Addressing “Heat of the Moment” Thinking that Leads to Unsafe Sex

Ron S. Gold, DPhil

For some time, my colleagues and I have been engaged in a research program designed to reveal factors that might contribute to decisions by gay men to have unprotected anal intercourse. One aim has been to explore the thinking processes that accompany decisions to have unsafe sex. We began with the hypothesis that the great majority of gay men who fail to maintain safe sex probably do so despite knowing of the potential risk. Further, we hypothesized that men who deliberately decide to behave in a way they know to be very dangerous may feel a need to justify this decision to themselves at the time they make it.

The self-justifications employed by people in this context would help to cause unsafe sex, not in the sense of being deep or underlying causes, but in the sense of enabling the unsafe behavior to proceed. It would follow that, if one could appropriately modify or extinguish these self-justifications, the incidence of unsafe sex should decrease. This model is similar to that used in cognitive therapy, in that cognitive therapists seek to identify what they call the "self-talk" or "internal dialogue" that they see as contributing causally to symptomatic behaviors. This article reviews some of the data regarding self-justifications that gay men use when deciding to have unsafe sex and then discusses the conditions that are required for AIDS education to address these self-justifications.

Self-Justifications

Our initial studies asked gay men who had recently engaged in unprotected anal intercourse—734 men in all—to describe the relevant sexual encounter in great detail. As part of the procedure, we presented a long list of possible self-justifications for having unprotected anal intercourse; for each one, the participant was asked if, and how strongly, it had been in his mind at the time he decided to have unprotected sex. As hypothesized, almost all the men had known at the time of the encounter that unprotected anal intercourse was risky. Further, most of the men reported that at least one of the self-justifications listed had been in their minds during the encounter.

Among the self-justifications commonly reported were: "This guy looks so healthy, he can't possibly be infected," "Most of the time I'm careful, but I can't be perfect—it's only human to break out occasionally," and "I just have to have good sex, and I can't have good sex without fucking, and I can't enjoy fucking if I use a condom—condoms take all the feeling away." This article focuses on one self-justification that was especially common: the thought that unprotected anal intercourse would occur, but that there would be withdrawal before ejaculation. In some of the study samples, this was the most frequently reported self-justification of all.

One interesting thing about the resolution to withdraw is the degree to which it was associated with premeditated unprotected intercourse, that is, with an early plan or intention to have unprotected intercourse. We obtained information about the sexual desires that had been in the men's minds at three stages of the sexual encounter: at the start of the "evening" (we told them it did not have to be literally an evening), at the time the participant met the man with whom he later had sex, and at the start of sex. For each stage of the encounter, we calculated the number of men who specifically want-
I don’t know about you, but I am an expert in self-justification when I fail to meet my own standards. These are private moments, times when I detail all the mitigating factors that interfered with my carrying out a commitment I had made to myself.

It is human nature to seek to gratify the insatiable appetite of the superego for deference to an unwavering code of personal conduct. These self-justifications serve the goal of protecting not so much against the criticism of others—those justifications are more conscious and more predictable—but against the less well-articulated criticisms of self toward self.

**Heavy Baggage**

Identifying a self-justification is not the same as identifying the reason for a self-justification. Hidden beneath all these layers is heavy baggage stuffed with the idiosyncracies of a personal psychology, family history, and emotion. Still, self-justifications work because they are assumptions made on the basis of inaccurate information or wishful thinking, and while confronting them will not eliminate the impulse to manufacture them, such confrontations do force a person to face the facts and the reality that he or she has been acting based on falsehoods.

Ron Gold is the pioneer of HIV-related self-justification research, and his work has led over the years to application in a variety of venues. In this issue of *FOCUS*, Gold looks at one of the most common self-justifications for unprotected anal intercourse among gay men: the commitment to withdraw before ejaculation. Through this exploration, he examines the distinction between what he calls “heat of the moment” and “cold light of the day” thinking: the moment when a person marshals a self-justification to enable him or her to contradict earlier commitments to safer sex versus the later moment outside of the sexual arena when he or she explores the reality or unreality at the foundation of that self-justification. James Dilley adds to Gold’s article by recounting the case of a client enrolled in an AIDS Health Project study, which is based upon Gold’s theories, and tests a counseling intervention.

**Consciousness-Raising**

I lied earlier. I do know about you: we are all experts in self-justification. Even if after years of consciousness-raising you or I have mastered our justifying tendencies, we have experienced a long history of applying these tricks to making life’s indiscretions palatable to the internal judge.

