WHY ADULTS INDULGE IN BEHAVIORS THAT PLACE THEM AT RISK FOR HIV/AIDS INFECTION: A NORTH TEXAS AIDS CLINIC EXAMPLE

A DISSERTATION

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BY

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To the Dean of Graduate Studies and Research:

I am submitting herewith a dissertation written by Helen Elizabeth Hughes entitled "Why Adults Indulge in Behaviors That Place Them At Risk for HIV/AIDS Infection: A North Texas AIDS Clinic Example." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Health Education.

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DEDICATION

To my beloved Edward,

Whose love and support made my dream a reality.

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Abstract

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The purpose of the study was to determine some of the internal motivations that adult HIV-infected persons from a North Texas AIDS clinic identify as relevant to their indulging in HIV/AIDS risk behaviors. The participants of the study ($N = 29$) were self-selected from a group of clients at a North Texas Health Care Clinic. The study was a retrospective study and used the Health Belief Model as a theoretical framework. The paper and pencil self-report instrument contained general demographic inquiries, the five original research questions, and questions that were drawn from the Texas Department of Public Health North Texas HIV-AIDS 2000 Report. These questions were concerned with HIV/AIDS knowledge, safe sex behaviors, condom use, and drug use/abuse. The theory of optimum bias, AIDS bias, and the handicap principle were among the motivating factors discussed. The participants provided insightful strategies for health and prevention education. Implications for Health Studies practice and recommendations for further research are included.

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CHAPTER I

INTRODUCTION

Twenty years ago, Acquired Immunodeficiency Syndrome (AIDS) was identified as a serious disease that eventually kills its victims. During the past 20 years, vast amounts of health promotion and health education materials have been produced, extolling the dangers of HIV/AIDS infection and the means for preventing infection (Centers for Disease Control and Prevention, 1999).

On December 31, 2000, The Centers for Disease Control and Prevention released a report stating that 774,467 persons had been reported as being HIV positive in the United States and that 448,060 of those had died. The number of persons living with AIDS, stated as being 322,865, was the highest reported to date (Centers for Disease Control and Prevention, 2000). At the same time this report was made available, the Texas Department of Public Health (TDPH) released a report on the incidence of HIV/AIDS in the different regions of Texas. The North East Texas Area, of which Denton County is a part, had one of the fastest rising incidence rates of HIV/AIDS (TDPH, 2000a). Although this area includes the cities of Dallas and Fort Worth and the smaller cities located within the 30-mile corridor between these two urban centers, the North East Texas Area is largely rural.

The TDPH report used certain questions to determine the potential reasons for this rise in incidence. After 20 years of HIV/AIDS education, notoriety of the disease, and deaths, several questions remain to be answered. Do people still not know of the risk, or are they unaware of the means of prevention? Are there other factors at work and, if so, what are those factors?

Purpose of the Study

The purpose of this study was to determine the internal motivations that adult HIV infected persons in North Texas identify as relevant to indulging in behaviors that placed them at risk for HIV/AIDS.

Definition of Terms

The following definitions are considered the medically correct and socially acceptable definitions of these terms. They are used consistently throughout the remainder of the dissertation.

1. HIV (Human Immunodeficiency Virus)--the virus that is responsible for the disease AIDS. HIV is transmitted through sexual contact and exposure to infected blood, blood products, and body fluids. The term HIV is used to denote the infection. AIDS is used to denote the medical illness (Department of Health and Human Services, 2001; Thomas, 1993).

2. AIDS (Acquired Immunodeficiency Syndrome)--a fatal immunological disorder that is acquired by exposure to the HIV virus during sexual contact and/or

exposure to infected blood, blood products, and/or body fluids (Department of Health and Human Services, 2001; Thomas, 1993).

3. Risk behavior--any, or all, actions that place an individual at risk for HIV infection. For the purpose of this dissertation, these may include use of injectable drugs, sharing of unclean drug usage paraphernalia, or the practice of sex without the use of a condom.

4. Optimum bias--a psychological phenomenon that acts as a self-preserving mechanism. It purports that bad things are more likely to happen to others than to oneself (Kirscht, Haefner, Kegeles, & Rosenstock, 1966; Weinstein, 1982, 1987). It may be an ego-defensive behavior, or a reluctance to admit vulnerability because the threat of harm would be too anxiety producing (Kirscht et al., 1966). This phenomenon may encourage people to fail to act (to prevent illness and/or accidents) because they expect misfortune to strike others, not themselves (Kirscht et al., 1966).

5. Mobile clinic--the clinic has three locations in the North East Texas Area and the staff travels to each of the clinics one day a week to provide care for the clients in a community based setting.

Limitations

The limitations of this study were as follows:

1. The sample was one of convenience.

2. The size of the sample was small, which could affect the generalizability of the information gathered.

3. Questions asked on the survey may have been considered deeply personal and the responses of the participants may reflect their ability or desire to discuss these issues.

Delimitations

Delimitations of this study were as follows:

1. Only persons over the age of 18 were asked to participate in the survey.

2. Only persons who were already diagnosed as HIV positive were surveyed.

3. Only clients from a North East Texas health clinic were asked to participate in the survey.

4. Only those persons who could read and write English were surveyed.

Assumptions

When conducting research, in which the client is asked to discuss motives, feelings, or experiences, there are certain assumptions that the researcher must make in order to evaluate that research. These assumptions were:

1. All of the participants in the study would answer the questions on the self-report questionnaire honestly and to the best of their ability.

2. All of the participants were aware of their behaviors and their attitudes toward the behaviors and experiences discussed on the questionnaire.

Background, Significance, Justification

Background

On June 5, 1981, the first report of AIDS was published when the CDC's Morbidity and Mortality Weekly Report reported on the first five cases of *Pneumocystis carinii* pneumonia (PCP) (Centers for Disease Control and Prevention, 2001a). In the 20 years since that first report, approximately 22 million people, worldwide, have died from the disease (Centers for Disease Control and Prevention, 2001e). As of December 31, 2000, there were 774,467 persons in the U.S. reported as having AIDS. Of those who were diagnosed as having AIDS, 448,060 persons are dead and another 3,542 have unknown or questionable status. At the time of that report, the number of people living with AIDS (PLWA) in the United States was 322,865, the highest ever reported. Of those, 79% were men, 61% were Black or Hispanic, and 41% were infected through male with male (M/M) sex (Centers for Disease Control and Prevention, 2001b).

Recent studies have discovered an upsurge in cases (Centers for Disease Control and Prevention, 2001c, 2001e; Cookson, 2000). The populations with the fastest rising incidence rates are those over 50 (Centers for Disease Control and Prevention, 2001f) and young women of color, especially Blacks and Latinas (Feig, 2001; Livni, 2000).

Justification

HIV/AIDS affects not only the infected persons but their families and loved ones, as well. Despite the fact that AIDS is a devastating disease, it is easily preventable. The prevention message is simple and seems so easy to implement: (a) don't have unprotected sex, and (b) don't share used injectable drug paraphernalia. Yet, the growth rate of the disease is again on the rise with approximately 40,000 new infections annually (Centers for Disease Control and Prevention, 1998). Yearly, millions of dollars are spent on HIV/AIDS prevention/health promotion messages. Haney (2001) asked, with the current rise in incidence, are the people who need to hear the prevention messages actually receiving those messages?

