At a recent discussion of health educators about relapse into unsafe sex among gay and bisexual men, a participant suggested that theory-based principles of behavior change be used as guides to develop relapse prevention interventions. Other participants responded with skepticism; the majority seemed to agree that theory should remain in the classroom.

What use, if any, does theory have in the critical area of sexual relapse prevention? To address this question, this article summarizes four basic behavior theories—The Health Belief Model, Social Cognitive Theory, Stages of Change, and Marlatt's Relapse Prevention Model—and examines the applicability of these theories in planning prevention interventions.

**The Health Belief Model**

The Health Belief Model grew out of research in the 1950s and 1960s—by Irving Rosenstock and colleagues at the United States Public Health Service—that investigated the widespread failure of people to take preventive health measures such as annual physical checkups, and screening tests for tuberculosis and dental disease. The model postulates that individuals will take preventive actions when they:

- believe that they are susceptible to a disease that would have at least moderately severe negative consequences;
- believe that taking such actions will be beneficial in reducing the threat of the disease and that this benefit will sufficiently outweigh the costs, such as the inconvenience and effort required, embarrassment, and financial expense;
- perceive a stimulus or "cue to action": either internal, for example, the perception of an uncomfortable bodily state; or external, for example, mass media campaigns, newspaper articles, or personal knowledge of someone affected by the disease.

The perception of threat and the occurrence of a cue to action, which raises awareness of feelings of threat, lead to the decision to act. The direction that action takes is influenced by beliefs about the relative availability and effectiveness of alternatives for reducing the threat, which, in turn, are influenced by social norms.

**Social Cognitive Theory**

Albert Bandura's Social Cognitive Theory suggests that in order to take a particular course of action, individuals must not only possess the required skills but must also believe that the action will lead to a desired outcome and that they are personally capable of performing the action. This belief in personal capability, known as "self-efficacy," is a pivotal concept in Bandura's theory: it influences how much effort a person invests in an action and how long he or she will persevere in the face of difficulties or disappointing results.

An individual develops self-efficacy by accumulating feedback from four primary sources: personal experience of successfully performing the behavior; vicarious experience through observing others perform the behavior ("modeling"); persuasion by others who convey that the individual is capable of performing the behavior; and physiological states.

Of these four sources of information, successful performance or "mastery" experiences are considered the most potent in raising levels of self-efficacy. Proficiency with new behaviors requires extensive practice. Ideally, this practice
Editorial: Right Behavior
Robert Marks, Editor

In the HIV community, the word “relapse” has taken on almost mythic proportions. In the wake of dramatic changes in sexual behavior among gay men, HIV prevention efforts were held up to the world as a model. Relapse was the David that tarnished this Goliath achievement, proving that our declarations of victory were premature.

Both beliefs—that behavior change succeeds or fails—are oversimplifications. Behavior change is a process, not an attribute that one acquires, not a vaccine that once injected protects for life. In this issue of FOCUS, David Silven’s examination of four behavior change theories demonstrates the complexity of this process and the variety of factors called into play each time an individual makes a decision about behavior. Wayne Blankenship’s survey of relapse programs shows how educators have begun to respond to this complexity.

As much as we hope that the behavior change process can be facilitated by the programs Blankenship covers, it is clear that the central arena in which the struggle plays out is in the minds of individuals. And these minds are not as easily manipulated to change sexual practices as they seem to be to change breakfast cereal or soft drink.

Defined more by individual than by cultural or societal perceptions about sex, intimacy, risk, and the value and struggle of life, the response to behavior change interventions is far more complicated than it might first appear. “Relapse” is an indication not of the failure of HIV prevention, but of the importance of counseling approaches that respond to these individual perceptions.

Mental health practitioners are faced with the crucial task of framing HIV prevention in this context and helping people work toward understanding their attitudes and feelings about these issues. Silven’s article will help counselors identify theoretical approaches, and Blankenship’s will help practitioners appreciate the range of prevention programs.