Counseling is an ideal venue for self-exploration and after many years, counseling is being recognized widely as the missing link in HIV prevention. Gold holds little hope for mass media interventions, and Dilley offers some insights into the shape of appropriate counseling approaches. Together they begin to suggest not only how prevention programs can harness counseling but also how traditional counseling venues can contribute to prevention.

What we found is that, for men who employed the resolution to withdraw, a desire specifically for unprotected intercourse arose only very late in the encounter. Compare, for example, the extent to which this desire accompanied two sorts of self-justification: that involving the resolution to withdraw and that involving dislike of condoms. Of the men whose self-justifications involved the resolution to withdraw (but not the dislike of condoms), only 7 percent specifically wanted unprotected intercourse at the start of the encounter. While this grew to 9 percent by the time the participant met his sex partner, it was still only 14 percent by the start of sex. In contrast, the corresponding proportions for those men whose self-justifications referred to a dislike of condoms (but not to a resolution to withdraw) were 37 percent, 40 percent, and 45 percent. This pattern of results held for all types of partner; for instance, the results were very similar for a lover and an anonymous partner.

Clearly, the resolution to withdraw was appreciably less likely than self-justifications involving dislike of condoms to be associated with an early decision to have unprotected anal intercourse. It seems instead that the resolution to withdraw is much more likely to be associated with a “very last minute,” rather than a premeditated, decision to have unprotected sex.

**In the Cold Light of Day**

What do these findings suggest about the reasoning that underpins the resolution to withdraw? One can draw a distinction between two broad types of reasoning that might be relevant: reasoning that is present only during sexual encounters—in the “heat of the moment”—and which is therefore relatively fleeting; and reasoning that
is more stable, being present also “in the cold light of day,” as it were.

One might hypothesize that the resolution to withdraw derives from “cold light of day” reasoning. It is conceivable, for example, that the men in our studies had stable beliefs that HIV cannot be transmitted without semen exchange (or, at least, that withdrawal reduces the risk to an acceptable level) and that, at least in this particular situation, they (or their partners) would be able to withdraw in time. But given such beliefs, there would have been no reason not to decide in advance to have unprotected anal intercourse.

The fact that the resolution to withdraw was comparatively likely not to be associated with premeditated unprotected intercourse suggests, therefore, that it may derive not from “cold light of day” thinking, but from “heat of the moment” reasoning—reasoning that would be rejected outside sexual encounters but which appears more acceptable during sex. It may appear more acceptable then because it is during sex that very strong arousal is present, arousal that could reduce available information-processing capacity to the point where it is insufficient to permit fully rational thought. Or, perhaps it is because during sex, the desire for unprotected anal intercourse is most urgent and this may lead to a deliberate tailoring of reasoning to enable that desire to be fulfilled.

While my comments here have focused on the resolution to withdraw, they probably apply, to varying degrees, to other self-justifications as well. If my analysis is correct, there are important implications for HIV education. Almost necessarily, HIV education is delivered outside the context of the sexual encounter. So the beliefs with which HIV education comes into contact are “cold light of day” beliefs. To the extent that self-justifications arise out of reasoning that is rejected in the cold light of day, they may be unaffected by educational information. Thus, for example, take a man who does not have a “cold light of day” belief that withdrawal is an effective strategy. Telling this person, in the cold light of day, that withdrawal is not an effective strategy may have little effect on his reliance on withdrawal during the heat of the moment.

It seems that AIDS education needs to make contact with the reasoning that is present during actual sexual encounters. We have carried out an intervention study in which we tried to ensure this by getting gay men to reflect on and evaluate, in the cold light of day, the thinking that they had employed in the heat of the moment.1 The sample comprised gay men who had recently “slipped up,” in that they had broken their safe sex rules by having unprotected anal sex. The men’s behavior was recorded for four months by means of sexual diaries. In the intervention phase, some of the men were asked to recall, as vividly as possible, a recent occasion when they slipped up. Given a list of possible self-justifications for having unprotected anal intercourse, each participant indicated any that had been in his mind at the time, selected those that had been present most strongly, and stated how reasonable each of these seemed to him now as he looked back on the encounter. This intervention resulted in a reduced incidence of multiple slip-ups in the post-intervention phase compared to both a no-intervention control group and a group given a more conventional form of AIDS education.

The Importance of Personal Involvement

The results of a subsequent study serve to sharpen our understanding of what is required for this sort of intervention to work.2 In the earlier study, the intervention was delivered via a questionnaire, suitable for use in individual counseling and in peer education. Counseling and peer education reach only relatively small numbers of gay men, however. Would the intervention still be effective if translated into a less wordy, more visual form, suitable for use in the mass media?