Studies of HIV infection often use "What did you do?" types of questions. The present study attempts to ask "Why?" What was the motivation for the individuals' behaviors, that in the face of a known, life-threatening disease, they deliberately indulged in behaviors that placed them at risk for that disease?

Significance

AIDS does not just affect people living in North Texas; AIDS affects the world community (Dye, 2001). Health care professionals and health promotion educators are desperately searching for strategies to provide information about this disease in such a way that everyone understands that HIV/AIDS is a killer. Individuals can decrease the risk of becoming infected with HIV/AIDS by using condoms and not sharing needles. Society, in general, and those who work in the

health care system will benefit from a better understanding of the motivations that cause people to take certain risks. Hopefully, this study will provide some insights that can be used to develop interventions, education materials, and treatment modalities that will address the specific motivations expressed by the participants in the study.

CHAPTER II

REVIEW OF THE LITERATURE

Taking risks, of one sort or another, seems to be an inherent characteristic of human behavior (Conniff, 2001; Gately, 2001; Moyzis, 2001; Vedantam, 2001). People take risks to gain mates, impress their peers, and gain social status (Conniff, 2001). However, there are some risks that are "more risky" than others. In today's society, behaviors that place one at risk for HIV/AIDS seem to be the most risky because AIDS is a life-threatening illness. At the present time, there are no drugs that will kill the virus and no vaccines that will protect people from infection (M. Harris, 2000b; University of California San Francisco, 2000). Once a person develops the symptoms of AIDS, the person will die (Centers for Disease Control and Prevention, 1998). Between 1981 and 2000, there were 448,060 deaths from AIDS reported in the United States (Centers for Disease Control and Prevention, 2001b, p. 430).

Health Belief Model

Since the HIV/AIDS epidemic, the Health Belief Model (HBM) has been used to gain a better understanding of sexual risk behaviors (Denison, 1996). The HBM is often used as a basis for health information programs that help people make informed choices about risk behaviors.

The theory underlying the HBM has been attributed to Kurt Lewin's theory of goal setting in the level-of-aspiration situation. Lewin (as cited in Maiman & Becker, 1974) hypothesized that behavior depends primarily upon two variables: (a) the value placed by an individual on a particular outcome, and (b) the individual's estimate of the likelihood that a given action will result in that outcome.

In the HBM (Rosenstock, 1974), an individual's motivation to act is analyzed as a function of whether or not he or she expects to attain a health-related goal. The HBM provides a theoretical basis from which health-related behavior might be predicted and altered. Rosenstock stated that the HBM is based upon the idea that the world, as it is perceived, will determine an individual's actions, not the actual physical environment.

"The HBM is a psychological model that attempts to explain and predict health behaviors focusing on the attitudes and beliefs of the individuals being studied" (Denison, 1996, p. 2). The HBM was originally conceived in the 1950s by social psychologists in the public heath service as a means of predicting those who would utilize health screening tests and/or vaccinations (Glanz, Lewis, & Rimer, 1999; National Cancer Institute, 2001; Redding, Rossi, Rossi, Velicer, & Prochaska, 2000). The HBM was one of the first models used to adapt behavioral science theory to health problems and remains one of the most widely recognized conceptual frameworks of health behavior (National Cancer Institute, 2001).

According to the HBM, individuals will act to avoid a health problem, but they first need to believe they are personally susceptible to the problem. Second, they need to perceive the severity of the situation before they will take a particular action. Third, the probability that an individual will act to improve his or her health is determined by the individual's perception of the benefits of and/or barriers to alternative behaviors. A beneficial alternative is one that is likely to reduce the severity of a health problem or one's susceptibility to it. Finally, a "cue to action" is needed to trigger the behavior change. This may be an internal stimulus, such as physical illness, or an external stimulus, such as a mass media campaign or personal knowledge of someone affected by the condition. According to the HBM, these cues must occur to trigger the appropriate health behavior (Becker, Drachman, & Kirscht, 1974; Denison, 1996; National Cancer Institute, 2001; Redding et al., 2000).

Perceived susceptibility refers to the probability that individuals believe they are personally at risk for contracting the disease or developing a health condition. Often, individuals tend to underestimate their own susceptibility to disease (Redding et al., 2000; Weinstein, 1982). The concept of perceived susceptibility has been demonstrated to be predictive of many health-protective behaviors. In the case of HIV/AIDS infection, these behaviors might be to use condoms or other barriers for all sexual encounters and to not share injectable drug paraphernalia.

Perceived severity refers to how serious an individual believes the illness or condition to be. This construct is sometimes described as the severity of the

consequences of the disease. These consequences may include altered social relationships, reduced independence, pain, suffering, disability, or even death (Redding et al., 2000). Within the HBM, the combination of perceived susceptibility and perceived severity constitutes the overall health threat.

Perceived benefits refer to the belief that, by engaging in the protective behavior, either the susceptibility to the disease or the severity of the disease will be removed or decreased. For example, individuals must believe that condoms can prevent or reduce the risk of HIV/AIDS infection.

Perceived costs refer to either barriers or losses that may interfere with the health behavior change (Redding et al., 2000). Together, perceived benefits and perceived costs constitute the concept of outcome expectation.

The three main beliefs of the HBM are belief in susceptibility to the disease, belief that the disease is severe, and belief that the preventative action will remove or lessen the perceived threat constituted by the first two beliefs. While belief alone is not enough to cause an individual to act, according to the HBM, unless the first three beliefs are in place, it is very unlikely that people will alter their behaviors.

Cues to action are stimuli that prompt an individual to engage in certain health behaviors. These may be internal stimuli, such as signs and symptoms of an illness that are experienced by the individual. Cues to action also can include external stimuli, such as knowing a family member or friend who has the illness, media campaigns, discussions with family members, friends, classmates, or health care

providers. If an individual's perceptions of susceptibility and severity are high, a small cue to action may be all that is needed to prompt behavioral change. On the other hand, a larger cue to action may be necessary if perceptions of susceptibility and severity are low.

Mediating factors to the HBM, such as demographic information, structural variables, and social variables, also may affect behavior by influencing an individual's perceptions of susceptibility, severity, benefits, and barriers (Redding et al., 2000). Structural variables may include knowledge of the disease or prior experience with the disease. Social variables may include the individual's personality, socio-economic class, peer or reference group, and internal or external pressures. Self-efficacy, or the confidence in one's ability to take action, was later added to the model (Glanz et al., 1999; Redding et al., 2000). Self-efficacy also can be influenced by other mediating factors (Redding et al., 2000).

In 1984, Janz and Becker published a meta-analysis of studies that applied the HBM from 1974-1984. The authors identified, across study designs and populations, that perceived barriers was the most influential variable for predicting and/or explaining health-related behaviors (Denison, 1996; Janz & Becker, 1984). The next two highest predictive variables were perceived benefits and perceived susceptibility. Perceived severity was identified as the least significant predictive variable.

Despite the wealth of information on HIV infection, people continue to choose behaviors that place them at risk for the disease, despite the fact that the means of

exposure, route of transmission, and means of prevention have been well established for 20 years. Therefore, there must be other motivations for risk taking behavior.