To succeed in their efforts, however, counselors might consider tempering ultimate therapeutic goals and redefining success. If lapses are a normal part of behavior change, and if it is in acknowledging our beliefs that we can recognize the motivations that determine the behaviors we choose, then the counselor’s goal is first and foremost to get clients to confront the thoughts and feelings that induce risky behaviors.

Given the complexity of these factors, the hardest part of the counseling effort is that it must go beyond the assumption that everyone will, or should, embrace life. Success for the therapist is not in deterring relapse but in enabling clients to consider these issues so that they may come to their own prevention-positive conclusions.

occurs with considerable external guidance, encouragement, and feedback; it progresses gradually to more challenging situations, the removal of external support, and increased opportunities for self-guided practice. Failure and difficulty during the learning process help build a resilient sense of self-efficacy by providing experience in overcoming setbacks.

Through modeling, people learn skills and judge their capabilities in comparison to others. It is crucial that individuals perceive themselves as similar to the models they observe, particularly in terms of the degree of hesitancy and fear they feel in challenging situations.

Persuasion by others provides encouragement that can lead people to believe they are capable of performing a desired behavior. The impact of persuasion varies according to the perceived credibility of the persuader.

Finally, individuals rely partly on their physiological state to judge their abilities to perform target behaviors. Self-efficacy is strengthened when people possess skills to reduce uncomfortable physiological reactions, such as agitation, and insight to interpret these reactions as normal rather than as a sign of inefficacy.

Stages of Change

In the early 1980s, James Prochaska and Carlo DiClemente outlined several fundamental stages through which individuals typically progress when making behavioral changes: precontemplation, contemplation, action, and maintenance of change. During the precontemplation stage, people are unaware—because they are uninformed or in denial—of having a problem in need of change, even though others may perceive the problem.

In the next stage, contemplators are seriously thinking about but not committed to changing their behavior. They tend to be relatively open to feedback and education about the problem behavior. The contemplation stage ends at the point that a commitment to change is made.
Progression through the stages is cyclical rather than linear. People will often revert to an earlier stage, which is then repeated. Relapse is seen as leading back to either the contemplation stage, from which the individual may again attempt to change, or to the precontemplation stage, during which the individual succeeds in avoiding, at least temporarily, having to think about the behavior as a problem.

People utilize different processes of change during the various stages. In the contemplation stage, for example, the processes include information-seeking and evaluation of one’s behavior. In the action and maintenance stages, processes include changing the environment to build in supports for new behaviors and to minimize risk-associated stimuli, and developing new responses to these stimuli.

Marlatt’s Relapse Prevention Model

Alan Marlatt and his colleagues developed in the mid-1980s a cognitive-behavioral model that focuses on coping during “high-risk situations,” situations that pose a threat to the individual’s sense of control and increase the risk of relapse. According to the theory, lapses—or single incidents of slipping into the avoided behavior—are considered important and expected components of the behavior change process. Through trial-and-error, new response patterns in high-risk situations are gradually acquired, corrected, and strengthened.

Whether lapses are followed by a total relapse, that is, a return to baseline levels of the behavior, is largely determined by how the individual reacts to the lapse: this is called the “Abstinence Violation Effect.” If he or she perceives the slip as a response to a particularly difficult situation or as a sign that he or she needs more practice with the new behavior, the lapse is unlikely to lead to relapse. On the other hand, if the individual attributes the slip to personal weakness or failure, the risk of relapse is greatly increased.

Another aspect of the Abstinence Violation Effect is the experience of cognitive dissonance resulting from the contradiction between the individual’s self-perception as an abstainer and the occurrence of the prohibited behavior. This dissonance creates conflict or guilt and motivates efforts to eliminate these unpleasant feelings. Thus, people may engage further in the prohibited behaviors in an attempt to produce positive feelings to replace these unpleasant ones. Alternately, there may be a change in self-image as lapsers begin to think of themselves as non-abstainers. In either of these cases, the stage is set for relapse.