To find out, we produced 10 posters, all dealing with self-justifications we had found to be fairly common. Some of the posters were designed to convey explicitly that the thinking that takes place in the heat of the moment can differ markedly from that which takes place in the cold light of day. These posters included two photos, one above the other. The top photo showed two men having sex. A thought bubble above the head of one man contained a self-justification for having unsafe sex.

The lower photo showed the same man, now fully dressed, and looking pensive or worried. A thought bubble indicated he
was reflecting ruefully on the self-justification he had used earlier. In one poster, for example, the thought in the top bubble was, "... I'm not perfect... everyone slips up sometimes... just once won't hurt..."; the thought in the bottom bubble was, "... it sounded OK last night... just sounds fucking stupid this morning!"

Other posters were designed to show how two sex partners can simultaneously use self-justifications that, when considered together, are paradoxical or even contradictory. These posters included just a single photo, showing two men having sex. A thought bubble was above each man. In one case, for example, one man's thought bubble read, "... he'll do it without a condom... must be negative like me...", while that of his partner read, "... he'll do it without a condom... must be positive like me."

In the study, these posters were shown to one group of men, who were asked to rate how effective the posters were at getting across the safe sex message to them personally, and to explain their ratings briefly. In contrast to the preceding study, this intervention had no effect whatsoever on behavior: in the post-intervention period, the men exposed to the posters were no less likely to slip up than were those in the control group.

Why were the results so different in the two studies? The explanation that seems most likely is that the posters were simply not as good as the questionnaire at involving the men in the intervention, that is, at inducing them to see the self-justifications as personally relevant. In the questionnaire, personal involvement was assured by the fact that the self-justifications emerged from the men’s own recall of a situation in which they slipped up. In this context, the men could scarcely do other than “own” the self-justifications. In

the posters, by contrast, the self-justifications were presented merely as thoughts going through the minds of the models featured in the photographs. Personal involvement may have been invited, but it was not guaranteed, and it seems very possible that it took place much less completely. Information that is perceived as relating to the self tends to receive deeper, more extensive processing than other information. It would follow that the self-justifications intervention may have made a much deeper impression when it was presented in questionnaire form than in poster form.

Conclusion

What are the implications for AIDS educators? It seems that the self-justifications approach to AIDS education does work, but only if the gay men targeted see the self-justifications presented as confronting them with their own thinking during sex. The problem is that it is very difficult to ensure this using the mass media.

Perhaps AIDS educators need to think more about how face-to-face counseling and peer education programs—in which it is much easier to ensure personal relevance—could be adapted to reach a great many more men than they presently do. For example, perhaps it would be effective to develop a type of “outreach counseling,” in which counselors would go regularly into gay venues to engage individual men in conversation and lead them through an instrument like the self-justifications questionnaire used in our first intervention study. In any case, interventions must focus on personal and situational relevance to challenge the self-justifications that contribute to the occurrence of unsafe sex.

Clearinghouse: Self-Justification

References


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Self-Reflection as a Tool for Behavior Change

James W. Dilley, MD

Despite years of public information campaigns and a variety of HIV prevention programs, people at risk for HIV infection often have difficulty maintaining a commitment to safer sex practices. Mental health providers have long appreciated that making and maintaining changes in sexual behavior is a complex process and in fact, expect some degree of relapse to occur. The difficulty in remaining consistently safe is particularly acute for people whose sexual partners come from groups where there is a high prevalence of infection, for example, among gay men in urban areas. Nevertheless, the question remains, how does a person “decide” to engage in behavior that he or she knows is risky? What are an individual’s thoughts or beliefs at the time of deciding to take a risk? And, if a person can identify these thoughts or beliefs, what is the likelihood that these can be changed or influenced?

A randomized long-term study conducted by the UCSF AIDS Health Project looks at the issue of justifications people use to rationalize unsafe sexual behavior. A case from this study offers insights into some of these questions and into an approach to help people learn from their justifications in order to strengthen their abilities to maintain safer behaviors.

Justifying Unsafe Sex

Several years ago, Australian psychologist Ron Gold asked gay and bisexual men ages 20 to 39 whether, and to what extent, a series of thoughts, or beliefs was in their minds at the time they engaged in unprotected anal intercourse.1,2 “Intercourse” was defined as including both insertive and receptive sex, with or without ejaculation, no matter how brief the penetration. Gold gave participants a list of self-justifications and asked the degree to which they had considered each justification at the time of the encounter.