The HBM, with its closely-knit constructs, provides a framework from which to examine the factors that influence those motivations. Many factors predispose persons to be at risk for certain conditions, in this instance HIV infection. Those predisposing factors might be one's sexual orientation, levels of education concerning the risk behavior, prevalence of the illness within the population, poverty, and alcohol or drug abuse. Enabling factors make access to the risk behavior easier or more difficult. Using injectable drugs and sharing drug paraphernalia, not liking and therefore not using condoms for sexual behaviors, or having no social support might make exposure to HIV more likely. These factors also could include living in an impoverished neighborhood where drug and alcohol use is high and peer pressure to participate in these activities is great.

Predisposing Factors

Predisposing factors are conditions that make an individual susceptible to a disease or condition. They are often conditions over which the individual has little or no control (The Learning Company, 1997). In the HBM, these factors would relate to the construct of modifying actions, sometimes referred to as mediating factors. These mediating factors include demographic information, psychosocial variables, and structural variables.

Several studies of HIV/AIDS have listed the following predisposing factors that increase the likelihood of risky behavior: (a) ignorance of the disease (Centers for Disease Control and Prevention, 2001f; TDPH, 2000), the prevalence, the seriousness, and available prevention methods (Centers for Disease Control and Prevention, 2001d); (b) poverty (Muir, 1991; Otto-Salaj & Stevenson, 2001); (c) drug use/abuse (Haney, 2001; Muir, 1991; Otto-Salaj & Stevenson, 2001); and (d) mental health issues (Muir, 1991; Otto-Salaj & Stevenson, 2001; Thomas, 1993). Another predisposing factor that has emerged in HIV/AIDS studies is a sense of complacency among individuals, fostered by drug regimens that prolong the life of PLWA (Bragi, 2001; Centers for Disease Control and Prevention, 1998; Gayle, 2000; Haney, 2001; D. Harris, 2000; M. Harris, 2000b). Thus, individuals may perceive AIDS to no longer be the killer it was once considered (Bragi, 2001; Stahl, 2001).

Ignorance

The results of a study (Centers for Disease Control and Prevention, 2001f) of risky sexual behaviors among people over age 50 indicated that this age group is at serious risk for HIV/AIDS infection due to past lifestyles of unprotected sex within a monogamous marriage. Many of these individuals did not know their risks for HIV/AIDS infection. Condoms were viewed as a means of birth control and, because these participants were past childbearing years, many reported they did not use condoms (Centers for Disease Control and Prevention, 2001f). In addition, the media tends to use young people for "safe sex" messages, implying the message is not

necessary for older individuals. Lastly, health care providers seldom inquire about the sexual health of their older patients and rarely conduct sexual activity assessments (Linsk, 2000). Unfortunately, the incidence of HIV/AIDS is increasing twice as fast in this age group, those over 50, as in those younger, those under 25.

Haley, Maheux, and Rivard (1999) assessed sexual health risk assessments and health teaching practices of general practitioners and obstetricians. "The general medical examination provides an ideal occasion for the physician to assess the patient's sexual risk behaviors and provide individualized STD prevention counseling" (Haley et al., 1999, p. 899). These researchers found that fewer than half of those surveyed inquired about condom use, number of sexual partners, gender of sexual partners, and the STD risk of sexual partners.

At the Eighth Annual Retrovirus Conference in Chicago, Haney (2001) reported that one-third of gay Black men in large U.S. cities are HIV positive. One reason for these numbers may be "that blacks are less likely to admit their homosexuality, so they miss the frequent exhortations for safe sex" (Haney, 2001, p. 1). This number was drawn from the CDC's Seven Cities study (Centers for Disease Control and Prevention, 2001c).

Livni (2000) stated that "poorly targeted prevention programs, an ineffective monitoring system [for STDs], and a growing complacency are thwarting the efforts to stop HIV in this country" (p. 1) in an article discussing new at-risk group needs for anti-HIV/AIDS programs. This researcher suggested more cost-effective education

measures should be provided for at-risk groups and criticized the government's "abstinence only" sex education policies (Livni, 2000).

Poverty

In the study, "Patient Care Influences of Psychiatric Diagnosis and Symptoms on HIV Risk Behavior in Adults with Serious Mental Illness," the researchers reported that poverty, as a social issue, increases the probability of HIV/AIDS risk taking behavior (Otto-Salaj & Stevenson, 2001). In "The Environmental Context of AIDS," Muir (1991) also discussed poverty as a serious social issue that increases HIV/AIDS risk-taking behaviors. In areas where many of the inhabitants live in poverty and impoverished surroundings, trading of sexual favors for subsistence items, drugs, and alcohol is high. Bragi (2001) reported that poverty, along with homelessness, causes health concerns to be less of a priority, while food and shelter become high priorities.

Drug Use/Abuse

A Centers for Disease Control (2001c) study reported that of the 3,449 participants, there were 1,756 who reported having sex while "high" on alcohol and drugs. There were 120 who reported having sex while on injected drugs. One of the cities included in this study was Dallas, TX (Centers for Disease Control and Prevention, 2001c). In a study of young college-aged English women and drinking, Farrow and Arnold (2001) found that the women reported "alcohol decreased their inhibitions, which often led to sexual encounters involving unprotected sex" (p. 4).

Mental Health and other Social Issues

Both Muir (1991) and Otto-Salaj and Stevenson (2001) reported that risk behavior is often the result of mental health issues, such as depression, schizophrenia, and bi-polar disorder. Other social issues, such as domestic violence, homelessness, and poverty also were discussed as predictive variables of risk behavior. Otto-Salaj and Stevenson (2001) reported that:

> Examination of behavioral risk factors for HIV infection among people with serious mental illness has found patterns of behaviors conferring HIV risk, including low rates of condom use during sexual activity; sexual behavior with multiple and same-sex partners; high rates of coercion into unwanted sexual activity; high rates of sex in exchange for drugs, shelter, or basic survival needs; living in impoverished inner-city areas with high rates of drug use, sexually transmitted diseases, and, increasingly, HIV infection; and coexisting substance use patterns, especially the use of alcohol and crack cocaine. (p. 197)

Feelings of helplessness, hopelessness, low self-esteem, and decreased self-efficacy frequently accompany depression, the "down" phase of bi-polar disorder, and may accompany signs of schizophrenia (Thomas, 1993). These feelings also are related to homelessness and poverty (Muir, 1991; Otto-Salaj & Stevenson, 2001).

Complacency

The Centers for Disease Control (1998) report, "Combating Complacency in HIV Prevention" (1998), stated that, "In the United States, complacency about the need for HIV prevention may be among the strongest barriers communities face as they plan to meet the next century's prevention needs" (p. 1). The antiretroviral drug cocktails have increased life expectancy and quality of life among PLWA to such an extent that many regard HIV/AIDS as a chronic, rather than a critical, illness. Research among gay and bisexual men has suggested that some individuals are less concerned about becoming infected than in the past and may be inclined to take more risks (Bragi, 2001; Centers for Disease Control and Prevention, 1998; D. Harris, 2000; M. Harris, 2000b; Stahl, 2001). The truth is, despite medical advances, HIV/AIDS remains a serious and usually fatal disease that requires complex, costly, and difficult treatment regimens. This is summarized by the following statement from the Centers for Disease Control (1998): "The underlying reality, however, is that the HIV epidemic in our country is far from over" (p. 1).

