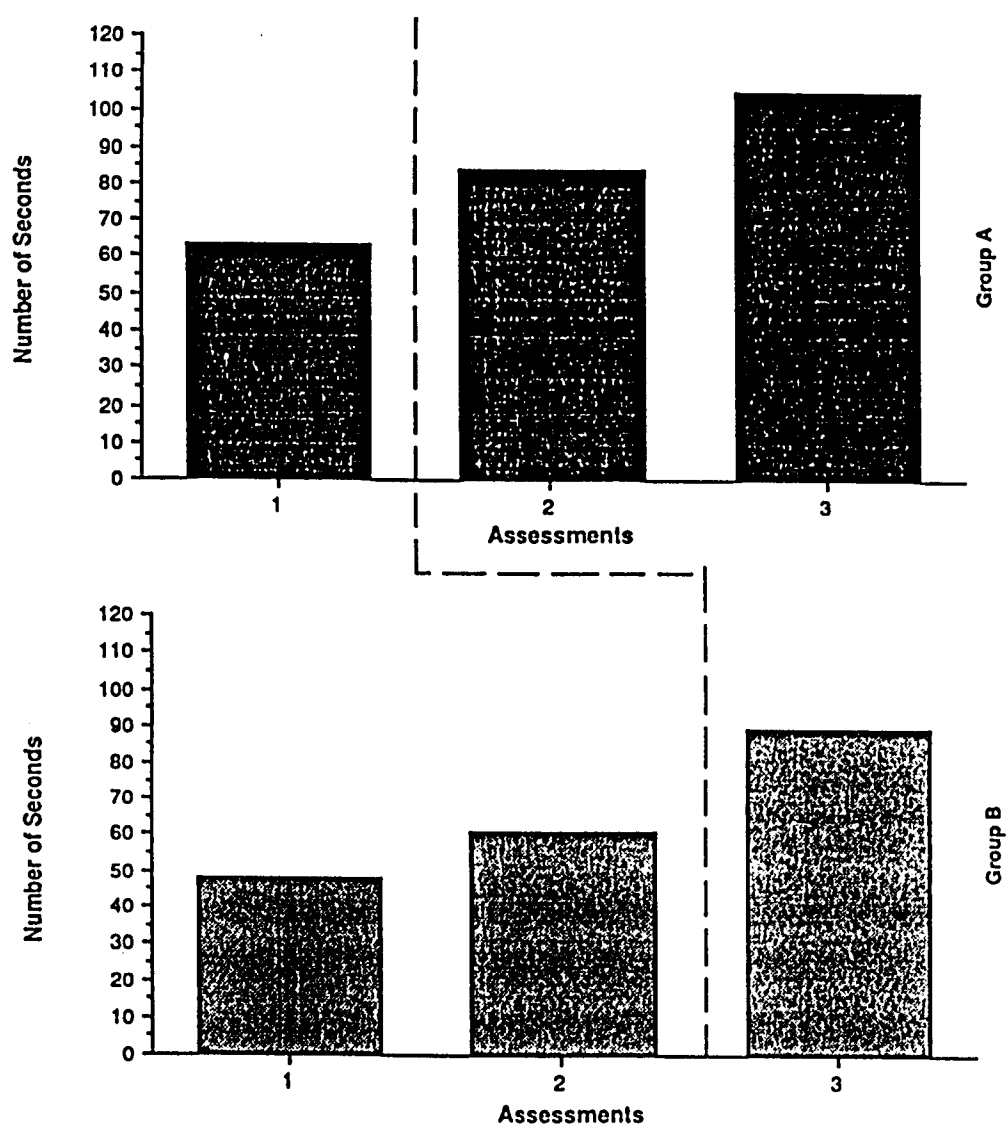


Figure 6. Mean Duration in Seconds of all Responses for all Role Plays Totalled per Group, Within Assessment Session.

exhibited a similar pattern. Novel Duration, however, exhibited no uniform trend across groups. Instead, it increased across time in the group receiving the earlier intervention. In the group receiving the delayed intervention, duration increased at the second assessment (approximately 32 seconds) and then decreased slightly (approximately 5 seconds) at postintervention. When all duration measures were subjected to a repeated measures ANOVA, the resulting statistics could not support any of these changes as significant: $F(2,13)=0.02$, $p=.98$ (Combined); $F(2,13)=0.03$, $p=.97$ (Standard); and $F(2,13)=0.04$, $p=.96$ (Novel).

A final statistical analysis was conducted with all of the above-mentioned measures. A one-sample T-test was applied to all data within groups on difference in pre- and postintervention assessment. None of the pre- and postintervention changes reached statistical significance, $t(4)=-5.29$ to 2.08 .

A Rank Order of Safe and Risky Behaviors, using raw data of all subjects at Assessment #1 and Assessment #3 (see Table 2) and then within groups at pre- and postintervention (see Tables 3 and 4) demonstrated some changes. Ranks encompassing all subjects at Assessments #1 and #3 (see Table 2) demonstrated little change in rank of the top three Safe Behaviors (i.e., solitary masturbation, drug injection with clean needles, and

Table 2
Rank Order of Behaviors: Safe or Risky
Pre- and Postintervention

<u>Safe Behaviors</u>	<u>Pre</u>		<u>Post</u>	
	Rank	n=	Rank	n=
Solitary masturbation	1	43.75	1	43
Drug injection with clean needles	2	12.00	3	12
Social interaction	3	8.50	2	16
Insertive anal intercourse: condom	4	6.75	-	0
Receptive anal intercourse: condom	5	6.50	<u>4</u>	6
Receptive anal intercourse: condom & nonoxynol-9	6	6.25	6	1
Insertive anal intercourse: condom & nonoxynol-9	7	5.50	-	0
Mutual masturbation	8	4.75	<u>4</u>	6
Frottage	9	1.50	<u>5</u>	5
Sex toys with a friend, not shared	<u>10</u>	.75	-	0
Sex toys alone (Other)	<u>10</u>	.75	-	0
French kissing (Other)	<u>11</u>	.50	-	0
Receptive oral intercourse: condom	<u>11</u>	.50	<u>5</u>	5
Insertive oral intercourse: condom	12	.25	-	0

Table 2--Continued

<u>Risky Behaviors</u>	<u>Pre</u>		<u>Post</u>	
	Rank	n=	Rank	n=
Unprotected insertive oral intercourse	1	10.75	1	10
Unprotected receptive oral intercourse	2	8.25	2	9
Drugs prior to sex	3	4.25	<u>6</u>	1
Unprotected receptive anal intercourse	4	3.75	3	6
Unprotected receptive digit insertion in anus	5	2.25	<u>5</u>	2
Unprotected insertive digit insertion in anus	6	1.75	4	3
Unprotected receptive tongue insertion in anus	<u>7</u>	.50	<u>5</u>	2
Ingestion of urine (Water sports) (Other)	<u>7</u>	.50	<u>6</u>	1
Unprotected insertive tongue insertion in anus	<u>8</u>	.25	<u>6</u>	1
Unprotected insertive anal intercourse	<u>8</u>	.25	-	0

Note. All Subjects with complete data sets.

Table 3
Rank Order of Behaviors: Safe or Risky
Pre- and Postintervention

<u>Safe Behaviors</u>	<u>Pre</u>		<u>Post</u>	
Group A	Rank	n=	Rank	n=
Solitary masturbation	1	28.00	1	26
Drug injection with clean needles	2	12.00	3	12
Social interaction	3	9.25	2	13
Insertive anal intercourse: condom	4	4.75	<u>5</u>	4
Receptive anal intercourse: condom	<u>5</u>	4.00	<u>4</u>	5
Receptive anal intercourse: condom & nonoxynol-9	<u>5</u>	4.00	<u>4</u>	5
Insertive anal intercourse: condom & nonoxynol-9	6	3.5	<u>5</u>	4
Mutual masturbation	7	3.25	<u>4</u>	5
Sex toys alone (Other)	8	.75	-	0
Sex toys with friends, not shared	9	.5	6	2
Receptive oral intercourse: condom	<u>10</u>	.25	-	0
Frottage	<u>10</u>	.25	-	0
Flirting (Other)	-	.0	7	1

Table 3--Continued

<u>Risky Behavior</u>	<u>Pre</u>		<u>Post</u>	
<u>Group A</u>	Rank	n=	Rank	n=
Drugs prior to sexual activity	1	3.5	<u>2</u>	4
Unprotected receptive oral intercourse	2	3.25	<u>2</u>	4
Unprotected insertive oral intercourse	3	2.5	<u>3</u>	3
Unprotected insertive digit insertion - in anus	4	1.5	<u>3</u>	3
Unprotected receptive digit insertion - in anus	5	1.25	1	5

Note. All subjects with complete data sets.

social interaction). There was quite a change, however, in the rank of insertive oral intercourse with a condom from a tied 11th rank at Assessment #1 to a tied 5th rank as Assessment #3. The top two Risky behaviors (unprotected insertive oral intercourse and unprotected receptive oral intercourse) remained relatively unchanged, however, there was a decrease in the frequency of "Drugs prior to sex" from it's number 3 rank at Assessment #1 to a tied number 6 rank at Assessment #3. Unprotected receptive anal intercourse remained relatively stable in rank (i.e., 4 at Assessment #1 and 3 at assessment #3). Finally, unprotected receptive digit insertion in the anus jumped from a rank of 5 at pre-intervention to a rank of 1 at postintervention for Group B in Table 4.

Table 4
Rank Order of Behaviors: Safe or Risky
Pre- and Postintervention

Group B	<u>Pre</u>		<u>Post</u>	
	Rank	n=	Rank	n=
<u>Safe Behaviors</u>				
Solitary masturbation	1	36	1	30
Social interaction	2	11	2	6
Receptive anal intercourse: condom	<u>3</u>	3	<u>3</u>	5
Receptive anal intercourse: condom & nonoxynol-9	<u>3</u>	3	-	0
Mutual masturbation	<u>3</u>	3	4	4
Receptive oral intercourse: condom	<u>4</u>	2	<u>3</u>	5
Frottage	<u>4</u>	2	<u>3</u>	5
Receptive digit insertion in anus	-	0	<u>3</u>	5
<u>Risky Behaviors</u>				
Unprotected insertive oral intercourse	1	10	1	9
Unprotected receptive oral intercourse	2	6	2	8
Unprotected receptive anal intercourse	3	4	3	6
Unprotected insertive tongue insertion in anus	4	2	<u>5</u>	1
Unprotected insertive anal intercourse	<u>5</u>	1	-	0
Unprotected receptive digit insertion in anus	<u>5</u>	1	<u>5</u>	1
Unprotected receptive tongue insertion in anus	<u>5</u>	1	<u>4</u>	2

Note. All subjects with complete data sets.

Because of the high frequency of unprotected oral sex and the availability of a Questionnaire item addressing knowledge of unprotected oral sex as a risky behavior, a crosstabulation was conducted to examine the relationship between knowledge and practice of risky behavior. A crosstabulation of correct knowledge and incorrect knowledge with practice and no practice of oral sex indicated that 97.3% of subject responses (n=37) were correct: i.e., oral sex without a condom is risky. However, of those who answered the question correctly, half also reported the practice of unprotected oral intercourse.

Kendall Rank correlations between perceived risk and number of STD's, number of PWA's known by subjects and number of PWA's known by subjects who have died as a result of AIDS at Assessment #1 did not support any significant relationship between these factors (STD's: $r = -0.02$, $p = .91$; PWA's: $r = -.45$, $p = .02$; and Deaths: $r = -.34$, $p = .04$). Additional correlations between knowledge and safe behaviors, and knowledge and risky behaviors provided no evidence of relationships between these factors (Safe: $r = -.07$, $p = .74$; Risky: $r = .38$, $p = .04$).