A Case of Withdrawal

In the fall of 1996, the AIDS Health Project (AHP) used these same questionnaires to study a group of San Francisco gay men who had engaged in unprotected anal intercourse (either receptive or insertive) and who had tested HIV-antibody negative at least once before. Further, AHP implemented an intervention using a single counseling session in the company of an empathic and observing therapist that focused on the encounter and a discussion of the client’s thoughts about it.

The case of Steve illustrates the study’s work:

Steve was a casually dressed, 33-year-old gay White man who moved to San Francisco about six months before his March 1998 interview. He was articulate, intelligent, psychologically minded, and curious about his motivations. He moved to San Francisco with big hopes of advancing his career in the retail sales trade; the corporate office of his employer was based in San Francisco. He recalled that after a “busy” and “fun” holiday sales season his job began to feel onerous and boring, and he felt little hope for advancement. He had little money.

Steve said that in late January, about three weeks after his boyfriend of six months had told him he “just wanted to be friends,” he became increasingly “horny” and ultimately decided to call an erotic massage therapist whose ad he saw in a

References


By carefully walking through the events that led up to his “decision” to have unsafe sex, Steve was able to see the links among his frustration with life, his loneliness, and his decision.

Steve described his escalating dissatisfaction with his life and acknowledged needing to “do something” to get back on track when he was feeling this way. The therapist emphasized the importance of Steve’s paying attention to his frustration and loneliness before they led him to actions he would later regret. They discussed other strategies Steve might employ in the face of these challenges, including contacting friends and being more socially active, and developing and pursuing other interests. Steve and the therapist talked about the advantages of planning—of taking the initiative to identify and engage in pleasant activities in order to intervene with his frustration and his sometimes desperate feelings to want “someone else to be in charge.” They also discussed Steve’s assumption that he could trust someone he barely knew “to withdraw before ejaculation.”

Afterwards, Steve said that the chance to talk in detail about his thoughts and his life was helpful in understanding his behavior and why he had acted as he had. He said he appreciated the link between his feelings and his eventual “poor” decision. He decided he needed additional support in his life and talked about finding a support group for seronegative gay men.

Conclusion

Further work is being done to evaluate the effectiveness of the counseling intervention used in this study. Isolating particular thoughts a client had at the time of the decision to have unsafe sex and re-examining them in the context of a counseling relationship may prove helpful in reducing high-risk activity. The study design will allow us to look at the effectiveness of the counseling intervention independently, and, if successful, could easily be taught to other counselors working with men who engage in high-risk sexual behaviors.

Authors

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Comments and Submissions

We invite readers to send letters responding to articles published in FOCUS or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals, including a summary of the idea and a detailed outline of the article. Send correspondence to:

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The Sex and AIDS Thought Scale

A study of the relationship between cognitive factors and specific sexual situations found that the fear of contracting HIV disease is not a strong predictor of condom use among gay men. Based on the responses of participants in the study, the researchers developed the Sex and AIDS Thought Scale (SATS), a list of thoughts gay men may experience prior to and during sexual activity.

In the first phase of the study, researchers derived the SATS from the anonymous responses of 16 gay men to an open-ended questionnaire that asked them to list all the thoughts that would either make them want to have sex with an attractive new partner or discourage them from having sex with him. In the second phase, 203 gay and bisexual men read the items in the SATS and rated on a five-point scale their likelihood of having any of these thoughts in the given sexual situation.

Subjects were from a large metropolitan area in the southeastern United States. Ninety-six percent were gay, and 4 percent were bisexual. The sample was 91 percent White, 1 percent Black, 4 percent Hispanic, and 4 percent of other races or ethnicities. The mean age of the subject pool was 31 years, and the mean education level was 16 years.

The final 38 items of the SATS comprised four cognitive subscales: "Safety Consciousness," relating to concerns about becoming HIV-infected; "Risk Justification," centering on the value of spontaneity, instant gratification, and risk-taking; “Sexual Importance,” focusing on the positive aspects of sex; and "Interpersonal Consequences," reflecting apprehensions about expressing a desire to practice safer sex because of a partner's potential negative reaction.

Correlations between the SATS scores and rates of condom use during both receptive and insertive intercourse corresponded to perceived partner risk level. Low-risk partners were those who recently tested seronegative, and high-risk partners were infected or of unknown HIV status. The perception of a partner's HIV status, regardless of its accuracy, provided the psychological context for decisions about practicing safer sex. For encounters with high-risk partners, responses to the Risk Justification and Interpersonal Consequences subscales, which reflect the inability to delay gratification and apprehension about suggesting condom use, corresponded to greater condom use for both insertive and receptive intercourse.