The theme of complacency is also reflected among many young gay men (Stahl, 2001). In the CBS News broadcast, "Nothing More to Worry About? San Francisco Focusing on AIDS Patients," Lesley Stahl spoke with numerous young gay men in the San Francisco area. Despite the fact that the available antiviral drugs do not cure AIDS, these young men believed that they were not susceptible to HIV/AIDS and that HIV/AIDS was not a serious disease, and if they acquired it, they would be

"able to manage it." The men made statements to the effect that "it won't happen to me" and demonstrated a complacency about the seriousness of HIV/AIDS (Stahl, 2001).

Optimum Bias

Several authors have discussed the perception of "that won't happen to me" (Farrow & Arnold, 2001; Kirscht et al., 1966; Weinstein, 1982, 1984, 1987), which is referred to as the theory of optimum bias. This theory states that bad things are more likely to happen to others than to oneself and one's friends. People often believe they are invulnerable (Kirscht et al., 1966). Kirscht et al. referred to this part of folk psychology as an "ego defense that allows people to function in a world of potential dangers" (p. 248). The theory reduces the fear of harm and allows people to live their lives in a comfort zone. A drawback of this type of thinking is that people often fail to act in a way to protect themselves from accidents or illness (Kirscht et al., 1966).

In a study of alcohol and drug use, peer influences, contraceptive use, sexual behaviors, and personality traits among young English college-age women, the participants discussed feelings of optimum bias. In the section about sexual behavior and contraception, they discussed HIV risk behavior, such as not using condoms for sexual encounters, especially when they had been drinking. Despite the known risks "these young women generally do not believe they are in any real danger" (Farrow & Arnold, 2001, p. 2). The bias states that "bad things will more likely happen to someone else than they will to you" (Farrow & Arnold, 2001, p. 2) and fostered a

decreased belief that they were vulnerable to HIV/AIDS. The women's optimum bias also extended to their close friends (Farrow & Arnold, 2001).

Complacency

D. Harris (2000) reported, "Public health officials worry that complacency about the disease could affect at-risk populations, especially young gay men, that could bring AIDS back" (p. 1). In truth, AIDS has never left; however, there was a short period during 1996, when there were sharp declines of AIDS incidences and deaths. These coincided with the introduction of the newer antiviral drugs. However, by 2000 the incidence had begun to rise again (Centers for Disease Control and Prevention, 2001b).

Enabling Factors

Enabling factors supply an individual with the means, knowledge, or opportunity to act or behave in a certain manner. These factors may be, to some degree, within the control of the individual (The Learning Company, 1997). In the HBM, these factors relate to the likelihood of action construct and may be either a perceived benefit or a perceived barrier (Denison, 1996; Redding et al., 2000).

The predisposing factors of ignorance of the disease, complacency about its prevention, poverty, drug use/abuse, and mental health and social health issues were frequently listed in the articles. Also listed were the enabling factors of a willingness to trade sex for drugs, money, shelter, daily subsistence, alcohol, cigarettes, thrills, and gratification of personal sexual needs (Otto-Salaj & Stevenson, 2001). Several

studies have revealed that a fear of pregnancy is viewed as more of a motivation for condom use than fear of HIV or STDs (Farrow & Arnold, 2001; Grady, Klepinger, & Nelson-Wally, 1999; Wilson, Hogben, & Minkoff, 1999). However, a dislike of condoms also ranks high as a reason for not using condoms (Grady et al., 1999). Other enabling factors include mass denial of the seriousness of the disease and the handicap principle, in which individuals believe that the reward will be greater if the risk is greater (Conniff, 2001). This behavior pattern has been related to alcohol and drug use/abuse, other addictions, and thrill seeking behaviors (Gately, 2001). Poverty, alcohol and drug abuse, mental health issues, and other societal issues may be enabling as well as predisposing factors.

In working with young Asian and Pacific Islander men, Choi et al. (1999) identified eight factors related to risky sexual behaviors: (a) negative feelings about oneself; (b) being "in the closet"; (c) trusting a partner (to tell the truth about HIV status, be responsible for protection); (d) desiring to please the partner; (e) passion overwhelming judgment; (f) being high on alcohol, drugs, or both; (g) sexual attitudes prevalent in the gay community (about condom use); and (h) lack of support from families. This list includes several of the aforementioned predisposing and enabling factors.

Fear of Pregnancy Rather than Fear of AIDS

Grady et al. (1999) reported that women considered prevention of pregnancy as the single most important characteristic when choosing a contraceptive method.

Women were less likely than men to consider condoms as "very good at pregnancy prevention" and less likely to make condoms their first choice of contraception. Protection from STDs was second in importance and the men and women in this study seemed to be aware of the role of the condom in risk reduction (Grady et al., 1999). As mentioned previously, Farrow and Arnold (2001) reported that the women in their study were more concerned about preventing pregnancy than STDs. When the women were drinking, they often misjudged their risk for HIV infection and made poor choices about sexual behavior and condom use. Two other studies found that when two methods of birth control were used together, such as the pill and condoms, condoms were typically used less consistently (Critelli & Suire, 1998; Wilson et al., 1999).

Condom Dislike

The Resource Center for Adolescent Pregnancy Prevention (2001) website lists negative beliefs about condom use including: (a) reduced sensation, (b) care in handling to prevent breakage or damage, (c) withdrawing quickly so as not to have it come off prematurely, (d) embarrassing to buy (for both men and women), (e) difficult to put on, (f) they come off during sex, and (g) condoms can be embarrassing to discard. Farrow and Arnold (2001) reported that the women in their study were embarrassed to talk about condom use. One member of the study expressed the feeling that "the condom demasculinized the man" (p. 2). "Asking a partner to wear one implies that you think he has AIDS. Wearing one yourself may make your partner

fearful that you have AIDS" (Resource Center for Adolescent Pregnancy Prevention, 2001, p. 3). Critelli and Suire (1998) also reported that condom use may explicitly suggest the sexual partner might have AIDS.

Other reasons men have offered for not using a condom are that it causes a loss of sensation, it interferes with the ability to maintain an erection, it is uncomfortable (pinch, squeeze, catch hairs), and it interrupts foreplay. One must use water-based lubricants with Latex condoms, which may increase the difficulty of use and cost. Although condoms are now available in flavors, scents, and colors (Resource Center for Adolescent Pregnancy Prevention, 2001), the plain Latex condom has a slight odor and taste that some find unpleasant (Finger, 1998). Latex allergy is another problem for some condom users and their partners (Scheck, 2000). When a group of 94 Latex sensitive men and women were questioned about when and how their reactions occurred, most of them replied that they had had severe symptoms, such as breathing difficulties, during or immediately after using a latex condom (Scheck, 2000).

Drug and Alcohol Use/Abuse

In the Farrow and Arnold (2001) study, the women reported that alcohol use bolstered their confidence and decreased their inhibitions. This often led to poor judgment concerning sexual behaviors. The young Asian men in the Choi et al. (1999) study reported that the use of alcohol and/or drugs, or both, influenced their risk-taking behavior, especially in regards to condom use. Issues of mental health affected both

condom usage and high levels of drug and alcohol abuse (Muir, 1991, Otto-Salaj & Stevenson, 2001).