An analysis of the communication skills data was conducted with a restricted scoring system (see Table 5) to indicate the presence or absence of Noncompliance, Safe Sex Position, AIDS-Related Words, Request Safe Sex

Table 5
 Number of Role Play Responses With Basic
 Communication Elements
 Present (+) or Absent (-)

	Assessment #1		Assessment #2		Assessment #3	
	+	-	+	-	+	-
Group A	14	4	*17	1	*15	0
Group B	17	1	22	2	*18	0

+ = Presence of one or more of the following communication elements: Noncompliance; Safe Sex Position; AIDS-Related Words; Request Safe Sex Behavior; or Request Alternate Behavior.

- = Absence of any of the following communication elements and/or scored for Compliance: Noncompliance; Safe Sex Postiion; AIDS-Related Words; Request Safe Sex Behavior; or Request Alternate Behavior.

* = Postintervention.

Behavior, or Request Alternate Behavior. The presence of Compliance was scored as an absence of AIDS-related communication elements. This abbreviated scoring system identified the presence of a "minimal AIDS-prevention response" or an absence of any prevention response.

Rescoring the communication data with this system prior to intervention identified seven instances where subjects did not respond with any AIDS-relevant communication skills. After delivery of the intervention, there was only one instance out of 51 role plays in which a subject did not respond with any form of AIDS-related prevention response.

Analysis of the Consumer Satisfaction data across all subjects on the mean, mode and range of each item endorsed on a 5 point Likert scale indicated a high level of comfort with the confidentiality precautions exercised (mean = 1.2; mode = 1; and range = 1-3). Satisfaction with the study as a whole, as measured by the item "Overall, participating in this study was more positive than negative", was also very high (mean = 1.1; mode = 1; and range = 1-2). Two items addressed the intervention directly. The items, "I believe I learned more about AIDS from participating in this study", and "I believe that I learned how to better communicate with other men about sexual activities as a result of participating in this study", were not rated as highly (means = 2.6 and 2.3, respectively; modes = 1/2 and 2, respectively; and ranges = 1-5 and 1-5, respectively).

CHAPTER IV

DISCUSSION

This study was conducted to determine whether printed AIDS information, specifically, the pamphlet, "AIDS in Black and White" and the booklet, "TalkTalkTalk", would produce change in knowledge, frequency of "safe" behaviors, frequency of "risky" behaviors, and communication behaviors. Although some change was evident through visual inspection of data and rank order of data, it was not of the magnitude to strongly support any evidence for change as a result of the pamphlet and booklet.

Several limitations of the research may have produced these results. A larger number of subjects would provide a more extensive range of data points, with a greater probability of encompassing a more diversified range of subject behaviors. When investigating semi-private behaviors such as sexual behaviors and communication behaviors related to sexual behaviors, a larger sample of the population may allow for a more complete investigation of the possible range.

Extended assessment sessions may have assisted in assessing trends or change in behaviors by providing more data points. This would be particularly beneficial if

more time is required to fully incorporate a skill, such as communication skills, into the repertoire of an individual. It is possible that communication skills require more subject initiated rehearsal across time to demonstrate any significant change. To investigate this hypothesis, monthly assessment sessions with self-report of communication skills use could begin to address this issue.

The nature of the subject population may also have resulted in the ceiling effect observed in the Knowledge scores. Although it is possible that there is a high degree of knowledge in the general population due to media events, the recruitment of volunteers for an AIDS prevention study undoubtedly appealed primarily to people with some vested interest in the subject. Based on informal spontaneous report, at least three subjects were directly involved in AIDS prevention activities. Subjects who regularly conversed about, worked with, or were personally vested in AIDS-related issues may have been more likely to know about AIDS and HIV transmission than others who may not as frequently have been in contact with AIDS-related issues.

Another element to be considered in this study was the possible chance provision of AIDS prevention materials or activities to the subjects, through television viewing, reading of books, magazines or pamphlets,

and participation in workshops or classes. University students, of whom there were several in this study, have access to numerous activities related to AIDS. One subject reported participation in such a university-sponsored event. Another subject reported attending AIDS prevention workshops at every opportunity. Increases in selected Communication scores over time, rather than according to intervention, may be reflective of such chance environmental interventions. Knowledge scores, as well, may have been affected by such chance interventions. Future design of related studies could incorporate questions about media events or activities, producing an "AIDS activity score" to be analyzed along with other variables controlled by the study.

Additionally, the communication skills scoring system may have resulted in data that were somewhat misleading. Closer examination of the communication skills scores suggests a possible ceiling effect when restricting the scores to three basic aspects of communication: Noncompliance, Compliance, and Request of Behavior. Prior to discussing the results, a rationale for limiting the scope of the scoring system will be presented.

The assessment of communication elements included in this study (see scoring protocol, Appendix B) are common in assertiveness and communication skills research

(Kelly, 1982). Whereas several components, such as lack of speech dysfluencies, decreased latency in reply, increased duration of reply, or the use of AIDS-related words and requests for nonsexual activity may lead to more sophisticated responses, there is a question as to their practical significance. For example, a high number of speech dysfluencies accompanied by a firm "No", or the very short duration of the response, "No", does not necessarily detract from the effective refusal of unsafe sexual behaviors. The most crucial elements of effective communication are the abilities to refuse or request safe sex behavior. With respect to the current study, these elements translate into the scoring of noncompliance, compliance, and requesting safe sex behavior.

Applying this more pragmatic scoring method to the study required redefinition of Noncompliance to include Safe Sex Position, Request Alternate Behavior and Use of AIDS-Related Words. Speech dysfluencies, latency and duration were considered irrelevant. Data resulting from the application of this more restrictive scoring criterion (Table 5) revealed that prior to any intervention, there were only seven instances where subjects were not able to respond effectively to role play situations (i.e., scored as "Absence") out of 60 role play responses. Even though the intervention was associated with a decrement from seven instances out of

60 opportunities to one instance in 51 opportunities, a ceiling effect was evident at pre-intervention. Therefore, when focusing only upon basic elements of effective communication, there was little improvement possible from pre- to postintervention, suggesting a subject population already exhibiting high levels of communication skills.

Finally, the nature of the intervention itself must be considered. The construction of the materials used in the study may not be completely representative of printed media predating this study. Because the "TalkTalkTalk" booklet represented a new approach in AIDS prevention and the printed media, the unique nature of the booklet is, to some degree, unavoidable. However, it's length was considerable, and despite 100% accurate reporting of the reading comprehension words, it is possible that the bulk of the material exercised some restriction as to the amount of material actually retained and later incorporated by subjects. Therefore, an intervention less lengthy and encompassing fewer aspects of AIDS-related communication may have demonstrated more effect on subject data.

The increases in risky behavior over time in both groups could be related to nonintervention variables. Subject exposure to situations which rendered the risky activities more rewarding or more available than is typical, could have been responsible for this increase.

The ingestion of more alcohol than normal, attending a party where there is much unsafe sexual activity, meeting an "old flame" with whom previous activities were unsafe, or meeting an extremely attractive and persuasive prospective sexual partner are but a few examples which could potentially facilitate risky sexual behaviors. Therefore, the spontaneous self-report of several subjects who related incidents during the study in which their attendance at parties and other major events for the Gay Community resulted in higher levels of sexual activity, was given validity in explaining this increase in risky behaviors. It is reasonable to consider the possible opportunities for risky behaviors which these events could provide as a potential source for the increase in report of risky behaviors.

A second possible explanation for this increase is related to the reliance on self-report of risky behaviors. The report used in Assessment #1 required recall of a four-week period's activities. Given the high frequencies of sexual activities reported by some subjects (i.e., 42 behaviors per week), it is possible that the recall did not accurately reflect subject behaviors. However, the following Assessments required only one-week recall and may therefore have been more reliable, and, higher in frequency of risky behaviors. Regardless of the recall period, subjects exhibiting a

high level of HIV transmission knowledge, knew which behaviors were risky. There may initially have been a reluctance to report risky behaviors accurately, believing these behaviors to be somehow "less desirable" when participating in a study on AIDS prevention. Over time, there may have been an adjustment to the experimental situation and it's nonjudgmental stance toward individual decisions about AIDS prevention, and the encouragement of open and honest reporting of behaviors, despite their status as "risky".

One notably positive outcome of the study was the increase in the rank of protected oral intercourse, moving from a tied rank of 11 for all subjects at Assessment #1 to a tied rank of 5 at Assessment #3. This increase is particularly remarkable since unprotected oral sex maintained its status as one of the most frequent sexual behaviors. Although the relationship of this small increase in protected oral sex cannot be attributed solely to the intervention used in this intervention, it's effect in regard to the increase in protected oral sex cannot be eliminated. Oral sex with a condom held a prominent place in the communication skills booklet and in the role play rehearsals. Therefore, future materials for AIDS prevention may benefit by including the explicit details of some of the less frequent safe sex behaviors, such as oral sex with a condom.

Despite the lack of support for the use of printed material as AIDS prevention, the study did raise relevant issues for AIDS prevention amongst gay men and other populations in general.

With regard to knowledge, the sample population demonstrated a high level of relevant AIDS prevention information: i.e., general knowledge about AIDS and HIV and what must be done to prevent HIV transmission. However, as the McKusick et al. (1985) study demonstrated, this knowledge had only limited impact on actual prevention behaviors. In the present study, there was no evidence of any correlational relationship of Knowledge scores to percentages of Safe or Risky behaviors. In addition, only 1 of 37 responses indicated that HIV could not be transmitted by unprotected oral sex. Ninety-seven percent of the responses were correct--HIV can be transmitted by oral sex without a condom. However, 50% of those "correct" responses were accompanied by the behavioral report of at least one incidence of unprotected oral sex during the immediately preceding time period. While it is possible that considerable modification of behaviors could have preceded this study, "risky" behaviors were reported by subjects--specifically, unprotected oral and anal intercourse, unprotected digit insertion, and use of drugs prior to sexual activity. Because it requires only one instance of a

"risky" behavior to allow for HIV transmission, the continued report of such behavior attests to the need for the implementation of more AIDS prevention programs. However, the simple provision of information for individuals to attain knowledge does not appear to be the complete answer to AIDS prevention. The Kelly et al. (1989) multiple component approach is therefore given additional support. By including information about HIV transmission as only one of several strategies aimed at behavioral change for AIDS prevention, significant modification of those risky behaviors were evinced.

The lack of any notable change in the Communication scores of the present study lend additional credence to the Kelly et al. (1989) treatment approach. The Kelly assertiveness training component included a number of elements, such as instructor modelling, role rehearsal, and feedback. The importance of subject rehearsal is further supported by the anecdotal report of a subject in Group B who, at Assessment #2, spontaneously cited the effectiveness of the "exercises" just prior to beginning the communication assessment. He related an incident from the previous week in which he effectively refused a risky sexual proposition. The subject's so-called "exercises", or, role play assessments, prior to the receipt of any intervention alludes to the effectiveness of rehearsal and practice. In the present study, such

practice and rehearsal was merely an artifact of the assessment, and even so, did not produce any significant behavior change. Despite the nature of this self-report and its inherent limitations it is undeniably congruent with the findings of Kelly et al. (1989).

Also noteworthy is the comparison of behaviors reported within versus across subject groups (Tables 2, 3, and 4). A wider variety of behaviors was reported across all subjects rather than within groups. A visual inspection of the categories of risky behaviors, as well as safe behaviors, suggests that there is no universal "behavior", that can be targeted for increase or decrease. Although it is possible that some behaviors, such as anal intercourse, may be more common among gay men, the hypothesis remains, that sexual behavior is quite individualized. Hence the wider range of activities displayed when both groups are inspected versus the number of activities cited within individual groups.

A number of health-related behavioral interventions, such as Meichenbaum's stress inoculation training (1985), tailor the intervention to the individual, as opposed to a focus on the "universal" elements of stress. Perhaps the incorporation of subject tailored interventions directed toward specific risky sexual practices, which may not exhibit any "universal" preferences for the

specific behaviors, would assist in the elimination, or further reduction of risky sexual practices. Additionally, safe sexual practices based on the individual's preferences for sexual stimulation could be identified and developed to substitute for risky behaviors while preserving active sexual expression. Such a component could easily complement multifactor treatment programs in AIDS prevention and would address the range of sexual behaviors reported in the present study.