Additional factors contributing to the risk of relapse include the use of denial to mask the potential negative consequences of slipping, and rationalization to justify the prohibited behavior based, for example, on the extreme demands of everyday life. Finally, relapse may be seen as the result of a chain of decisions leading to a high-risk situation.

Applying the Theories

These theories suggest several reasons why sexual relapse might occur and guidelines for how to minimize the risk of its occurrence. First, as suggested by the Health Belief Model, people may relapse because they no longer perceive unsafe sex as a significant problem. As suggested by the Stages of Change theory, behavior change may naturally involve back-and-forth movement among stages, including repeated reentry into the precontemplation stage of unawareness. Alternately, people may initially change behavior from unsafe to safer sex as a result of external pressure, and prior to a firm internal commitment to safer sex; once the external pressure diminishes, the behavior change breaks down. A third explanation, using Marlatt’s model, is that people fail to perceive unsafe sex as a problem because of the psychological denial they employ to avoid anxiety.

HIV-infected people, in particular, may relapse because they question the legitimacy of warnings against the dangers of “re-infection” by HIV. Others may be unaware of the seriousness of the risk to their immune systems of other diseases that can be contracted through unsafe sex.

Successful prevention efforts should first establish whether the target audience is fully aware of the dangers of unsafe sex before proceeding with information about prevention strategies. For those who are not yet committed to avoiding unsafe sex, educators might direct efforts at mobilizing interest in exploring whether a problem really exists. For those who are misinformed or uninformed, providing information about risk is critical.

Second, as suggested by the Health Belief Model and Social Cognitive Theory, people may relapse because they are not
Convinced that safer sex adequately reduces the chances of infection. Specifically, they may question whether condoms are truly effective barriers against transmission. They may have heard stories about condoms breaking, or about people becoming infected presumably without having participated in unsafe sex or other high-risk activities. Again, supplying clear and credible information—in this case, about the effectiveness of condoms—would seem critical.

Third, people may relapse because, as the Health Belief Model further suggests, they do not feel convinced that the health benefits of safer sex outweigh the effort required to avoid unsafe sex. As Marlatt points out, those who experience day-to-day life as full of demands may reach a point where they no longer feel motivated to pursue long-term goals—in this case, health and longevity—that involve depriving themselves of short-term pleasure or relief. Or, they may not feel they have the internal strength and resources needed for prolonged efforts avoiding unsafe sex. This may be particularly true of many who are feeling the effects of loss and grief. Help in coping with extreme stress, depression, and loss may be necessary before these individuals can feel renewed commitment to safer sex.

Fourth, according to Social Cognitive Theory and Marlatt, people may relapse because they do not have, or do not feel they have, the necessary skills to avoid unsafe sex in all situations. This may result from insufficient trial-and-error learning. People may lack skill or confidence in using condoms or in having satisfying forms of safer sex that do not require condoms. They may also lack the skill or confidence required to effectively deal with various situations that can easily lead to unsafe sex. These include negotiating or talking about safer sex with partners; insisting on safer sex; coping with stress related to social anxiety; and responding to social or internal pressures to drink or use drugs in conjunction with sex.

Finally, according to Marlatt, people who relapse may lack the awareness or resolve to break the chain of events that tends to lead to high-risk situations. For example, a man may be unable to stop himself from going to a bar to find a sex partner, despite the fact that he knows that this will lead to the pressure to drink heavily, the likelihood that he will become intoxicated, and the heightened risk that he will engage in unsafe sex as a result. Furthermore, they may lack the ability to see failures or setbacks as normal parts of the learning process, leaving them unable to rebound when slips do occur.

Conclusion

These theories suggest that behavior change interventions must go beyond providing prevention information and limited practice with condoms. Educators must make efforts to identify additional areas in which target audiences lack skills, including negotiating safer sex and avoiding situations in which sex and mind-altering substances are mixed. They must help people acquire skills and achieve mastery, provide practice in coping with mistakes, and prepare individuals for the possibility that lapses may occur. Finally, for those not ready to commit to avoiding unsafe sex, supplying basic information may be ineffective without efforts to address the reluctance to change.