Issues of Mental Illness

Poor mental health is not only a predisposer to risky behaviors, it also is an enabler. When a person is not able to control his or her emotional state, this can affect judgment, thought processes, and critical thinking. Disordered thought processes distort an individual's perceptions of the world in which they live (Muir, 1991; Thomas, 1993). Approximately 3% to 5% of the world's population suffers from depression at any give time, and schizophrenia affects many young adults, often beginning in the teen years (Thomas, 1993). High levels of risk behavior are observed among persons with mental illness (Otto-Salaj & Stevenson, 2001). Persons with certain mental health issues exhibit high levels of sharing and trading of sexual favors. Alcohol and drug usage also is high among this group, while condom use is low (Otto-Salaj & Stevenson, 2001). This seems to be especially true among those who exhibit signs of depression, schizophrenia, or suffer from bi-polar disorder (Erbelding, 2001; Otto-Salaj & Stevenson, 20017).

Other Societal Issues

Muir (1991) proposed that HIV and risk behaviors are related to many complex social and cultural issues, such as sexuality, drug use, and alternative lifestyles. This idea is supported by other studies, as well, in which alcohol, drug usage, family issues, and domestic violence influenced risk behaviors (Butcher, Cohen, Urbina, & Flanigan,

2001; Choi et al., 1999; Farrow & Arnold, 2001). Choi et al. (1999) reported that not having family support, regarding the men's sexual orientation, was an enabler of risk behavior, as it engendered isolation from one's family, a predominant value in most oriental cultures. However, if they had the acceptance of the family concerning their sexual orientation, it provided support to not engage in risky behaviors, as it kept the person connected to family and validated their self-worth. Butcher et al. (2001), Muir (1991), and Otto-Salaj and Stevenson (2001) mentioned positive support systems as being helpful to maintain risk prevention behaviors and the lack of positive support systems could increase risk behaviors.

Mass Denial

Another major concern in the prevention of AIDS is an almost universal denial of the seriousness of the disease (Centers for Disease Control and Prevention, 2001f; Farrow & Arnold, 2001; Linsk, 2000). Until recently, many in Africa, India, and China maintained that AIDS did not exist and, if it did, it was not a major health threat (Ayitty, 2000; Bharat, Aggelton, & Tryer, 2001; Pan, 2001).

Ayitty (2000) reported that "The African government officials for years dismissed AIDS as a 'racist conspiracy plot' invented by the West" (p. 3). The ambassador from Swaziland commented, "For a long time we have been in denial. We looked at AIDS as a foreign problem, involving white people, foreign people" (Ayitty, 2000, p. 3).

Sadly, this attitude is held by a growing number of young people in America, as well. The group, Act Up, actively campaigns that HIV does not cause AIDS and that HIV is a "lie and a conspiracy" (Stahl, 2001, p. 5). Jeff Getty, one of Lesley Stahl's interviewees and an AIDS patient of 15 years and AIDS activist stated,

> I do college lectures at times, and at the end of the lecture, there is inevitably a group of people that gathers around me, that wants to argue with me that HIV and AIDS doesn't even exist. And every year that group of kids is getting larger and larger and larger. (p. 6)

Antiviral drugs and the search for a vaccine have tended to take the fear out of AIDS (Bragi, 2001; Stahl, 2001; University of California San Francisco, 2000). Some drug manufacturers have even gone so far as to use very healthy, physically fit models engaging in vigorous and physically challenging activities to insinuate that, with their medications, the person living with AIDS can participate in these activities (Bragi, 2001; Stahl, 2001).

The Handicap Principle

This principle is the belief that the greater the risk taken, the greater the reward collected (Conniff, 2001). This is personified by the daredevil behavior of many teens out to impress peers. People are more likely to take great risks if they believe that the reward for that risk is great enough. This also applies to persons who take risks to impress mates or gain sexual partners (Conniff, 2001). An extramarital affair is a form of sexual partner seeking. The mechanisms of this behavior appear to be similar to

behaviors exhibited during gambling, anticipation of the reward, taking the risk, and gaining the reward (Gately, 2001). Results from the National Aids Behavior Survey indicated that persons who had participated in an extramarital affair rarely used condoms (Choi, Catania, & Dolcini, 1994). Because people are having unprotected sex during an affair, they may be placing themselves at risk for HIV infection.

Summary

Since its inception in the 1950s, the Health Belief Model has been used to investigate behavioral attitudes. "Since then, the HBM has been adapted to explore a variety of long- and short-term health behaviors, including sexual risk behaviors and the transmission of HIV/AIDS" (Dennison, 1996). The HBM is a psychosocial model that attempts to examine health behaviors related to attitudes and beliefs (Janz & Becker, 1984). It also is clear that other forces influence a person's health actions as well as their beliefs and attitudes (Janz & Becker, 1984). These forces are categorized as the enabling and predisposing factors. The predisposing and enabling factors that are presented in this chapter are by no means the only ones; however, they represent those most commonly listed in the literature. By attempting to understand what personal and societal factors influence a person's behavior, the researcher hopes to present a description of these motivators in order to find ways to address them in the future. This study examined the factors presented by a sample of HIV-positive adults.

CHAPTER III

METHODOLOGY

The methodology used for this study was a retrospective survey. The actual design was a one-shot case study (Campbell & Stanley, 1963; McDermott & Sarvela, 1999). Burns and Grove (1993) and Polit and Hungler (1993) described this type of study as "pre-experimental as there is no means to determine cause and effect" (p. 306). Polit and Hungler (1993) described the design as "after only one-shot posttest only. An experimental design in which data are collected from the participants only after the experimental intervention is instituted" (p. 431). Being HIV positive could be considered as the intervention. In this research design there is no effort to control who receives the intervention. Polit and Hungler (1993) also referred to this type of research under pre-experimental, as descriptive, as it seeks to "describe the status of some phenomena of interest as it currently exists" (p. 166). The research questions were worded to allow the participants to describe their lived experiences and motivations for their behavior. The focus of this study was to examine the motivations that either prompted or allowed individuals to indulge in behaviors that were potentially harmful to themselves or to their sex partners.

Risks to Participants

Because of the sensitive nature of many of the questions, the following statements of risk were offered to the participants, along with the steps that would be taken to minimize those risks, should they participate in the research.

Loss of Confidentiality

You will self-select survey sheets and deposit them in a sealed container upon completion. Only the researcher will have access to the raw data. For purposes of data entry for analysis, each survey will be given a number just prior to its entry. During the analysis the surveys will be kept in a locked file cabinet in the home of the researcher.

Loss of Privacy/Self-disclosure/Sensitive Nature of the Questions/Embarrassment

You are not required to answer any question you might feel is too sensitive or revealing. You will complete the survey in a private place. There will be no identifying marks on the survey.

Introspection/Feelings of Guilt/Regret

A Licensed Mental Health counselor will be available to discuss these feelings with you.

Interacting with a Stranger

The researcher is a volunteer at the clinic in order to establish a level of comfort and trust with the clients.

As with any research project where the questions are sensitive, there is always the possibility that each participant may not answer all of the questions. However, that right is always reserved for the participant and validates their right to choose to participate, or not, and by how much.

Population and Sample

The 29 participants were from a population of HIV-positive persons who voluntarily chose to complete the survey. They were all clients of a North Texas Mobile Health Care Clinic. All of the participants were over the age of 18 and all had been previously diagnosed as being HIV positive. No one who wished to participate was turned away.