Another potential use of the Meichenbaum (1985) multiple component approach to stress reduction is the incorporation of cognitive restructuring. It could potentially address the more covert aspects of beliefs and self-talk which may lend support to the continued practice of risky behaviors, despite knowledge of the risk. In this study, several subjects spontaneously mentioned the difficulty in adopting a "safe sex" lifestyle, because it was not "as much fun.". Many reported gradual compliance with safe sex guidelines, and one stated that, "People just don't do ("safe sex" practices)". One subject clearly reported one of the beliefs that presented difficulty in a totally "safe" approach to sex. He reported that part of the excitement of unprotected oral sex was ingesting the ejaculate of one's partner. He went on to describe that when he "came out" (i.e., affirmed his sexual orientation by adopting a

gay lifestyle), his sexual mentors taught him that swallowing ejaculate was vital in the practice of oral sex. Although once more relying on anecdotal report, these citations repeatedly turn to cognitions (i.e., beliefs and attitudes) acquired about sexuality and its expression. An AIDS prevention program incorporating individual cognitions about sexual behaviors related to AIDS may begin to assist in the change of the risky behaviors for safe behaviors.

Finally, this study offers some practical suggestions for the dissemination of printed AIDS prevention materials. One of the primary motivating factors for reliance on the distribution of printed materials to alter AIDS-relevant behaviors appears to be financial concerns (Seigel et al., 1986). However, the cost-effectiveness of this intervention must be questioned when producing so little effect in the behaviors of their target audiences. It would appear that a more prudent investment of funds would be in the allocation of monies for group interventions and workshops, already demonstrated (Kelly et al., 1989) to be more effective in effecting behavior change than the present study of printed information.

Printed information, however, as one component of AIDS prevention, may still provide a useful service. Although the extent of knowledge about AIDS and HIV

exhibited by subjects in this study may be due to a variety of media campaigns and interventions, it is possible that at least part of those campaigns included printed matter. Therefore, the provision of printed information to naive audiences may still be warranted.

Given the current level of AIDS and HIV knowledge, however, it may be time to change the focus of pamphlets and brochures produced for more knowledgeable populations. Pamphlets could begin to address the need for participation in AIDS prevention treatment groups. If properly constructed, pamphlets could "create" a cognitive environment in which participation in programs and workshops becomes an attractive choice and the rewards of attending become stronger than the aversives of maintaining an "unsafe" sexual lifestyle. The provision of social supports provided in such programs could be highlighted as an attribute to one's social life rather than a detriment to one's confidentiality. Emphasis could be placed on the need for healthy sexual lifestyles and the consequences of continued risky sexual practices. A rationale for the limited public acknowledgement required to participate in AIDS prevention groups could be provided and reframed as a positive step toward personal well-being. Suggestions for seeking out such a program and dealing with issues of confidentiality could be outlined.

The distribution of pamphlets has long been an inexpensive and effective means of addressing the public on crucial issues, be they political issues or health issues. However, with respect to AIDS prevention, it may be necessary to carefully consider the content of such materials. If a pamphlet is used as a format to present basic information to an audience where such information is absent, this would apparently constitute an inexpensive and cost-effective use of the medium. However, if a pamphlet is presented as a substitute for a more expensive but effective intervention, the production and distribution of this "inexpensive" pamphlet is no longer cost-effective and borders on the unethical.

Based on the results of this study coupled, with the results of others cited above, future research is indicated in two areas. First, there is a need for additional controlled investigations of the impact of printed materials on behaviors targeted for change. It is possible that other aspects of behavior change programs could be effective in printed form, such as a workbook for identifying cognitions related to the maintenance of risky behavior practices. Such investigations do not necessarily apply exclusively to the area of AIDS prevention. As mentioned above, pamphlets are used extensively, including other health-related behavior change topics such as heart disease, strokes, cancer, and

diabetes. Additional investigations will assist those considering the use of the medium in making sound, cost-effective decisions.

Secondly, and more importantly in the area of AIDS prevention, there is a need for research outlining the effective components in multiple intervention treatment packages. In addition, the investigation of components typically utilized in health related behavior change has not been exhausted in application to AIDS prevention. It is anticipated that the latter efforts hold the most promise, as well as the most cost-effective solutions, to effectively impact upon the transmission of HIV.

Appendix A

Informed Consent for Participation in the Study

If you decide to participate in this research project, you would be assisting in the development of materials to be used in AIDS prevention for gay or bisexual males.

As a participant, you will be asked to attend an initial interview, two assessment interviews and a follow up interview four weeks after completing the previous interview. Each of these interviews will last approximately one hour. They will be held with the researcher, Cheryl Knight, at the Behavioral Medicine Laboratory (272B Wood Hall) or at a location which you identify as one which better suits your needs for confidentiality. The sessions will be scheduled at times convenient for you. During the first assessment, you will be asked to read this Informed Consent, and if you decide to participate in the study, you will be asked to choose a code word that you will use to identify yourself on all written forms. You will write the code word on a piece of paper, place it in an envelope that has your first name on it, and seal the envelope. This envelope will be kept in a locked file drawer with those belonging to all the other participants. The researcher will never open this envelope, and will never know your code word. This envelope will simply be available for your use if you forget your code word. You will also be asked to write your code word on the outside of a large manilla envelope, and place it in another file drawer which the researcher will then lock. In future sessions, you will be asked to fill out a form to assist the researcher in developing several scenarios that will be a part of future assessments. This form will ask questions about the kinds of places where you interact (i.e., meetings, bars, churches), the types of social interactions you might have, etc.

At each of the following three sessions, you will be asked to fill out a questionnaire that will have items designed to discover what you know about AIDS (its transmission; what it is; etc.), your attitudes in relation to the disease, and the number of times you have engaged in behaviors (primarily sexual) that may or may not be identified as risky for the transmission of AIDS. When finished, you will be asked to find the manilla envelope with your code name on the outside and place the questionnaire in the envelope.

You will then be asked to listen to an audio tape of three sexual advances or propositions. These tapes will be based on the information you gave in the first session on the form asking about typical social settings, typical ways men might approach you to request sex, etc. The tape will then be stopped and you will be asked to respond to each of these propositions. Your responses will be audio taped to permit the researcher to tabulate these responses at a later time. Following each session, you will be asked to mark the tape with your code name and place it in the same manilla envelope that you have been storing your written information.

The researcher will then request that you fill out a "customer satisfaction" form in which you will be asked about your experience

in the session. This form will have your first name on it so that the researcher can adjust future sessions to meet your needs. These forms will be kept in yet another locked file drawer.

At some point during the four sessions, you may be asked to read some printed material about AIDS.

You will be paid \$15.00 at the completion of the fourth session.

Because the interviews are focused on the gay or bisexual community and the contracting and transmission of AIDS, it is possible that you may experience some personal discomfort with the subject matter. AIDS is a very serious condition which undoubtedly results in concern and emotional discomfort for most everyone. If you experience an inordinate amount of concern and emotional discomfort, the researcher will be available to discuss such concerns. As she is not licensed to practice psychology or medicine, however, the researcher will refer any special concerns to the appropriate medical or mental health contacts. Any personal expense incurred as a result of your follow up on these referrals will be your responsibility and not the responsibility of Western Michigan University, its employees, or the researcher.

All information obtained in this study will be confidential. By signing this form you allow use of this information in scientific presentations and publications, with the removal of any information that may identify you as a subject. If you request it in writing, the results of the study will be sent to you upon its completion (approximately April, 1989). All of the forms and tapes you complete will be destroyed one year after the completion of the study (approximately April, 1990). Until that time, they will be kept in a locked file drawer with your code name on the outside of the envelope. The envelope with your first name on the outside and your code word on the inside will be destroyed within 24 hours after the completion of your fourth session.

Your participation is completely voluntary and any decision to cease participation does not in any way effect your relations with Western Michigan University. Payment of the \$10.00, however, is based on your attendance at all four interviews. You are free to discontinue your participation at any time, but your participation in all four sessions will result in data which can be used to better evaluate AIDS prevention for the above identified segment of the gay or bisexual community. If you have completed forms or tapes and decide to cease your participation, these forms will be destroyed within 24 hours after you arrange to either come into the laboratory and identify your envelope or you identify your envelope by giving the researcher your code name in writing or over the phone.

Any complaints or questions can be directed toward the researcher, Cheryl Knight, at the Behavioral Medicine Laboratory,

616-387-4492, or R. Wayne Fuqua, Professor of Clinical Psychology, 616-387-4474. If your complaints are not effectively resolved, you may contact the Chairperson of the Human Subjects Institutional Review Board, Dr. Ellen Page-Robin at 616-387-2647.

Your signature below indicates that you have read and understood the above information and wish to participate. You will receive a copy of this form to keep.

Signature

Date

Time

Signature of Researcher

Appendix B

AIDS Questionnaire, Scoring Protocol, Communication Response Definitions

AIDS QUESTIONNAIRE

Bernardine Pinto & Cheryl L. Knight

AIDS QUESTIONNAIRE

Code Name _____

This questionnaire is designed to assess your knowledge, attitudes, and behaviors in relation to AIDS. Some of the questions ask about specific intimate sexual practices. Please recall that all information is confidential and is to be read only by the primary researcher. Further access to the information you may give on this questionnaire will not identify you by name, but only by your "code name". All conditions presented in the Informed Consent are in effect. This reminder may assist you in being as open and honest as possible when you fill out the questionnaire.

PLEASE PLACE AN "X" IN THE APPROPRIATE AREA.

NOTE: A "true" or "false" answer is appropriate when it applies 95% or more of the time.

TRUE FALSE

- | | | |
|-------|-------|--|
| _____ | _____ | a.) AIDS is a disease only gays and drug users get. |
| _____ | _____ | b.) An AIDS cure is available. |
| _____ | _____ | c.) HIV damages a person's immune system and it's ability to fight disease. |
| _____ | _____ | d.) There are vaccines which can prevent AIDS. |
| _____ | _____ | e.) Some people with HIV remain or appear well for 5-9 years after being infected. |
| _____ | _____ | f.) People with HIV can transmit it even if they do not show symptoms of AIDS. |
| _____ | _____ | g.) Children born to mothers with AIDS have a good chance of being infected with HIV. |
| _____ | _____ | h.) The way people respond to/become ill from HIV varies. |
| _____ | _____ | i.) HIV is transmitted primarily through sexual contact with an infected person or sharing drug needles with an infected person. |

- _____ j). Early signs of AIDS include fever, night sweats, chronic fatigue, persistent cough and loss of appetite.
- _____ k). Deaths associated with AIDS are usually caused by certain cancers or pneumonia.
- _____ l.) Proper use of condoms during any form of intercourse decreases the possibility of being infected with HIV.
- _____ m.) Nonoxynol-9 does not affect HIV.
- _____ n.) A blood test can, in most cases, identify whether a person has been exposed to HIV.

ONE CAN BECOME INFECTED WITH AIDS/HIV BY TAKING PART IN THE FOLLOWING ACTIVITIES:

TRUE = One CAN become infected

FALSE = One CANNOT become infected

TRUE FALSE

- _____ a.) Eating food prepared by someone with AIDS.
- _____ b.) Anal sex without a rubber (condom).
- _____ c.) Sitting on a toilet seat in a restroom.
- _____ d.) Oral sex without a rubber.
- _____ f.) Touching door knobs, phones, furniture.
- _____ h.) Sharing razors or toothbrushes with someone who has AIDS.
- _____ i.) Swimming in a pool with someone with AIDS.
- _____ e.) Vaginal intercourse without a rubber.
- _____ k.) Making a blood donation.
- _____ n.) Being sneezed or coughed on by a person with AIDS.
- _____ o.) Having fingers or fists inserted in rectum.
- _____ p.) Putting a tongue in rectum.