Clearinghouse: Preventing Relapse

References


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The unprecedented success of safe sex programs for gay and bisexual men has led to the recent focus on relapse prevention programs aimed at men who have made a commitment to safe sexual behavior but have experienced lapses into unsafe sex. This article examines current gay and bisexual men's relapse prevention programs ranging from peer education and professional counseling—which seek on a personal level to encourage consistency—to social marketing strategies—which are designed to solidify community norms supporting safe behaviors.

It is important to note that designing relapse programs is complicated by the difficulty of identifying and recruiting participants. Even the best programs will fail if those targeted do not participate.

Peer Education Models

Peer education models have sought to create a safe and nonjudgmental environment in which men can discuss the complexities of long-term behavior change while learning from others. One such program at Gay Men's Health Crisis (GMHC) in New York—the "Keep It Up" workshops—began in 1989, before the terminology of "relapse" had been used to describe what GMHC had identified as "inconsistencies" in safe sex behavior.1 "Keep It Up" workshops were designed as follow-up support for men who had attended a safe sex forum. The day-long workshop, facilitated by small group discussion leaders, focused on eroticizing safe sex, developing negotiating skills, and resolving other challenges related to behavioral inconsistencies. Also, some men described relapse in terms of compulsive or out-of-control situations while others described it as a conscious decision to have unsafe sex.

Among the peer education programs that first focused specifically on relapse were the STOP AIDS Project in San Francisco and LIFEGUARD in Los Angeles. In the past few years, relapse-related workshops have become more targeted and specific, for example, focusing on mixed serostatus couples. City agencies collectively produce San Francisco's annual "Carnal Carnival," which includes live demonstrations and games geared to sustain an interest in safe sex in a city where some men have become numb to the usual educational messages. Other programs around the country have found that workshops using dating and relationships as a primary focus—"How to Meet a Man" is the title of one—are successful in breaking through the resistance to attend yet another safe sex workshop.

Another innovative strategy coordinated by Jeffrey Kelly at the University of Wisconsin trains popular gay men to serve as "key opinion leaders" in the gay male community.2 By instructing them in developing a new vocabulary—for example, "I am learning to..." rather than "You..."
A new study suggests that overestimating risk of unprotected oral sex may, in fact, contribute to relapse into unprotected anal sex.5

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Counseling Models
Counseling models have sought to provide therapeutic behavior modification or structured referral and prevention for men experiencing relapse. The ARIES Project from the University of Washington in Seattle uses a group phone counseling format in a cognitive-behavioral approach.3 Men either participate in 14 half-hour anonymous phone sessions or as members of a control group. Initial results indicate that men from rural areas and men who are less identified with the gay community access this type of service at higher rates than they access other types of services.

Two San Francisco programs—the UCSF AIDS Health Project’s Safer Sex Counseling Program and 18th Street Services, which targets gay men in recovery—offer relapse-specific counseling interventions.

Also in San Francisco, the Gay Men of Color Consortium, Japanese Community Health Center, Stop AIDS Project, and San Francisco AIDS Foundation are beginning to provide city-wide referral and individual case management concerning behavior maintenance. Men who have identified relapse as a concern will get help developing a prevention plan with realistic goals and individualized completion criteria.

Social Marketing
Several agencies have been successful in using high-profile, environmental ad campaigns to encourage change in peer norms for safe behaviors. The Northwest AIDS Foundation in Seattle designed an ad campaign using the “Keep It Up, Seattle” slogan to send a congratulatory message encouraging consistency and a sense of personal and gay community pride.

The San Francisco AIDS Foundation ran a relapse-specific ad campaign including two full-page ads on consecutive pages—one titled “Relapse” and one titled “Maintain.” The first ad articulated a clear definition of relapse, and the second acknowledged and encouraged safe behavior maintenance.