Setting

The clinic has three locations within the North Texas Area that provides community based health care. One of the clinic sites is within the suburbs of a major city, one is in a semi-rural setting, and the third is in a distinctly rural setting. The clinic provides other services besides health care, including a registered dietician, a food pantry, mental health services, and social services. The clinic also serves as a social gathering place for informal meals and classes. At each site, there is a living room where the participants could sit and complete the survey in a quiet place that provided privacy.

Procedures

Posters that announced the upcoming study and contained basic information about it were put up in strategic places within the three clinics on January 21, 2002, one week before data collection was scheduled to begin on January 28, 2002 (see Appendix C). On January 28, 29, and 30, 2002, the researcher delivered a supply of survey instruments and a sealed collection container to each of the sites. The researcher replenished the supply of surveys as needed. Data collection was scheduled to proceed from January 28 until February 28, 2002.

Data Collection

After their scheduled health care appointment, potential participants were approached by the researcher and asked if they would be interested in completing the survey. They were informed that participation was strictly voluntary and were shown where the surveys and pencils were located and where to place the surveys when completed. They were offered a quiet place to complete the surveys and were left alone to decide. If they chose not to complete the survey, they either left the clinic unobserved by the researcher or went about other business at the clinic.

The collection containers were cardboard boxes, covered with heavy Kraft® paper and were securely taped shut. A small, narrow slit, only large enough to insert the folded survey instrument, was located on the short side of the container. The container was tall, placing the contents too far below the opening to be reached. Each container was clearly marked with the same graphic as the recruitment poster and

labeled "*Please Place Surveys Here.*" Participants placed their completed instruments in the boxes.

At the end of the data-gathering period, February 28, 2002, the researcher picked up the collection boxes from the clinics, removed the surveys, and began the data analysis. When the surveys were not in use, they were kept in a locked file cabinet within the home of the researcher.

Study Design

The study was a one-shot case study, using a pencil and paper self-report survey. The survey was retrospective in that it asked for information concerning events that happened in the past (Thomas, 1993). Survey research examines attitudes, behaviors, intentions, and experiences. These constructs have no right or wrong answers and can, in many instances, only be described (Burns & Grove, 1993). The participants were asked to discuss their motivations for risk-taking behaviors. The underlying framework of the study was the Health Belief Model (Denison, 1996; Glanz et al., 1999, Redding et al., 2000; Rosenstock, 1974).

Instrumentation

The instrument was a four-page pencil and paper self-report survey, containing a cover letter identifying the researcher, the purpose of the study, and how to contact the researcher if there were questions. Also included in the cover letter were the confidentiality statements required by the Institutional Review Board, the list of risks the participants might incur, and what would be done on their behalf if they

experienced any of those risks. There were instructions on how to answer the survey, what to do should the person choose not to complete the survey, and where to deposit the survey (see Appendix D).

The participants were offered no tangible rewards for completing the survey. The participants were told that the information gathered would be used to write a dissertation and might be shared, in the form of reports or articles, in order to benefit others by providing information that might be used in the future to design health promotion/HIV/AIDS prevention education.

The first page of the survey consisted of 10 demographic multiple-choice response questions. These questions followed the general pattern for demographic questions. However, because the population is unique in many ways, some of the questions were modified to fit. The question on gender included male, female, and transgendered as response categories. The question on sexual orientation offered the responses of Male/Male, Female/Female, Male/Female, and Bi. The participant could also check the box, "*Do not wish to share this information*," if they chose. Throughout the survey instrument, the participants were reminded that if a question was more sensitive than they wished to share, they were under no obligation to answer. They were, however, asked to check the "*Do not wish to share this information*" box so that the researcher would know that leaving the question unanswered was a conscious choice.

Questions of ethnicity, for the client and their partner, provided response categories of Asian, Black/African American, Hispanic/Latino, Caucasian/white, Don't know, Other (please write in your choice), and Do not wish to share this information. The question on marital status provided the choices of Married, Single, Partnered (a seriously committed relationship, often of long-standing), Significant Other (also a serious relationship but not quite as committed as partnered), and No One Special at the Moment. The last three questions asked about occupation, working status, and salary ranges.

Page 2 contained the five research questions. In order to personalize the questions and have them relate more closely to the lived experience of the participants and their everyday speech, the formal research questions were rephrased. The research questions, as presented to the participants, were:

1. "Before you were diagnosed, did you truly believe that HIV/AIDS was a deadly disease?"

2. "Did you believe that you might get HIV/AIDS? If not, why not?"

3. "What could have helped prevent the risk behaviors?"

4. "To whom would you have listened about risk behaviors?"

5. "How could this information been presented to you that would have altered your behavior?"

There were several lines following each question so that the participant could write in his or her answer.

Pages 3 and 4 were multiple-choice risk behavior assessment sheets with 9 questions assessing basic knowledge of risk behavior and 12 questions addressing drug use and risk behavior. These questions were based on questions posed by the Texas Department of Public Health in the North Texas HIV Profiles Report (Texas Department of Public Health, 2000b). Some of the questions required the participant to write in the answer and some were multiple choice answers that the participant could select by placing an X in the box provided.

Validity

The study was not pilot tested. The Institutional Review Board of Texas Woman's University suggested a sample size of between 20 to 30 participants for this study.

The five research questions, based on the constructs of the Health Belief Model, were reviewed by a panel of experts in the field of HIV/AIDS care to verify construct validity. The panel of experts included the Director of the Facility (PhD), a Mental Health Specialist (MSW), a Physician's Assistant (PA), the Clinic Manager (RLD), the Clinic Nurse (LVN), and two Case Managers (BSW). The reviewers judged the questions to be pertinent to the problem and within the scope of the survey.

The first two research questions required only a "yes" or "no" answer. Part B of question 2 and questions 3, 4, and 5 were open-ended questions that allowed the participant to share what, and however much or little, information they wished to share. In survey research, the attitudes, behaviors, experiences, and intentions of the

participant are examined. Therefore, the participants' truth is the truth and provides its own validity (Benoliel, 1984). Also, the researcher must assume that the participants have answered the questions honestly.

The questions in the gaps in knowledge sections were similar to those used by the Texas Department of Public Health North Texas Region HIV/AIDS Report (2001). Comparable questions were used in the Youth Risk Behavior Surveillance-United States, 1999 Survey (Kann, Kinchen, & Williams, 2000) and the Kaiser Family Foundation's (1998) National Survey of Americans on Sex and Sexual Health Survey.

Treatment of the Data

All of the questions that could be answered with a Yes/No answer or a choice of an A, B, C, or D answer were entered into an Excel Spreadsheet. These were tabulated, counted, and the numerical data reported (see Appendix E). Questions that were designated by the words "Other," which required the participant to write in the answer, were recorded verbatim in a Microsoft Word document. All similar responses were grouped together, numerically counted, and reported (see Appendix E).

The five research questions also were entered into the word document, in table format, so that similar key words, ideas, themes, or concepts could be identified. These were grouped together, given a descriptive heading, and reported. A list of the responses is provided in Appendix E.

CHAPTER IV

REPORT OF THE FINDINGS/ANALYSIS OF THE DATA

The data gathered were in three distinct groupings. The first group of questions was demographic in nature. In the modifying actions construct of the Health Belief Model (HBM), demographic information is considered as variables that influence people's behavior (Denison, 1996; Redding et al., 2000). Poverty, substance abuse, mental health issues (such as low self-esteem and emotional disturbances), and a lack of knowledge are all enabling factors that contribute to wider social problems (Butcher et al., 2001; Lehrer, 1999; Muir, 1991).