- _____ q.) Anal sex with a rubber.
- _____ r.) Any kind of sex with a non-HIV-infected partner.
- _____ s.) Massage.
- _____ t.) Oral sex with a condom.
- _____ u.) Mutual masturbation.
- _____ w.) Sharing a used needle with someone to inject drugs.

THIS SECTION LOOKS AT YOUR ATTITUDES AND CONCERNS ABOUT AIDS. PLEASE PLACE THE NUMBER OF THE RESPONSE CATEGORY IN THE SPACE NEXT TO EACH ITEM WHICH BEST REPRESENTS YOUR FEELINGS ABOUT THE STATEMENTS BELOW.

Strongly Agree... = 1

Agree..... = 2

Undecided..... = 3

Disagree..... = 4

Strongly Disagree = 5

- _____ a.) I'm afraid of getting HIV from a current sex partner.
- _____ b.) I'm afraid of getting HIV from a future sex partner.
- _____ c.) Even though I practice so-called "risky" behaviors, I'm less likely than most people to get AIDS.
- _____ d.) It's important to learn about AIDS and its prevention.
- _____ e.) People who change their "risky" sexual behavior because of fear of AIDS are overreacting.
- _____ f.) It's very easy for people to change sexual behavior that places them at risk for HIV.
- _____ g.) I know what I can do to protect myself from AIDS, and I'm doing it.

- _____ h.) I know what I can do to protect myself from HIV, but I
find it difficult to do so.
- _____ i.) I know how to protect myself from HIV, but most of
the time, I don't do it.
- _____ j.) It's just people who "live in the fast lane" that
get infected with HIV or get AIDS, so I really don't
have to worry.

PLEASE ESTIMATE THE CHANCES THAT YOU HAVE/WILL CONTRACT HIV:

- _____ 0-5%
- _____ 6-25%
- _____ 26-50%
- _____ 51-75%
- _____ 76-100%

HAVE YOU EVER HAD A SEXUALLY TRANSMITTED DISEASE?

- _____ No.
- _____ Yes, I have had:
- _____ Gonorrhea
- _____ Herpes
- _____ Venereal Warts
- _____ Other

PLEASE FILL IN THE BLANKS WITH NUMBERS TO MAKE THIS SENTENCE TRUE FOR YOU:

"I have known _____ persons with AIDS, and _____ of them have died from it."

PLEASE MARK THE APPROXIMATE NUMBER OF TIMES IN THE PAST WEEK THAT YOU ENGAGED IN THE FOLLOWING BEHAVIOR. If the wording or terms used in an item are unclear, please ask about what they mean.

- _____ a.) Receptive (you on the bottom) anal intercourse with a rubber.
- _____ b.) Receptive (you on the bottom) anal intercourse without a rubber.
- _____ c.) Receptive (you on the bottom) anal intercourse with a rubber and lubrication with nonoxynol-9.
- _____ d.) Insertive (you on the top) anal intercourse with a rubber.
- _____ e.) Insertive (you on the top) anal intercourse without a rubber.
- _____ f.) Insertive (you on the top) anal intercourse with a rubber and lubrication with nonoxynol-9.
- _____ g.) Using sex toys or other paraphernalia with a friend, where toys inserted in the body aren't shared.
- _____ h.) Receptive oral intercourse (you getting sucked) with a rubber.
- _____ i.) Receptive oral intercourse (you getting sucked) without a rubber.
- _____ j.) Insertive oral intercourse (you sucking) without a rubber.
- _____ k.) Insertive oral intercourse (you sucking) with a rubber.
- _____ l.) Frottage (rubbing up against one another until you come).
- _____ m.) Genital intercourse with a female with a rubber.
- _____ n.) Genital intercourse with a female without a rubber.
- _____ o.) Masturbating alone.
- _____ p.) Inserting fingers or fist in someone else's rectum (i.e., fisting), without a rubber.

- _____ q.) Inserting fingers or fist in someone else's rectum (i.e., fisting), with a rubber.
 - _____ r.) Someone inserting fingers or fist in your rectum, without a rubber.
 - _____ s.) Someone inserting fingers or fist in your rectum, with a rubber.
 - _____ t.) You and a friend you feel sexually attracted to spending time alone together (i.e., dinner, movies, dancing, talking, etc.).
 - _____ u.) Inserting your tongue in someone else's rectum without a rubber.
 - _____ v.) Inserting your tongue in someone else's rectum with a rubber.
 - _____ w.) Someone inserting their tongue in your rectum, without a rubber.
 - _____ x.) Someone inserting their tongue in your rectum, with a rubber.
 - _____ y.) Mutual masturbation.
 - _____ z.) Sharing a needle with someone to inject drugs.
 - _____ aa.) Using a clean needle to inject drugs.
 - _____ bb.) Using any kind of drugs (i.e., alcohol, cocaine, etc.) prior to any kind of sexual activity.
 - _____ cc.) Other: Please describe. _____
-

THIS COMPLETES THE QUESTIONNAIRE. THANK YOU VERY MUCH.

SCORING PROTOCOL

CODE NAME: _____

SESSION: Assessment 1 Assessment 2 Assessment 3

QUESTIONNAIRE:

KNOWLEDGE: _____ (Maximum Score = 32)

PERCEIVED RISK: _____

STD's: _____

PWA's: _____

DEATHS: _____

BEHAVIORS:

SAFE: _____

RISKY: _____

COMMUNICATION: (First Blank = Combined; Second Blank = Standard)

Loudness: _____;_____

Noncompliance: _____;_____

Compliance: _____;_____

Request Behavior: _____;_____

Safe Sex Position: _____;_____

Request/State Preference for Alternate: _____;_____

Use of AIDS-Related Words: _____;_____

Speech Dysfluencies: _____;_____

Latency: _____;_____

Duration: _____;_____

Total Communication Score: _____;_____

Response Definitions
Communication Assessment

LOUDNESS (Audibility): Score one point if all words are audible to researcher during assessment session, regardless of audibility on tape and any adjustments to the equipment on which tape is later played for scoring purposes. Score zero points if there is a mix of audible and inaudible words. Score minus one point when no words are audible.

NOTE: This is the only item scored during the assessment session.

NONCOMPLIANCE: Score one point when subject makes a statement to indicate resistance or disagreement with the other person or behaviors suggested by the person.

Resistance could include partial acceptance with stated conditions, such as, "I want to, but only if we play safe," or "Sure. That sounds like fun. But we will be using condoms, right?" Key items which indicate resistance include words such as "but" or "if" and phrases such as, "as long as we. . ." followed by conditions stated in terms of any of the "AIDS-related words" listed below.

An expression of uncertainty about engaging in the activity (i.e., "I'm not sure I want to do that"), or ignoring that the proposal was unsafe and then accepting it as safe or non-sexual (i.e., responding "Sure. My lover and I would love to join you," to a proposal identified in the roleplay as risky and involving the subject only) also constitutes resistance. The function of these responses would stop or temporarily divert progression toward risky activity.

Possible future compliance does not negate scoring this item when a refusal of the immediate suggestion is present. Although the scoring of "Understanding", described below, requires scoring of "NonCompliance", the presence of "NonCompliance" does not necessarily indicate "Understanding."

COMPLIANCE: Score minus one point when subject makes a statement that indicates agreement with or acceptance of a situation that is identified in the stimulus role play (or by the subject) as being unwanted or potentially "risky".

If the agreement or acceptance is followed by a stated safe sex position, request for safe sex behavior, request for input on safe sex, or any of the AIDS-related words, then compliance is not scored.

If the subject requests other person to join him for a non-sexual activity, such as going for a drink, talking, etc., then compliance is not scored.

REQUEST BEHAVIOR: Score one point when subject asks the other person to engage in a "safe" sexual activity, such as intercourse with a condom, mutual masturbation, kissing and touching, in the form, "Can we do it with a condom?" "Let's do it with a condom," or "Why don't we just touch each other instead," is also considered a request because the words "let's" and "why" allow for feedback from the other person. The words "we" and the contraction of "us" in these examples also indicate the subject's emphasis on such activity being mutual and therefore requiring consent from the other person.

Scoring this item also includes explicit direction for mutual participation in a safe sex activity, such as describing condom use by both partners. In this situation, "teaching" is seen as an extended request for safe sex activity.

This does not include telling the person that the subject only practices "safe sex", which would be scored as "Safe Sex Position." When words or phrases are open to either sexual or nonsexual interpretation, such as "cozy", "cuddle", or "Let's go have some fun," do not score the item as Request Behavior.

USE OF AIDS-RELATED WORDS: Subject receives one point when he uses one or more of the following words or phrases in a single role play response: Condoms; Lubricant with Nonoxynol-9; Nonoxynol-9; Play Safe; Precautions; Protection; Risk; Risky; Rubbers; Safe; Safe Sex; Safety; Safe Lubricant; Safe Lube; Spermicide.

This does not include the words "dangerous", "endanger", or the word "lubrication" alone.

REQUEST OR STATE PREFERENCE FOR NONSEXUAL BEHAVIOR (ALTERNATE): Subject proposes or states an interest in nonsexual activity. For scoring purposes, "nonsexual activity" refers to dancing, going out to eat, or even developing a friendship, i.e., "I'd like to get to know you," etc. This item includes the subject's request for the development of a friendship or the subject discusses the pace of the relationship as "slow", "easy", or states a desire to "wait and see how the relationship develops."

SAFE SEX POSITION STATEMENT: Subject directly states his personal belief in or adherence to only safe sex practices.

This differs from "Request Behavior" because subject states his position rather than asking for safe sex behavior from or with the other person.

SPEECH DYSFLUENCIES: One point is subtracted for the presence of every three dysfluencies per single role play. A dysfluency is the presence of vocalized behaviors which do not add to or detract from stating a position. An "Ah", "Um", "Uh", repeated words ("I, I. . ."), leaving off the end of a sentence, laughing all constitute one

dysfluency. A vocal behavior preceding any response that is removed by more than five seconds from spoken words is not considered a dysfluency. Dysfluencies do not include any grammatical or syntactical errors.

"You know" is not included as a speech dysfluency due to it's occasional use to verify understanding of preceding verbal behavior.

LATENCY: Time in hundredths of seconds from the end of tape recorded verbal prompt to when subject begins making a response. Speech dysfluencies which precede initial word of response by more than five seconds do not end the latency period. The latency reported for each session is the total number of seconds of latency combined for all three role plays.

DURATION: Time in hundredths of seconds from the time the subject begins verbally responding to the stimulus tape to the end of the last spoken word of the response. A speech dysfluency which precedes the first spoken word by less than five seconds is included in duration. The duration reported for each session is the total number of seconds of responding to the tape combined for all three role plays.

NOTE: With the exception of "Speech Dysfluencies", a subject cannot score more than one point per category of response per individual role play.

Several definitions based on Kelly, 1982.

Appendix C

Pamphlet: "AIDS in Black and White"

Booklet: "TALKTALKTALK"

AIDS in Black and White

Acquired Immune Deficiency Syndrome (AIDS) is the body's reaction to infection with a new kind of virus known as Human Immunodeficiency Virus (HIV).

The virus takes away the body's ability to fight other diseases (opportunistic diseases). Diseases which are uncommon and not very serious become, for people with HIV, more common and sometimes deadly.

In the U.S., a little over half the people diagnosed with AIDS have died, usually from one or more of these opportunistic diseases.

When initially infected with HIV, people with HIV react differently to the virus.

Some people may look and feel healthy for up to 5 to 9 years after infection, but they can still pass HIV on to another person.

Some come down with diseases like:

Kaposi's Sarcoma (KS): a skin cancer, which looks like purple or brownish splotches or growths on the skin.

pneumocystis carinii pneumonia (PCP): a pneumonia that doesn't respond to the usual treatments.

candidiasis: a yeast infection that makes white patches inside the mouth and throat.

The early symptoms for AIDS look like those of many other common illnesses, such as the flu, except that they are usually more extreme and last much longer than two weeks. They include:

heavy sweats at night
diarrhea
swollen lymph glands (neck, armpits, groin)
dizziness
extreme tiredness
chronic coughing
unusual bleeding
loss of appetite

AIDS is a frightening disease. Some people may panic, believing every minor change in their health could be AIDS. They begin thinking thoughts such as:

Everybody else at work has the very same problem I do.
They're calling it the flu, but for me, it's AIDS.