Relapse Prevention Counseling
Roffman RA, Stephens RS, Curtin L, et al. Relapse prevention as an interventive model for HIV risk reduction in gay and bisexual men. AIDS Education and Prevention. 1998; 10(1): 1-18. (University of Washington, Seattle; Virginia Polytechnic Institute and State University; Appalachian State University; and the Los Angeles County Department of Mental Health.)

A 17-session counseling intervention based on a cognitive-behavioral addiction relapse prevention model was effective in temporarily reducing HIV risk in gay and bisexual men, according to a preliminary study. The model increased the rates of protected sex for three months, however, after six months, these rates dropped to below pre-treatment levels.

Participants—159 gay and bisexual men from Seattle—completed a pre-treatment survey to assess demographics, sexual activity, AIDS risk knowledge, feelings associated with high-risk behavior, loss of control, self esteem, and social support. Ninety-one percent of participants were White, 65 percent were college educated, 80 percent were employed, 62 percent were seronegative, and 79 percent were not in primary gay relationships. The mean age of the sample was 35.

Researchers divided subjects into a relapse prevention counseling group and a control group. The relapse prevention group focused on HIV education, identifying high-risk situations, developing coping strategies for and alternatives to high-risk sexual behavior, and improving assertiveness and listening skills. Exercises included role playing scenarios and discussing successes and difficulties in avoiding unsafe sex. At the end of the program, members of the relapse prevention and control groups

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**Recent Reports**

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Researchers used a variety of methods to evaluate sexual activity, assertiveness skills, situational efficacy, and coping. Over the course of treatment, self-efficacy and sexual assertiveness scores in the role-playing scenarios increased significantly, and participants became less likely to associate unprotected sex with sexual or emotional fulfillment. Rates of condom use returned to baseline levels one year after end of treatment; however, although condom use did not increase, the total amount of sex decreased. After completing the 17-session relapse prevention counseling intervention, members of the control group reported similar results.

Print Media versus Community Outreach


A study comparing two types of community-level HIV prevention campaigns for women found that print media reached a larger number of people, but community outreach was more effective in reaching women at highest risk for HIV infection, including those who exchanged sex for money or drugs. The study, conducted in Philadelphia, found a correlation between exposure to print media and increased communication about condom use, but there was no correlation between exposure to either intervention and changes in condom use.

The print media campaign consisted primarily of handouts recounting the true stories of women from the community who had changed or were trying to change their HIV-related risk behaviors. More than 40 role-model stories focusing on how to practice safer sex and communicate with a primary partner were distributed by outreach workers and through businesses and organizations frequented by women. For three years, outreach workers distributed condoms to women and counseled peers on safer sex. The target population consisted of women at risk for HIV infection, sexually transmitted diseases (STDs), or unwanted pregnancy. Researchers estimated the target population to be 4,000 women, and determined that 2,000 women were directly exposed to the campaign, with print media reaching 46 percent of the women and outreach contacting 23 percent.

Two years after implementing the campaign, researchers interviewed 479 randomly selected women between the ages of 15 and 34 to assess the efficacy of the interventions in reaching subjects and in changing condom use behavior with primary partners. Ninety-six percent of the women were African American, and 69 percent had at least a high-school education. Forty-one percent reported prior STD infection, and 30 percent had used drugs in the past six months.

Each campaign strategy was effective in reaching different portions of the target population. Although women in substance abuse rehabilitation were eight times more likely than those not in treatment to have contact with print media, women with a history of STDs were twice as likely as those who had never had an STD to interact with community outreach. The groups with the highest rates of exposure to outreach—women who exchanged sex for money or drugs and women who had an STD history—were also those with the lowest rates of condom use. Young women who had high rates of exposure to print media had similar rates of condom use as young women not exposed to print media.

Next Month

If HIV complicates everything, it complicates sex perhaps more than anything else. Safer sex guidelines are relatively clear, but once HIV enters a relationship, nothing else is straightforward. A beginning point for clarifying this situation is for both partners to disclose serostatus. In the September issue of *FOCUS*, Peter Keogh, PhD, a prevention researcher from London, discusses the conundrum of disclosure of seropositive HIV status and the factors associated with it.

Also in the September issue, an anonymous author who is seronegative talks about his seropositive partner who is having unprotected sex outside the relationship. Here disclosure is not an issue—his lover is honest with everyone about his serostatus—but sexual practice is, and this author discusses the whole range of feelings he experiences related to this.
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