The second group of questions was the five research questions posed by the researcher. These questions, based on the constructs of the HBM, assessed the participants' belief in the seriousness of the disease of AIDS, their belief in their own susceptibility to this disease, and how/by whom could the message of risk prevention be delivered to possibly prevent infection.

The last group of questions was taken from the Texas Department of Public Health North Texas HIV/AIDS report of 2000. These questions addressed what the Public Health Department defines as gaps in knowledge and pertain to sexual behaviors, condom use, and substance abuse.

Definition of the Sample

All of the participants were persons living with AIDS (PLWA), over 18 years of age, and clients of a North Texas Area health care clinic. All of the participants were volunteers. The sample size was 29, with 25 males and 4 females. Their ages ranged from 22 to 53 years. The mean age was 39.31, while the median was 39, and the mode was 44 (SD = 6.985). The participants of this study were predominantly males between the ages of 31 and 47. Age ranges of the participants are shown in Table 1.

Table 1

Age Ranges of the Participants

Age ranges (years)	Number of participants	Percent
22 to 32	5	17.2
33 to 42	14	48.3
43 to 52	9	31.0
53 and over	1	3.4

Demographic Information

Educational Levels Achieved

All except 2 participants had a high school education. Following high school, several participants had pursued specialized training in the areas of computer repair,

computer programming, cosmetology, machinist, and apartment/hotel management training. Table 2 illustrates the educational levels attained.

Table 2

Highest Education Levels Attained by Participants

Level of Education	Participants	Percent
Junior high school (Grades 7-9)	2	6.9
High school (Grades 10-12)	13	44.8
Technical school (1-3 years College or Specialized Training)	11	38.0
Bachelor's degree	2	6.9
Master's degree	1	3.4

Gender and Sexual Orientation

Of the 29 participants, 25 were male and 4 were female. None of the participants described themselves as being a transgendered person (see Table 3).

Table 3

Gender of the Participants

Gender	Participants	Percent
Male	25	86.2
Female	4	13.8
Transgendered	0	0.0

Of the 10 who claimed male/female sexual orientation, 4 of those were female, leaving 6 males who claimed to have a sexual orientation of male/female. There was 1 bisexual person. The participants were predominantly male who identified themselves as having a male/male sexual orientation (see Table 4).

Table 4

Sexual Orientation of the Participants

Sexual orientation	Participants	Percent
Male/Male	17	58.6
Male/Female	10	34.5
Female/Female	0	0.0
Male/Male/Female (Bisexual)	1	3.4
Declined to answer	1	3.4

Racial Origins/Ethnicity

As shown in Table 5, the participants were predominantly Caucasian (n = 16). There were 7 Black/African Americans and 2 Hispanic participants. Four participants listed "other" and, of those 2 claimed Native American ancestry along with another racial group. One participant was Jamaican and none of the participants claimed Asian/Pacific Islander or Alaskan Native as their ethnicity.

Table 5

Participants' Racial Origins/Ethnicity

Racial origin/ethnicity	Participants	Percent
Black/African American	7	24.1
Caucasian	16	55.2
Hispanic	2	6.9
Other	4	13.8

Participants' Marital Status

As Table 6 indicates, 16 participants were single. Three were married and 4 were partnered. Three had significant others (SO), while 3 reported that they had no one special at the moment. From the information that was available, it appears that the majority of the participants were single and 10 were in committed (monogamous) relationships.

Table 6

Participants' Marital Status

Status	Participants	Percent
Married	3	10.3
Single	16	55.2
Partnered	4	13.8
Significant Other (SO)	3	10.3
No One Special	3	10.3

Spouse's/Partner's/Significant Other's Ethnicity

Of those claiming a relationship, 11 had spouses/partners/SOs who were Caucasian, 4 had spouses/partners/SOs who were Black/African American. One spouse was Jamaican and no one claimed a spouse/partner/SO of Asian/Pacific Islander, Hispanic, or Alaskan Native ancestry (see Table 7).

Table 7

Spouse/Partner/Significant Other Racial Origin/Ethnicity

Partners' Race/Ethnicity	Partners	Percent
Caucasian	11	37.9
Black/African American	4	13.8
Other	1	3.4
Don't know	1	3.4
Declined to answer	12	41.4

Participants' Occupations

The participants came from varied work backgrounds. They were asked to provide current or past occupations, when they were able to work. One participant was self-employed, but did not disclose the type of business. One participant worked in retail sales, 2 were in management positions, and 1 person was an administrative assistant. Six were skilled workers: computer programmer/technician, corporate trainer, nurse's aide, machinist, cosmetologist, and stylist. Seven were unskilled workers: sandwich shop employee, delivery driver, moving person, housewife, sales person, apartment manager, and a warehouse worker. One participant did not answer the question (see Table 8).

Table 8

Occupations (Present or Past) of Participants

Occupation	Participant	Percent
Computer programmer/tech	1	3.4
Corporate trainer	1	3.4
Management	2	6.9
Self-employed	1	3.4
Retail sales	1	3.4
Housewife	1	3.4
Nurse's aide	1	3.4
Food preparer	1	3.4
Machinist	1	3.4
Administrative assistant	1	3.4
Cosmetologist	1	3.4
Stylist	1	3.4
Apartment manager	1	3.4
Warehouse worker	1	3.4
Unemployed	13	44.8
Disabled	7	24.1
Declined to answer	1	3.4

Participants' Current Employment Status

Fifteen of the participants were gainfully employed at the time of the survey. Thirteen were unemployed. Seven of these were both unemployed and disabled and, thus, gave both answers. One participant declined to list employment status (see Table 9).

Table 9

Participants' Current Employment Status

Employment status	Participant	Percent
Employed	15	51.7
Unemployed	6	20.7
Unemployed and disabled	7	24.1
Declined to answer	1	3.4

Participants' Salary Ranges

The participants were asked "If you are working now, or when you worked in the past, at your chosen profession, what was your salary range?" Table 10 describes the participants' salary ranges. Thirteen (45%) of the participants were unemployed at the time of the survey.

The Federal Register (U.S. Department of Health and Human Services, 2002) lists $8,860 yearly as the poverty level for a one-person family. At the time of the

survey, 13 of the participants had incomes below this level as they were not working or were unable to work. Sixteen participants reported that they had a relationship, forming a two-person family. The poverty level for a two-person family is $11,940 yearly. As the salaries were only given in ranges, it is unknown how many of those earning over $10,000 were at or below the poverty level for a two-person family (see Table 10).