Sometimes it becomes difficult to tell the difference between unreasonable fears and realistic concerns.

So what can you do?

Things done in the past cannot be changed, but if you think that you might have AIDS--or even if you are just very frightened that you might have AIDS--you have some options:

Visit a clinic or doctor for some of those symptoms that demand instant attention and don't go away. It may or may not be AIDS. In either case, there may be some help for those problems.

Find a place where you can get anonymous testing for HIV antibodies. Most places have you talk to someone before and after the test, to make sure you understand all the issues. Anonymous testing means that no one asks for your real name, so that no one will be able to report any findings to employers, insurance companies, etc.

Find a place that offers confidential testing. This will be the same as anonymous testing except that you give your real name and all the persons working at the clinic promise not to reveal any test results with your name on it.

If you think there is a good chance you have been infected, you may choose not to go for testing. If so, you should carefully follow the precautions listed in the rest of this pamphlet to protect others from possible infection.

AIDS is transmitted when HIV infected blood or semen from one person comes in contact with blood in another person.

ANYONE, regardless of sex, sexual orientation, race, or religious beliefs can become infected with HIV if they practice risky sexual behaviors or share needles (or any part of their "works") to inject any kind of drug.

People are infected with HIV from:

- anal intercourse between males, when one is infected
- sharing needles or shooting up with shared works from an infected person
- oral, anal or vaginal intercourse between an infected male and an uninfected female
- oral, anal or vaginal intercourse between an infected female and an uninfected male
- blood of an infected mother shared with her unborn child
- HIV infected blood transfusions or blood products before mid-1985 when testing procedures were developed

People are not infected with HIV from:

- living in a household with persons with AIDS

- casual contact with persons with AIDS (touching, holding, etc.;

- being sneezed or coughed on; being touched by tears or sweat)

- casual contact with objects touched or used by persons with AIDS (doorknobs, toilet seats, swimming pools, dishes, etc.)

- mosquito bites

Lifestyle Decisions & Changes

Your Sexual Identity

It is possible that you have never considered it necessary to make your sexual orientation known to more people than a few select persons. But now, due to the spread of AIDS, you may begin to wonder about such things as :

Do I need to tell my family doctor about my sexual orientation?

Do I need to tell a former female sex partner?

Can I ask questions about the health coverage I receive at work in relation to AIDS?

If these kinds of questions concern you, it might help to consult with a gay organization in a city near you. Such a group may help to provide answers for your questions. You may also find support for your lifestyle and any changes you might want to make.

Your Behaviors

AIDS is a result of specific behaviors, and steps can be taken to prevent or minimize its spread. However, the changes may involve work and effort.

For example, abstinence (no sexual intercourse with any one) guarantees your safety (unless of course you share contaminated needles). However, it is not an acceptable option to a large number of people.

Others may choose mutual monogamy with an uninfected partner. This means that both people must be tested to insure that they are not infected (remember a person can be infectious even if they feel fine and look healthy). This also means that neither partner ever has sex with a person outside the relationship.

A third option includes sexual contacts with multiple partners (or, a series of mutually monogamous relationships) with some changes in the specific sexual behaviors.

You may need to use your creativity to discover a style in which you can express yourself sexually: a style that fits your values and your needs.

SAFE

Masturbation: Alone or with others, as long as no semen (cum) makes contact with blood in another person.

Frottage (Rubbing penis against another person): Again, safe, as long as no semen (cum) makes contact with blood in another person (can be more pleasurable with body oils etc.).

Dildos or other Toys: Just to be extra careful, it's a good idea to use only your own, and not share.

Erotic massage and touching.
Kissing and hugging.

LIMITED RISK

Intercourse (anal, oral, vaginal intercourse, either active or passive) with a latex condom (rubber) and spermicide containing nonoxynol 9. Condoms, if used properly, so that they do not break, decrease the spread of HIV. Additionally, spermicide can kill HIV thus reducing the risk of infection.

Watersports, if nothing is swallowed or allowed contact with blood in another person. Blood or semen is sometimes mixed in urine.

HIGH RISK

Intercourse (oral, anal, vaginal) without a condom (rubber) and spermicide, since blood or semen white rabbit could be transferred to each other.

Fisting, since a fist, arm, or even fingers inserted in someone's rectum may cause injury to the rectum, allowing direct access of the virus to the blood.

Rimming, because both tongue and rectum could have openings or sores that allow the virus to enter the blood.

Injecting any substance (shooting up) with shared needles, syringes, etc. (i.e., your works) allowing blood to be exchanged.

Having many different sex partners. Each person could unknowingly be infected with the virus and pass it along to you.

Heavy use of any substance (alcohol, poppers, coke, etc.) that might impair your judgement to the point where your inhibitions are down, your desire is up, and you're less likely to consider the facts.

LK,TALK,TALK,TALK,TALK,TALK,TALK,TALK,TALK,TALK,TALK,TALK,TA

Why More Talk About Sex and AIDS?

If you've got the facts on AIDS, then it's time to decide what you'll do to protect yourself from the disease. Your choice can range from becoming a sexual hermit to pretending AIDS doesn't exist. But, more than likely, your decision will be somewhere in between these two extremes, tailored to reflect your individual lifestyle.

Once you've made your choice, you need to consider how to communicate it. Although some situations don't require talking, there may be times when you need to state your position. Inadequate preparation for those times can result in unclear or mixed messages. Through a combination of misunderstanding and healthy sexual feelings, you could end up taking more risk than you initially intended.

Preparation can help reduce those misunderstandings. If you have a good idea what you will and will not do or say before one of the most desirable men you've ever met looks deep into your eyes, then you're better prepared to smoothly handle the situation with clear communication and not exclusively with emotions.

Sex Talk

Some people use nothing but a glance to begin a sexual encounter. But with AIDS, it's not that simple. Blindly accepting or initiating an offer with a seductive glance can result in a situation with very severe consequences.

If you decide to "play safe", you may need to be prepared to talk about it. Most people aren't used to talking about sex. They may think about it or do it, but talking's a little different. However, you can fine tune your skills or learn some new ones to reduce the awkwardness. Then, when that man with ~~the~~ incredible eyes walks up to you, you'll be prepared.

Other Benefits

In addition to providing protection from the HIV virus, talking can enhance your Ruby Slippers satisfaction with relationships in general. Skillful negotiation through the occasional awkwardness of sex talk shows the other person that you care enough about him and yourself to go to the trouble of making the message clear.

Learning Sex Talk

This booklet outlines several kinds of AIDS prevention sex talk and provides specific examples. But because talking is just as individual as one's sexual turn-on's, it's unlikely that you will find any example that perfectly fits your style. However, you can use

the samples as guides to create your messages. Save what you like, drop what you don't, combine several, or use them as a kind of checklist to decide if there's more you need to be saying. And, you can practice your "lines". Practice in front of a mirror, with a friend, or while driving in your car until it becomes comfortable. The more prepared you are ahead of time, the better your chances of carrying through with your intentions when a situation arises.

The Situations

Refusing a Sexual Proposal

There may be times when you decide it is necessary to turn down a sexual proposition. You may have decided to avoid sexual activity that has any risk (i.e., screwing with or without a condom, oral sex with or without a condom, etc.). Or, you may have decided to have sex with one partner exclusively Toto (i.e., mutual monogamy), or with several established partners and not with the guy who is propositioning you. Whatever your reasons for choosing to turn down a proposal, the following situation may give you some ideas for tailoring your own approach to such a situation.

The Setting:

You're at a gathering of friends, and at the moment, you're not talking to anyone. You see a man walking toward you. You've seen him before, and have exchanged a few words with him. You find him very attractive.

He walks up to you and the two of you talk. It becomes obvious that he is as attracted to you as you are to him.

Suddenly, he says, "Let's go to my place." You can tell by the way he is touching you and looking at you that he has more than just a friendly conversation in mind. Although you enjoy talking and flirting with him, you want to make it clear that you are not interested in pursuing a more intimate relationship.

Some of the ways you might respond include:

"No." (The old standby.)

"No. I don't want to start anything where the two of us might be tempted to start making love. I won't go home with you."

"I can see that if I went home with you, I'd want to get more involved, so I'm going to say, 'No' now."

"I'm flattered by the invitation. I find it very tempting to say 'Yes' because you're very attractive, but no, I won't go home with you."

Proposing an Alternative Non-Sexual Activity

There may be times when you want to keep a relationship going with someone, but only at a social level. Maybe you find the guy attractive, would like to get to know him better before getting physically involved, or you may just want a close friendship. In these cases, a simple 'No', or even a 'No' with an explanation might not be enough. You might suggest doing something besides intimate sexual activity in order to express interest in him. Try to imagine yourself in the following situation, read the suggestions for responses, and then change the responses to fit your style.

The Setting:

You are visiting a friend at his house. You like him and you know you want to keep seeing him. Both of you are standing in the living room when he moves very close to you. He has never gotten quite this close before, and suddenly the sexual feeling is very strong. He leans over and kisses you very deeply, while running his hand down your chest.

He says, "You want to visit my bedroom?"

Although you find this very stimulating, you know you have to tell him right away that you don't want the situation to become any more intimate than it is right now. You might say something like:

"I like it that you find me attractive, but I've chosen to be abstinent. Maybe now would be a good time to (go for a walk; go play some racquetball; etc.)."

"I'm not willing to get more involved because I'm not taking any chances with AIDS. However, I do like to spend time with you. Could we do something else?"

"I like this a lot, but I need to let you know right now that this is as far as I go. And because this feels a little too good, now might be a good time to go see that movie you've been talking about."

"I hate to ruin this moment, but I want to let you know that this is as intimate as I want to get. I want to be with you, and keep getting to know you better. You might need to think about that a little bit, so in the meantime, why don't we (listen to some music; go for a swim; etc.)."

"Let's get to know each other better first."

Proposing an Alternative Sexual Activity

Sometimes, a situation may arise where you want to make love with a man, but he suggests a specific activity that you find too risky, such as oral sex without a condom, or screwing you without a condom. In these cases, you might want to suggest a "safe" activity, such as

screwing with a safe lubricant (i.e., a lubricant with nonoxynol 9) and a condom. Or you may want to substitute a nonpenetrative activity, (such as jacking each other off) with his suggestion of a penetrative activity (such as oral sex with a condom). See if any of the following statements might give you some ideas of what to say.

The Setting:

You're in bed with a man. You've been kissing and touching and both of you are getting really turned on. You've been feeling so Dorothy good that you haven't really talked about each other's preferred sexual activities.

All of a sudden he rolls you over and says, "I just can't wait to screw you."

If you want to get screwed, but only the "safe" way, you might say:

"I'm just not comfortable with that unless we use a condom and some safe lubricant." As you're talking, you reach for the condoms you keep in your nightstand, while you keep your legs intertwined with your partner's.

"With AIDS getting spread around more and more, I only screw with a condom and the safe kind of lubricant." Although you've partially rolled back over to make eye contact with your partner, you continue to touch him, gently massaging his chest to let him know you're still interested in pursuing the activity.

If, instead of rolling you over to screw you, you find him licking his way down your body to the point where he starts to go down on you, you can use the same lines as those suggested for unsafe screwing, eliminating the suggestion of safe lube.

If you want to substitute screwing or oral sex with an activity that doesn't involve penetration, you might say:

"Look, I care about you and I know that would feel real good, but I can only be comfortable having 'safe sex', and for me that means no screwing. So how about if we just jack each other off." As you say this, you roll over and start to move into it.

"I'm really only comfortable having 'safe sex' these days. What do you think if we rub each other all over instead." As you roll over to make some eye contact, you reach over and begin to firmly stroke his butt.

Proposing "Safe Sex" Before You Hit the Sheets

If you're the kind of man who likes to prepare, then you might propose "safe sex" ahead of time. See if this next situation gives you any ideas.