Many of the recent high-profile ad campaigns from “first wave” cities, like the foundation’s 1992 “Moral Majority, Family Values, Right to Life” subway and bus shelter posters are designed to support behavior maintenance by asserting that safe sex is an accepted norm for gay men. These public programs seem to be most effective when other interventions are in place to provide further information and support.

Future Applications
This short history of gay men’s relapse prevention programs raises as many questions about the future of relapse prevention as it answers about the current state of safe sex education. Do we adopt the terminology of “relapse” or “behavior maintenance” in our education strategies? Do we follow the model of substance abuse prevention, and if so, do we employ strategies that stress abstinence or gradual and systematic risk reduction?

How do we rethink our primary messages to gay and bisexual men who may have believed that safe sex was a temporary concession in the mid-1980s rather than a lifetime commitment? What message are we offering seropositive men about the need for continued safe sex? How do we discourage some behaviors without the financial support from government to “promote” less risky ones? How do we counter media stories that characterize our efforts as failures in headlines like “Gay Men Still Engaging in Unsafe Sex?”

These questions cannot be answered without additional funding for research regarding such issues as gay male sexuality and the relative risk of behaviors like oral sex, and how behavior is affected by grief and other responses to surviving the epidemic. They also cannot be answered without comprehensive and scientific evaluation of prevention approaches.

Ironically, the goals of current relapse prevention strategies—to encourage confidence and self esteem—are often in conflict with cultural messages about gay men. As we struggle to create images of confident and successful gay men—supported by their peers to engage in healthy behaviors—continued underfunding of prevention programs affirms the frightening idea that the lives of gay men are expendable sacrifices to the first decade of the epidemic.

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:

Editor, FOCUS
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A Critique of the Concept of Relapse

The concept of relapse confuses efforts to understand why some gay men engage in unprotected anal intercourse after periods of not doing so. According to a methodological and empirical critique of the term relapse, this concept fails to convey the contexts and decision-making processes within which sexual behaviors occur. Use of an absolute category obscures the nature of relationships within which risks are taken and overlooks how knowledge of antibody status affects choices. For example, the risk of engaging in unsafe sex is lower between antibody negative gay men in monogamous relationships. In this context, a decision to engage in risky sex is best described not as a “relapse” but as a decision made after an analysis of relative risks. The design of some relapse studies also obscures the facts that some gay men may be better described as “chronic high-risk takers” and that younger gay men may be commencing a particular sexual activity rather than relapsing.

“Relapse,” borrowed from medical science specifically in terms of alcohol and drug addiction, imparts a negative moral judgment to sexual behavior. The concept also implies that unsafe sex is addictive, whereas research demonstrates that gay men who engage in unprotected anal intercourse cannot be distinguished in any way from other gay men. Further, the model of human sexual response that underlies the concept of relapse portrays gay male sexuality as governed by powerful penetrative needs that require long-term policing. This portrait plays into societal prejudices and stereotypes about gay men.

To accurately understand gay male sexual behavior and HIV transmission, future studies should be more process-oriented, that is, focused on how the nature of each relationship affects decisions to take sexual risks. Analysis of other situational factors, such as the antibody status of partners, the emotional dimensions of relationships, and prevalent local and social realities would reveal the true complexity of gay male sexuality.

Interventions That Reduce Risk Behaviors

A comprehensive review and analysis of the research on AIDS interventions published from 1980 to 1990 found that a combination of AIDS information, motivation, and behavioral skills can reduce risk behaviors. A suggested model features interventions targeted at populations whose needs must be clarified through research to determine levels of AIDS knowledge, motivation, and behavioral skills. The resulting population-specific interventions must then be evaluated in terms of specific outcomes. The reviewers analyzed 48 published and unpublished reports of interventions directed at gay and bisexual men, injection drug users, prostitutes, college students, adolescents, STD clinic attendees, and the general public. They described the nature of the intervention, the numbers of people affected, and the intervention's impact. Most interventions were based on an informal mix of logic and practical experience, rather than on social psychological theory, and rarely included research to identify the specific needs of the target populations. Interventions with a broader focus conveying HIV-related information, motivation, and behavioral skills tended to have a greater impact, although most of these interventions had methodological problems that undercut their usefulness and applicability.