The Setting:

You're walking out to your car from a club with a man you've just invited to your apartment. You're thinking ahead to your arrival at home. It's O.K.--you took the trash out to the dumpster, there are clean sheets on the bed, and condoms and lubrication in the nightstand. "Wait a minute," you tell yourself, "would talking about the details of sex now make it less awkward when things start developing at home?"

You might say something like:

"I feel real good about you. I'd like to make love with you, but only the 'safe sex' kind."

"Just in case things get more intimate, I want to let you know that I take precautions when it comes to screwing and I have condoms and safe lube at home."

"I'm really turned on by you. So, before we get to my place, how about if we talk about 'safe sex'? I mean, I'd really like to (suck your cock; fuck you; have you fuck me) but only with a condom and lube. What kind of 'safe sex' do you like?"

"If you want to do this, we need to play 'safe'."

Interrupting a Moment of Passion to Talk About "Safe Sex"

Sometimes, sex--even the safe kind--just happens. But things don't always work out this smoothly, and then you may find it necessary Emerald City to talk about what turns each other on and how to do it safely. See if any of the following ways to address the "safe sex" issues might work for you.

The Setting:

You can't believe how good he kisses. You want this man. In fact you've been thinking so much about it that you haven't talked about playing "safe". It's the first time the two of you have been together and you're beginning to think that some talking may be in order. You say:

"I think now would be a good time to find some condoms and safe lube. What do you think?" As you talk, you keep rubbing his body.

"How about if we do that with a condom? I've got some right here." You reach for the condom and run your foot gently but firmly up and down his legs.

"Can we take a break for a minute? I just want to get some condoms and lube." You give him just one more passionate kiss before getting your condoms and lube.

"I think we'd both enjoy that a little more with condoms. Let me get one." As you get up, you run your hand the full length of his body.

Initiating a Mutually Monogamous Relationship: Starting the Talk

Some people want a mutually monogamous relationship--that is, seeing only each--for various reasons. It might be the only comfortable way for one or both partners to be sexually intimate. This situation may also be appealing because reducing the number of sexual partners has been cited by some experts as a method of AIDS prevention. (Of course, if one of the persons in the relationship is HIV positive, this kind of relationship will not prevent AIDS.) If you want to initiate a mutually monogamous relationship, here are some suggestions for bringing up the topic for discussion.

The Setting:

The two of you have had sex with other men. You both have practiced safe sex exclusively for several years now. But given the steadily increasing amount of time you have been spending with each other, it's becoming obvious that there just couldn't be other partners like there used to be. In fact, you just don't have the desire to make love with anyone else but this man. When you look ahead to the future, you just can't imagine it without him. You sometimes see yourself with him, enjoying the emotional benefits of an exclusive relationship, and possibly even pursuing HIV testing and, depending on the results, forgoing the safe sex practices. You decide it's time to talk about all this. You make sure that you will have some time alone and that he seems in a mood to discuss an intimate relationship with you. You turn to him and say:

"I find you very attractive--in a lot of ways. I've been considering the possibility of starting an exclusive sexual relationship with you. Does that interest you at all?"

"I'm really more comfortable seeing only you. What do you think?"

"You may find discussing sex as awkward as I do, but nowadays, I think it's absolutely necessary. I'm wondering about the possibility of you and I starting a mutually monogamous sexual relationship."

These lines can also fit a situation where one or both partners have not been sexually active with each other or anyone else.

Proposing Mutual HIV Antibody Testing

Everybody has a different opinion about HIV antibody testing. But if you're in a situation with a steady lover, and you decide that you want to talk about mutual testing, take a look at the following situation.

The Setting:

You are very happy in the relationship you have. The two of you have been seeing only each other for over six months, and you've been doing safe sex from the first time on. You think it would be nice to drop the safe sex, given your steady arrangement. But sometimes you get a little concerned about AIDS. Both of you have had other lovers. The two of you have never talked about HIV antibody testing. You pick a time when both of you are relaxed and you know there will be time to talk. You move close to your lover, and touch him gently and lovingly on the shoulder. You look him in the eyes and say:

"We both used to see other people. With AIDS, I'm uneasy about what it might mean to us. It may be awkward for both of us, but I think we should be tested, just to be more sure."

"You're so very important to me. I don't want to jeopardize our health. I'm thinking we could get tested."

"This may sound a little strange to you, but I think that getting the HIV test would ease both our minds a little."

Limiting the Use of Alcohol (or Other Drugs) as AIDS Prevention

One final area in which people are choosing to change their behavior to decrease the possibility of contracting AIDS is related to the use of alcohol and other drugs. When your judgement is not Munchkins quite what it usually is, sexual desires just may overpower your concerns about contracting the AIDS virus despite all your carefully considered, logical decisions. Therefore, some people decide to limit their intake of alcohol and other drugs as a means of AIDS prevention.

See how this next situation might apply to you.

The Setting:

You're visiting a friend at his house. You've been drinking a bottle of wine. You're on your second glass. Based on previous experiences, you know that anything beyond two glasses tends to knock you out. In fact, you've found yourself doing some pretty unusual things when you've gone beyond your limit. And besides all that, you're beginning to feel a little tipsy.

When you've visited this man before, he's made it clear that he wants to have you share his bed. You've set your limits, saying that you're only willing to kiss and touch, but you know that he'd like more, and there have been times when he's even asked for more.

Your friend reaches for the bottle and moves to fill up your glass. You say:

"No thanks, I'm all set."

"You're very generous, but I've had enough."

"No. Could I have a soda instead, please?"

These responses could apply to a variety of situations and to a variety of drugs. The basic response remains the same--you don't want any.

Going Beyond the First Response

These situations give you some "opening lines". Of course, these lines may reveal a very concerned, caring, and cooperative listener. However, your partner may Scarecrow respond to your concerns with anger, fear, or even indifference. He may become defensive, accusatory, or he may minimize the importance of your preferences. Worse yet, he may become very seductive, thinking that if he just tries hard enough, you'll give in.

If these concerns are important enough that you've thought them out ahead of time, you've already set your limits, and you've decided that you care enough about yourself to present these concerns in the first place, you have two choices:

1. Attempt to persuade him if he does not accept your limits. This will involve restating your position until he agrees with you, or until it becomes obvious that there is no room for agreement or compromise from him. You can then move on to the next step.

2. Walk away. Accept the emotions that may include anything from hurt to disappointment, anger, unresolved sexual tension, and then congratulate yourself. You know what you want, you did everything you could to get it, and you are important enough to take care of yourself and walk away.

Appendix D

Social Validation Summary

Social Validation Survey

Summary of Data
Social Validation Survey

Survey Return Rate: 10 + 1 unusable

Survey Return Rate by Category:

Communication: 4 (3) + 1 unusable

Human Sexuality: 4

Community Leaders: 2 (3)

Range of Responses per Item:

1 - 5: 50% (58 of 116 items)

2 - 5: 36% (42 of 116 items)

3 - 5: 6.8% (8 of 116 items)

5 - 5: 1.7% (2 of 116 items)

4 - 5: 1.7% (2 of 116 items)

1 - 4: 1.7% (2 of 116 items)

1 - 3: 1.7% (2 of 116 items)

Number of Items Meeting Pre-Survey Criteria: (i.e., average response of 4.0 or greater) = 38 of 116, or 33%

NOTE: Items on the following survey marked with an asterisk indicated those items meeting criteria for inclusion in the communication booklet.

Communication Between Gay Males

Communication between Gay males prior to sexual activity is related to the prevention of AIDS. Some exchange of communication typically precedes all forms of sexual activity. Until recently, many persons negotiated sexual activity with seductive glances or with a short discussion of "where" and "when". The onset of AIDS, however, requires a more complex form of communication. Communication in which sexual histories are discussed, in which unsafe sexual activities are refused, or in which safe sexual activities are proposed is communication that can assist in the prevention of AIDS. However, many sexually active persons are not yet skilled at this type of sexual communication. Therefore a pamphlet containing guidelines for communication skills relevant to AIDS prevention is being developed.

The information will be in printed form to provide easier access for Gays who are not self-affirming and for Gays who do not live in areas where more intensive intervention is made available. Because the intended audience for this pamphlet is fairly specific, we are asking for your feedback on the following elements of communication. Any information must be presented in a manner that is relevant to the intended reader. Therefore, you are asked to respond to the following items with respect to their importance for inclusion in such a pamphlet. When considering each item, please keep the following questions in mind:

Is the language and wording clear, specific, and understandable?

Can you imagine a Gay or Bisexual man who is not self-affirming or who lives in a more rural setting using these skills?

Is the item necessary as an example for the specified kind of communication?

Is it likely that the reader could duplicate or appropriately modify the example to meet his needs?

Below are several general types of communication that could be used to talk about sexual behavior. Please rate the following kinds of messages as to their importance in serving as a model for communication between Gay or Bisexual males.

Not Important at all	1-----2-----3-----4-----5	Very Important
*Refusing an unwanted sexual proposition.	1	2 3 4 5
*Refuse a specific sexual request and suggest an alternate "safe sex" behavior.	1	2 3 4 5
*Refuse a sexual proposition and suggest a nonsexual alternate activity.	1	2 3 4 5
Refuse an unwanted sexual proposition by ignoring that the request occurred.	1	2 3 4 5
*Propose "safe sex" activity.	1	2 3 4 5
Propose mutual HIV testing to a partner.	1	2 3 4 5
*Initiate the discussion of forming a mutually monogamous relationship.	1	2 3 4 5
*Initiate the discussion of sexual histories.	1	2 3 4 5
*Expressing concern and fear of AIDS.	1	2 3 4 5
*Refuse offers of alcohol or other drugs that might interfere with AIDS prevention behaviors.	1	2 3 4 5

REFUSING A SEXUAL PROPOSAL

Please rate the following examples of refusing an unwanted sexual proposition.

Not Important at all	1-----2-----3-----4-----5	Very Important
*"No."	1	2 3 4 5
"Well, I don't know. . ."	1	2 3 4 5
"Why don't we go to that new club instead?"	1	2 3 4 5
"Please don't take this the wrong way--I have absolutely no reason to think you might have anything I could get--but I've decided to play it safe and not be sexually active."	1	2 3 4 5
"I'm sorry, but I'm so afraid of this AIDS thing that I'm not taking any chances with sex."	1	2 3 4 5
"You're very attractive, and the offer is tempting, but I'm not sexually active."	1	2 3 4 5

"What you're suggesting probably would be fun, but I've decided to go without sex." 1 2 3 4 5

"I'm just so plain scared that I don't have sex anymore." 1 2 3 4 5

"To be completely honest, I'm just so afraid of getting AIDS that I don't have sex anymore." 1 2 3 4 5

"Well, you are willing to take some risks that I'm just simply not willing to take. I guess we all have to decide what's right for ourselves, but I'll have to say 'No' to your suggestion". 1 2 3 4 5

"I'm gonna have to say, 'Thanks but no thanks' to that one." 1 2 3 4 5

"I've decided not to have sex anymore." 1 2 3 4 5

"I've decided not to have sex." 1 2 3 4 5

PROPOSING AN ALTERNATIVE SEXUAL BEHAVIOR

Please rate the following examples of refusing (or clarifying) one sexual proposition and suggesting one that the person considers "safe".

Not Important at all 1-----2-----3-----4-----5 Very Important

*"I'm just not comfortable with that unless we use a condom and spermicide." 1 2 3 4 5

"Instead of screwing, why don't we jack each other off?" 1 2 3 4 5

*"With AIDS getting spread around more and more, I only screw with a condom and spermicide." 1 2 3 4 5

"I bet you'd be good at that, but I'd rather just kiss, hold and touch each other." 1 2 3 4 5

"Just a minute. If we do anything, we'll do it my way or not at all. I only go for 'safe sex'." 1 2 3 4 5

*"Look, I care about you and I know that would feel real good, but I can only be comfortable having 'safe sex'." 1 2 3 4 5

"I'm really only comfortable having 'safe sex' these days. What do you think?" 1 2 3 4 5

"What would you think about sleeping together but not screwing each other?" 1 2 3 4 5

"I'm too worried about screwing to do it anymore. How about if we just touch each other instead?" 1 2 3 4 5

PROPOSING AN ALTERNATIVE NON-SEXUAL BEHAVIOR

Please rate the importance of the following examples of refusing a sexual proposition and suggesting a nonsexual activity in it's place.

Not Important at all 1-----2-----3-----4-----5 Very Important

"I like being with you, but I'm not looking for something sexual. Could we do something else together?" 1 2 3 4 5

"Let's try that new club instead." 1 2 3 4 5

"I'm not sexually active, but could we still see each other?" 1 2 3 4 5

"I'm just not ready for that. I would like to keep spending time together." 1 2 3 4 5

"I like it that you find me attractive, but I've chosen to be abstinent." 1 2 3 4 5

"Are you crazy? In the age of AIDS?" 1 2 3 4 5

"I find that offer very tempting, but I'll have to refuse. Are you still interested in spending time together?" 1 2 3 4 5

"I just don't feel comfortable having sex right now. I do like to go sailing, though. Would you like to join me sometime?" 1 2 3 4 5

"I'm not sexually active because I'm not taking any chances with AIDS. However, I do like to spend time with you. Could we do something else?" 1 2 3 4 5

IGNORING A SEXUAL REQUEST

Please rate the importance of the following examples of ignoring that the request occurred.

Not Important at all	1-----	2-----	3-----	4-----	5	Very Important
"Would you like another drink?"	1	2	3	4	5	
"Oh, I didn't realize it was so late. I'd better leave."	1	2	3	4	5	
"Have you seen that new Tom Cruise movie?"	1	2	3	4	5	
"Well, I've had a real nice time talking, but it's late and I have to be going."	1	2	3	4	5	
"Oh, look. There's my friend Tom. Do you mind if he joins us?"	1	2	3	4	5	
"What do you think about that new AIDS research?"	1	2	3	4	5	

PROPOSING "SAFE SEX"

Please rate the following examples of someone initiating "safe sex" activity.

Not Important at all	1-----	2-----	3-----	4-----	5	Very Important
*"I feel real good about you. I'd like to start having sex, but only the 'safe' kind."	1	2	3	4	5	
"Let's go to my place for some of that 'safe sex'."	1	2	3	4	5	
"I think about AIDS, but I'm not willing to choose abstinence. I think that screwing with a condom and spermicide is fairly safe, though."	1	2	3	4	5	
"I feel intimidated enough by the consequences of AIDS to be more careful with my lovemaking. So I was thinking we could go to my place and kiss, and hold and touch each other."	1	2	3	4	5	
"You really turn me on, you look so good. Let's go to my place and do some of the 'safe' stuff, you know, kissing and touching."	1	2	3	4	5	
*"I'm thinking now would be a good time to find some condoms and spermicide. What do you think?"	1	2	3	4	5	

PROPOSING HIV ANTIBODY TESTING

Please rate these examples of proposing mutual HIV testing with a proposed or current sexual partner.

Not Important at all 1-----2-----3-----4-----5 Very Important

"We've been doing this 'safe sex' thing for several months. Do you ever think about us getting tested?" 1 2 3 4 5

"I know we've been together for a long time, but sometimes I just can't help but wonder about AIDS. Let's get tested." 1 2 3 4 5

"I think we should get the AIDS test." 1 2 3 4 5

"Do you think we should get the AIDS test?" 1 2 3 4 5

"Look, I know you used to see other men, so you just simply have to get an HIV test if you want to keep sleeping with me," 1 2 3 4 5

"*We both used to see other people. With AIDS, I'm uneasy about what it might mean to us--I don't want to hurt you and I know you don't want to hurt me. I think we should be tested, just to be more sure." 1 2 3 4 5

"*You're such a good partner. I don't want to jeopardize our health. I'm thinking we could get the AIDS test." 1 2 3 4 5

"*This may sound a little strange to you, but I think that getting the AIDS test would ease both our minds a little." 1 2 3 4 5

INITIATING A MUTUALLY MONOGAMOUS RELATIONSHIP

Please rate the following ways a gay or bisexual man might propose forming a mutually monogamous relationship.

Not Important at all 1-----2-----3-----4-----5 Very Important

"So, are you sleeping with anybody?" 1 2 3 4 5

"I like being with you, but with AIDS and all, I'm only willing to go the safe sex route in an exclusive relationship--no one sleeps around." 1 2 3 4 5

"When I think about sex, I only consider safe sex in a mutually monogamous relationship." 1 2 3 4 5

"What do you think about sex, but only with each other?" 1 2 3 4 5

"I still want to be sexually active--despite AIDS--but I only feel comfortable having sex in a situation where we have sex only with each other. Do you think that might work?" 1 2 3 4 5

"I find you very attractive--in a lot of ways. I've been considering the possibility of starting an exclusive sexual relationship with you. Does that interest you at all?" 1 2 3 4 5

"You may find discussing sex as awkward as I do, but nowadays, I think it's absolutely necessary. I'm wondering about the possibility of you and I starting a monogamous sexual relationship." 1 2 3 4 5

"I'd like to start including sex in our relationship, but only if it's just with you and me--mutually monogamous." 1 2 3 4 5

INITIATING DISCUSSION OF SEXUAL HISTORIES

Please rate the following samples of initiating discussion of sexual histories. This type of message could apply to a new or an ongoing, long-term relationship in which partners have not yet broached the subject of AIDS.

Not Important at all 1-----2-----3-----4-----5 Very Important

"We've been together for quite a while, Maybe it's time to talk about AIDS." 1 2 3 4 5

"Let's talk about AIDS." 1 2 3 4 5

"Let's talk about AIDS and what it might mean to us." 1 2 3 4 5

"I'm feeling uneasy with all this talk about AIDS. I think it's time to talk." 1 2 3 4 5

"AIDS is pretty serious business. I think it might clear the air a little if we talked about it. What do you think?" 1 2 3 4 5

"I'm not sure just how to bring this up. It could easily sound like I'm accusing or blaming you for something, but I'm not. I just care about us and now days, caring includes talking about AIDS." 1 2 3 4 5

"I trust and care about you enough that I think it's time to talk about AIDS. We've never really talked about how it affects us." 1 2 3 4 5

"You aren't keeping a lover on the side, are you? I mean, you wouldn't take that kind of chance with our lives, would you?" 1 2 3 4 5

"It never used to matter--every once in a while, I'd see someone, you'd see someone--we knew that we would always be together. But with AIDS, it's different. Now it matters. Let's talk." 1 2 3 4 5

EXPRESSING CONCERN ABOUT AIDS

Please rate the following examples of ways a gay or bisexual man could express concern about AIDS in a conversation with a potential or current partner.

Not Important at all 1-----2-----3-----4-----5 Very Important

"I'm just plain scared about AIDS. I mean, you can die from it." 1 2 3 4 5

"You seem intelligent--what do you think about AIDS?" 1 2 3 4 5

"AIDS is frightening, but things can be done about it." 1 2 3 4 5

"I think it's important to take AIDS seriously." 1 2 3 4 5

"Just about everybody has some kind of concern about AIDS. How do you feel about it?" 1 2 3 4 5

"It's hard not to take AIDS personally--I mean look at all the gays that have died from it. But still, it's not a gay disease--it's a disease spread by behaviors." 1 2 3 4 5

"It used to be different--sex was so uninhibited. But all that's changed with AIDS." 1 2 3 4 5

"It did used to be different--sex was so uninhibited. But with AIDS it simply has to be more creative. Sex is still great, it's just different." 1 2 3 4 5

"The thought of AIDS paralyzes me with fear." 1 2 3 4 5

LIMITING USE OF INTOXICANTS AS AIDS PREVENTION

Please rate the following ways to refuse or otherwise limit intake of intoxicants that could impair judgement and otherwise alter AIDS prevention behaviors.

Not Important at all 1-----2-----3-----4-----5 Very Important

"I'd rather go somewhere where there is no alcohol served. I find I can maintain better control that way." 1 2 3 4 5

"Let's go somewhere where there isn't any alcohol." 1 2 3 4 5

*"No. I don't want another drink." 1 2 3 4 5

*"Thanks, but I don't care for another drink." 1 2 3 4 5

"No thanks, that stuff just seems to get me to the point where I don't know what I'm doing--or at least, where I don't care." 1 2 3 4 5

*"You're very generous, but I've had enough." 1 2 3 4 5

*"Could I have a soda instead, please?" 1 2 3 4 5

"No, I'm only drinking water tonight." 1 2 3 4 5

"You know, the more I have, the less careful I am about what I do." 1 2 3 4 5

"Why do you offer me liquor? You know I can't deal with it." 1 2 3 4 5

"I just get too loose when I drink, you know, I'll do just about anything with anybody." 1 2 3 4 5

"I'm not able to manage my self when I've had too much. And with AIDS, I definitely have to manage myself better in these situations." 1 2 3 4 5

"No thanks, I don't drink anymore." 1 2 3 4 5

"No thanks, I don't drink anymore. All these 1 2 3 4 5
problems with AIDS--I'm not taking any chances."

CHOICE OF WORDS

In this final section, we are attempting to clarify what constitutes specific and typical language of Gays or Bisexuals who are not self-affirming and who might live in more rural areas. Please rate the following terms as to their importance for inclusion in the pamphlet, so that the pamphlet is most likely to make sense to Gays or Bisexuals.

Not Important at all 1-----2-----3-----4-----5 Very Important

intercourse 1 2 3 4 5

*screw 1 2 3 4 5

*fuck 1 2 3 4 5

*butt 1 2 3 4 5

*ass 1 2 3 4 5

*safe sex 1 2 3 4 5

having sex 1 2 3 4 5

being sexual 1 2 3 4 5

sexually active 1 2 3 4 5

oral intercourse 1 2 3 4 5

*suck 1 2 3 4 5

penis 1 2 3 4 5

*dick 1 2 3 4 5

fisting 1 2 3 4 5

*rimming 1 2 3 4 5

Other suggested words:

Appendix E

Subject Data

SUBJECT DATA

Knowledge (Number Correct Out of 30 Possible)

Group A

Group B

	<u>A #1</u>	<u>A #2</u>	<u>A #3</u>		<u>A #1</u>	<u>A #2</u>	<u>A #3</u>
S1	27	27	27		32	32	32
*S2	30	31	—		29	29	29
S3	28	29	29		31	29	31
S4	32	32	32	*	29	30	—
S5	32	31	32		28	31	31
S6	30	30	29	*	31	29	29
S7					28	27	28
Average Across Subjects, Rounded to Whole Numbers, Excluding Incomplete Data Sets							
<u>AVG.</u>	30	30	30		30	30	30

Perceived Risk (Ranging from -2 to 7, with 7 = Highest Perceived Risk)

Group A

Group B

	<u>A #1</u>	<u>A #2</u>	<u>A #3</u>		<u>A #1</u>	<u>A #2</u>	<u>A #3</u>
S1	1	1	1		2	2	2
*S2	1	2	—		5	6	0
S3	3	3	6		3	3	3
S4	3	3	3	*	5	5	—
S5	1	-1	-2		5	3	2
S6	6	4	6	*	5	5	5
S7					5	7	4
Average Across Subjects, Excluding Incomplete Data Sets							
<u>AVG.</u>	2.8	2.0	2.8		4.0	4.2	2.2

STD's (Number of STD's reported contracted by subject.)

Group A

Group B

	<u>A #1</u>	<u>A #2</u>	<u>A #3</u>		<u>A #1</u>	<u>A #2</u>	<u>A #3</u>
S1	3	2	2		0	0	0
*S2	0	0	—		0	0	0
S3	3	3	2		1	1	1
S4	1	1	1	*	0	0	—
S5	0	0	0		2	2	2
S6	0	0	0	*	2	2	2
S7					0	0	0
Average Across Subjects, Excluding Incomplete Data Sets							
<u>AVG.</u>	1.4	1.2	1.0		0.6	0.6	0.6

PWA's (Number of PWA's known by subject).