In the proposed intervention model, information is necessary but not sufficient to produce change. Motivation to change AIDS-risk behavior must also be present. Using the theory of reasoned action developed by Fishbein and Ajzen, individual and societal attitudes towards preventive behavior are the key elements affecting motivation. Identifying these attitudes and designing interventions to change them is the focal point of prevention efforts. Finally, the intervention model...
asserts that behavioral skills must be taught, rehearsed, and modeled. Among these skills are communicating and being assertive with sexual partners about specific safer sex practices and self-efficacy, that is, a belief in one’s ability to behave in certain ways.

**Long-Term Risk Reduction by Drug Users**


Factors that influence initial HIV risk reduction do not affect maintenance, according to a study of injection drug users in New York City. Initiating risk reduction was associated with having fewer sex partners and with having friends who practiced risk reduction. But maintaining risk reduction was linked to ethnicity—specifically, Latino/Hispanic—and to a belief that risk reduction protects against HIV infection.

Following a face-to-face HIV prevention intervention focusing on sexual and drug-using behaviors, researchers recruited and questioned 399 injection drug users in New York City about their sexual practices, drug use, beliefs about AIDS, and demographic characteristics. Subjects were primarily White men (45 percent), most were male (71 percent), and 44 percent had less than 12 years of education. The mean age was 35 years. Although 80 percent had initiated risk reduction, a significant minority (36 percent) reported some degree of relapse to pre-intervention risky behaviors. Most instances of relapse, however, were episodic.

Because the factors affecting initiation and maintenance were different, risk reduction is best understood as a process accomplished in stages. To be successful, interventions must address the motivational demands appropriate to each stage.

**Predicting Relapse among Gay Men**


Being in monogamous relationships, receiving minimal peer support for safer sex, and lacking assertiveness in negotiating about sex were among the interpersonal factors that predicted relapse among subjects in a large study of gay men in Chicago. Personality factors, such as self-esteem and mastery, and sociodemographic factors were not predictive.

Researchers analyzed questionnaires submitted by 910 participants in the Chicago component of the Multicenter AIDS Cohort Study (MACS). A majority of respondents were White (92 percent); the mean age of the group was 35, mean income was $26,000, and mean educational attainment was 16.3 years.

From 1986 to 1987, of those practicing receptive anal intercourse, 53 percent maintained safer sexual practices and 31 percent relapsed; of those practicing insertive anal intercourse, 47 percent maintained safer sex practices and 35 percent relapsed. For both groups, relapse occurred among those who were less motivated to reduce transmission risk, had lower limit-setting skills, were less assertive in negotiating safer sex, and had a lower tolerance of safer sex. Men who practiced receptive anal sex were also less likely to be satisfied with condom use.

The results of this study may be biased by study design and data collection techniques, including self-selection and self-report biases, and a dropout effect. It is best applied to individuals similar to the

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**Next Month**

Among the greatest HIV prevention challenges is delivering messages to populations that have been traditionally underserved and hard-to-reach. There are few groups that meet this description more precisely than inner city, African-American adolescents. In the February issue of *FOCUS,* Patrick McLaurin and Ivan J. Juzang, co-founders of Philadelphia-based MEE Productions, which is connected with the University of Pennsylvania, discusses this challenge, using as a starting point data from an MEE study on delivering substance abuse and “prosocial” messages to Black inner city teenagers. He summarizes this data and examines its application to HIV prevention education.

Also in the February issue, Anita D. Taylor, Director of Public Policy of the National Minority AIDS Council in Washington, discusses the effect on prevention programs of Magic Johnson’s announcement of his HIV infection and outlines the prevention challenges for the African-American community.
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