Group A			Group B				
	<u>A #1</u>	<u>A #2</u>	<u>A #3</u>		<u>A #1</u>	<u>A #2</u>	<u>A #3</u>
S1	3	2	2		3	4	4
*S2	5	3	--		1	1	1
S3	1	2	2		2	2	2
S4	0	0	0	*	4	5	--
S5	3	3	3		1	1	1
S6	0	0	0	*	0	0	0
S7					0	0	0
Average Across Subjects, Excluding Incomplete Data Sets							
AVG.	1.4	1.4	1.4		1.4	1.6	1.6

Deaths (Number of AIDS-related deaths of persons known by subject.)

Group A			Group B				
	<u>A #1</u>	<u>A #2</u>	<u>A #3</u>		<u>A #1</u>	<u>A #2</u>	<u>A #3</u>
S1	2	3	4		0	1	1
*S2	2	1	--		0	0	0
S3	0	0	0		1	1	1
S4	0	0	0	*	3	3	--
S5	2	2	2		1	1	1
S6	0	0	0	*	0	0	0
S7					0	0	0
Average Across Subjects, Excluding Incomplete Data Sets							
AVG.	0.8	1.0	1.2		0.4	0.6	0.6

Safe Behaviors: (Number of "Safe" Activities, per Week)

Group A			Group B				
	<u>A #1</u>	<u>A #2</u>	<u>A #3</u>	<u>A #1</u>	<u>A #2</u>	<u>Chklst. #3</u>	<u>A #3</u>
S1	4.00	7.00	2.00	4.25	8.00	4.00	4.00
*S2	7.25	6.00	--	4.50	7.00	---	10.00
S3	9.00	9.00	13.00	4.75	7.00	15.00	16.00
S4	34.75	38.00	15.00	*23.00	25.00	16.00	--
S5	6.50	5.00	4.00	10.00	16.00	17.00	12.00
S6	16.50	16.00	18.00	* 3.25	4.00	1.00	5.00
S7				17.75	28.00	23.00	27.00
Average Across Subjects, Excluding Incomplete Data Sets for Assessments #1, #2, & #3.							
AVG.	14.15	15.00	10.40	8.25	13.20		17.25

Risky Behaviors: (Number of "Risky" Activities, per Week)

Group A			Group B			Chklst. #3	A #3
A #1	A #2	A #3	A #1	A #2			
S1	0.50	0.00	1.00	11.00	7.00	10.00	5.00
*S2	0.25	2.00	--	0.00	10.00	---	10.00
S3	0.50	0.00	1.00	1.75	0.00	2.00	4.00
S4	7.25	16.00	2.00	* 0.25	1.00	0.00	---
S5	1.50	3.00	2.00	0.00	0.00	0.00	0.00
S6	2.50	0.00	0.00	* 0.50	6.00	0.00	0.00
S7				7.25	17.00	13.00	17.00
Average Across Subjects, Excluding Incomplete Data Sets for Assessments #1, #2, & #3.							
AVG.	2.45	3.80	1.20	4.00	6.80		7.20

Safe Behaviors: Percentages

Group A			Group B			Chklst. #3	A #3
A #1	A #2	A #3	A #1	A #2			
S1	89	100	66	29	53	29	44
*S2	97	75	--	100	41	--	50
S3	95	100	93	73	100	88	80
S4	83	70	88	* 99	96	100	--
S5	81	62	67	100	100	100	100
S6	87	100	100	* 87	40	100	100
S7				71	62	64	61
Average Across Subjects, Excluding Incomplete Data Sets for Assessments #1, #2, & #3.							
AVG.	87	86	83	75	71		67

Risky Behaviors : Percentages

Group A			Group B			Chklst. #3	A #3
A #1	A #2	A #3	A #1	A #2			
S1	11	0	34	71	47	71	56
*S2	3	25	--	0	59	--	50
S3	5	0	7	27	0	12	20
S4	17	30	12	* 1	4	0	--
S5	19	38	33	0	0	0	0
S6	13	0	0	* 13	60	0	0
S7				29	38	36	39
Average Across Subjects, Excluding Incomplete Data Sets for Assessments #1, #2, & #3.							
AVG.	13	14	17	25	29		33

Communication: Combined Role Play Scores per Assessment

Group A				Group B			
	<u>A #1</u>	<u>A #2</u>	<u>A #3</u>		<u>A #1</u>	<u>A #2</u>	<u>A #3</u>
S1	5	8	4		7	9	1
*S2	6	7	-		8	4	7
S3	11	9	7		8	8	8
S4	3	8	8	*	8	8	-
S5	8	6	9		4	7	7
S6	7	8	9	*	-	7	6
S7					9	9	8
Cumulative Across Subjects, Excluding Incomplete Data Sets							
Total:34	39	37		36	37		31
Average Across Subjects, Excluding Incomplete Data Sets							
AVG.	6.8	7.8	7.4	7.2	7.4		6.2

Communication: Novel Role Play Scores per Assessment

Group A			Group B				
	<u>A #1</u>	<u>A #2</u>	<u>A #3</u>		<u>A #1</u>	<u>A #2</u>	<u>A #3</u>
S1	4	4	1		4	7	2
*S2	4	3	—		6	2	4
S3	7	6	4		5	6	6
S4	2	5	5	*	5	5	—
S5	5	5	6		4	7	4
S6	3	6	5	*	—	7	6
S7					5	6	5
Cumulative Across Subjects, Excluding Incomplete Data Sets							
Total:21		26	21		24	28	21
Average Across Subjects, Excluding Incomplete Data Sets							
AVG.	4.2	5.2	4.2		4.8	5.6	4.2

Communication: Standard Role Play Scores per Assessment

Group A				Group B			
	<u>A #1</u>	<u>A #2</u>	<u>A #3</u>		<u>A #1</u>	<u>A #2</u>	<u>A #3</u>
S1	1	4	3		3	2	-1
*S2	6	7	-		2	2	3
S3	4	3	3		3	2	2
S4	1	3	3	*	8	8	-
S5	3	1	3		0	0	3
S6	4	2	4	*	-	7	6
S7					4	3	3
Cumulative Across Subjects, Excluding Incomplete Data Sets							
Total:13	13	16			9	9	8
Average Across Subjects, Excluding Incomplete Data Sets							
AVG.	2.6	2.6	3.2		2.4	1.8	2.0

Latency: Seconds, Combined Role Plays, per Assessment

Group A			Group B			
	A #1	A #2	A #3	A #1	A #2	A #3
S1	21.79	37.08	17.37	26.38	9.33	17.42
*S2	18.01	10.32	---	34.45	25.57	8.31
S3	17.65	24.41	14.91	6.46	5.86	7.76
S4	8.85	8.09	7.79	* 12.34	50.18	---
S5	19.59	10.51	13.47	26.33	42.24	26.38
S6	42.49	12.02	12.81	* ---	29.58	12.13
S7				12.73	13.76	7.42
Average Across Subjects, Excluding Incomplete Data Sets						
AVG.	22.07	18.42	13.27	21.27	19.35	13.46

Latency: Seconds, Novel Role Plays, per Assessment

Group A			Group B			
	A #1	A #2	A #3	A #1	A #2	A #3
S1	15.50	27.95	14.27	19.95	5.86	14.61
*S2	7.11	6.74	---	18.73	4.45	5.53
S3	5.69	17.85	10.79	2.92	3.99	5.44
S4	4.81	9.85	5.88	* 3.34	48.53	---
S5	9.90	8.13	6.81	16.56	36.54	19.91
S6	35.82	9.83	8.83	* ---	28.37	10.35
S7				9.02	11.17	4.72
Average Across Subjects, Excluding Incomplete Data Sets						
AVG.	14.34	14.72	9.32	13.44	12.40	10.04

Latency: Seconds, Standard Role Plays, per Assessment

Group A			Group B				
	<u>A #1</u>	<u>A #2</u>	<u>A #3</u>		<u>A #1</u>	<u>A #2</u>	<u>A #3</u>
S1	6.29	9.13	3.10		6.43	3.47	2.81
*S2	10.90	3.58	---		15.72	21.12	2.78
S3	11.96	6.56	4.12		4.10	1.87	2.32
S4	3.28	2.49	1.91	*	9.00	1.65	---
S5	9.69	2.38	6.66		9.77	5.70	6.47
S6	6.47	2.19	3.98	*	---	1.21	1.78
S7					3.71	2.59	2.70
Average Across Subjects, Excluding Incomplete Data Sets							
AVG.	7.54	4.55	3.95		7.95	6.95	3.42

Duration: Seconds, Combined Role Plays, per Assessment

Group A			Group B			
	A #1	A #2	A #3	A #1	A #2	A #3
S1	86.48	238.73	320.48	68.19	131.62	246.60
*S2	65.71	89.57	---	56.41	81.02	81.82
S3	122.02	80.34	103.87	32.47	15.95	34.04
S4	50.00	45.89	47.32	* 54.35	32.53	---
S5	40.90	40.61	39.98	54.34	32.53	38.95
S6	14.79	12.02	12.81	* ---	24.53	41.94
S7				30.97	44.56	43.43
Average Across Subjects, Excluding Incomplete Data Sets						
AVG.	62.84	83.52	104.89	48.48	61.14	88.97

Duration: Seconds, Novel Role Plays, per Assessment

Group A			Group B			
	A #1	A #2	A #3	A #1	A #2	A #3
S1	48.88	207.62	228.22	40.16	175.63	150.28
*S2	45.79	85.99	---	25.80	58.36	65.33
S3	75.52	47.97	54.00	18.70	12.24	28.97
S4	4.81	9.85	5.88	* 16.76	15.01	---
S5	24.24	28.85	25.09	52.64	31.22	19.70
S6	4.64	12.74	17.94	* ---	24.53	41.94
S7				18.70	38.39	25.92
Average Across Subjects, Excluding Incomplete Data Sets						
AVG.	31.62	61.41	66.23	31.20	63.17	58.04

Duration: Seconds, Standard Role Plays, per Assessment

Group A			Group B			
	A #1	A #2	A #3	A #1	A #2	A #3
S1	37.60	31.11	92.26	28.03	44.01	96.32
*S2	19.92	15.51	---	30.61	22.66	16.49
S3	46.50	32.27	49.87	13.77	3.71	5.07
S4	18.45	14.53	12.66	* 29.11	9.63	---
S5	16.67	11.76	14.89	1.71	1.31	19.25
S6	10.15	15.75	12.54	* ---	10.06	17.22
S7				12.27	6.17	17.51
Average Across Subjects, Excluding Incomplete Data Sets						
AVG.	25.87	21.08	36.44	17.28	15.57	30.93

* * *

* Incomplete Data Set

Appendix F

Human Subjects Institutional Review Board Letter of Approval



Western Michigan University
Kalamazoo, Michigan 49008-3899

*Human Subjects
Institutional Review Board*

TO: Cheryl Knight
R. Wayne Fuqua

FROM: Ellen Page-Robin, Chair *EP.R*

RE: Research Protocol

DATE: October 25, 1988

This letter will serve as confirmation that your research protocol, "AIDS Prevention through Printed Media: Knowledge and Communication Behaviors of Gay College Males in an Area with a Low Prevalence of AIDS," is now complete and has been signed off by the HSIRB.

If you have any further questions, please contact me at 387-2647.



Western Michigan University
Kalamazoo, Michigan 49008-3899

*Human Subjects
Institutional Review Board*

TO: Cheryl L. Knight
FROM: Ellen Page-Robin, Chair 6.2-2.
RE: Research Protocol
DATE: January 30, 1989

This letter will serve as confirmation that your research protocol,
"A Social Validation Survey on AIDS Prevention Communication Between
Gay or Bisexual Males in an Area with a Low Prevalence of AIDS"
is now complete and has been signed off by the HSIRB.

If you have any further questions, please contact me at 387-2647.

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