Table 10

Salary Ranges Participants Are Earning Now or had Earned in the Past

Salary ranges	Participants	Percent
Under $10,000	1	3.4
$10,000 to $20,000	13	45.0
$21,000 to $30,000	5	17.2
$31,000 to $40,000	2	6.9
$41,000 to $50,000	0	0.0
$51,000 to $60,000	2	6.9
Above $60,000	0	0.0
Declined to answer	6	20.7

Discussion of the Demographics

The majority of the participants (n = 17) came from the clinic that was located in the suburban area of a major city. The next largest group (n = 7) was from the semi-rural area. The smallest group (n = 5) was from the rural area. A brief description of the participants (N = 29), drawn from the demographic data, gives the picture of a primarily male (n = 25), primarily Caucasian (n = 16), sample between the ages of 31 and 47 (n = 23). All except 2 (6.8%) of the participants were educated to the level of high school or above, 93% (n = 27), earning between $10,000 and $20,000 yearly ($n$ = 14), when they were able to work. However, at the time of the study, 45% (n = 13) were unemployed, and 24.1% (n = 7) were disabled. Of those responding to the question, "What is your occupation?" 45% (n = 13) responded that they were unemployed and gave no occupation. Of those who listed an occupation, 20% were skilled craftsmen or highly trained persons (n = 6) and 20% (n = 6) were unskilled workers.

Analysis of the Research Questions

In stating the ideas, feelings, or beliefs of the participants, responses were quoted verbatim. Misspellings occurred and words were left out of sentences. If it was possible to discern the meaning of the sentence, the missing word was added in brackets. When in doubt, the responses were left as written. When possible to do so, common themes or ideas were grouped together. Sometimes the answers were not related to the questions and were so noted. Some of the participants declined to

answer some of the questions and these were noted as "participant left the question blank."

The questions are stated first as formal research questions and are then restated in the form in which they were rephrased and presented to the participants. Research questions were rephrased to make the questions more personal and resemble more closely the lived experiences of the participants.

Could it be that persons do not believe that AIDS is a deadly disease?

This question was drawn from the personal perceptions construct of the HMB that states that the person must believe that the threat is serious. The question was phrased as, "Before you were diagnosed, did you truly believe that HIV/AIDS was a deadly disease?"

Eighty-six percent of the participants believed that HIV/AIDS was a deadly disease; therefore, they perceived the seriousness of the threat (see Table 11). In the HBM, this is one of the key criteria required for change to take place.

Table 11

Participants' Belief that HIV/AIDS is a Deadly Disease

	Participants	Percent
Believed (yes)	25	86.2
Did not believe (no)	2	6.9
Unsure	2	6.9

Is there some mechanism, such as optimum bias, that allows people to believe that they are not vulnerable to HIV infection?

Also drawn from the personal perceptions construct of the HBM, this question tested the persons' belief of their susceptibility to the threat (see Table 12). This question was rephrased on the survey as, "Did you believe that you might get HIV/AIDS? If not, why not?"

Table 12

Participants' Belief of Their Susceptibility

Susceptibility belief	Participant	Percent
Believed (yes)	14	48.2
Did not believe (no)	13	44.8
Maybe	1	3.4
Did not consider	1	3.4

For the second part of the question, "If not, why not?" the participants who responded "no" gave the following answers:

1. "No because I am not gay. I thought it was a gay deises (sic)."
2. "No, because I had protected sex and avoided any risk behaviors."
3. "No, because that happens to other people."
4. "No, didn't do drugs. Misunderstood about it."

5. "No, never did things to get AIDS. Not used protection--at my age didn't think about it."

6. "No--honestly I thought it couldn't happen to me."

7. "No/because I am very safe and my ex-wife had contracted it through a hic (sic) she dated who died from AIDS."

8. "No I didn't becaue (sic) I didn't pay it any mind of it."

9. "No, no one believe truly that it would happen to one self"

While approximately half of the participants (48.2%) believed that they were susceptible to the threat, 44.8% stated they did not believe they were susceptible. This is the second key criterion of the HBM that must be met. Without a belief that the person is susceptible to the perceived threat, behavior change is most likely not to occur.

What information or behavioral strategy might have helped to prevent the risk behaviors?

Using the modifying actions construct of the HBM, the participants were asked, "What could have helped prevent the risk behaviors?" Table 13 presents the participants' suggestions for behavioral strategies that might have prevented their HIV infection. Two participants mentioned that they believed they had become infected prior to the time that HIV/AIDS was recognized as a threat and, they were unaware that prevention strategies were needed.

While 3 participants could not offer suggestions for risk prevention strategies or behaviors, the remaining participants mentioned several strategies. The most commonly mentioned risk prevention strategy was the use of condoms. The participants also advocated education and public policy change towards HIV/AIDS care and services, as well as not using drugs. The fact that they were able to offer positive suggestions for prevention indicated that they recognized strategies and behaviors to protect themselves.

Was there a person who might have been able to dissuade the person from risk-taking behaviors?

Drawing on both the psychosocial variables in the modifying actions construct of the HBM and the cues to action construct, the question was posed as, "To whom would you have listened about risk behaviors?" Table 14 shows the persons to whom the participants might have listened for information and counseling about practicing safe sex, not using drugs, and other risk-taking behaviors. The participants offered nine different sources to whom they might have listened for risk reduction information.

Table 13

Participants' Preventative Behavioral Strategies

Strategies	Participants	Percent
Condom use	11	38.0
[Having] education [about the risks of HIV infection]	6	20.6
Not using drugs	2	6.8
Positive public policies for AIDS education and HIV/AIDS care	2	6.8
Committed relationships	1	3.4
Abstinence	1	3.4
More careful partner selection	1	3.4
Clean blood supply	1	3.4
Seeking help [for emotional problems]	1	3.4
Didn't know	2	6.8
Declined to answer	1	3.4

Table 14

Persons to Whom the Participants Might Have Listened for Information/Counseling

Person	Participants	Percent
Anyone with knowledge	8	27.6
Doctor or nurse	5	17.2
Friends	5	17.2
Parents--especially their mother	4	13.8
Persons in authority	4	13.8
Family	3	10.3
Peers	1	3.4
Media	1	3.4
HIV+ person	1	3.4
Used own common sense	1	3.4
No one	1	3.4
I don't know	1	3.4
Declined to answer	4	13.8

How could information have been presented that might have altered the risk-taking behaviors?

Also drawing on the cues to action construct of the HBM, the researcher asked, "How could this information have been presented to you that would have altered your behavior?" Of those who answered, the participants believed that sex education/safe sex should be taught at an early age, within the schools, and by families. Discussions should be "informal and confidential." The seriousness of HIV/AIDS should be depicted "straight up" and in "graffic (sic) detail." They suggested that "HIV POZ" (positive) people should make presentations to youngsters so that they could witness the ravages of the disease. Seeing "sick friends and peers who are ill" might be a serious cue to action. Table 15 contains the participants' suggestions.

Knowledge of Risk Behavior

In the survey segment that asked the participants about their knowledge of risk behaviors, the question was stated, "Is reducing the risk of getting HIV/AIDS important to you?"

Table 15

Participants' Suggestions for Information Presentation

Suggestions	Participants	Percent
Early information	1	3.4
"Graffic (sic) details" and "straight up"	2	6.8
From other gays	1	3.4
Seeing a POZ (positive) person	1	3.4
In the schools	2	6.8
Informal and confidential	1	3.4
In family discussion	1	3.4
From friends and peers who were ill	1	3.4
Declined to answer	6	20.7
Don't know	2	6.8
Answers not related to the question	5	17.2

Table 16

Participants' Responses to "Is Reducing the Risk of Getting HIV/AIDS Important?"

Is reducing risk important?	Participants	Percent
Yes	29	100
No	0	0

Table 17

Participants' Responses to "How Important, on a Daily Basis, is Protecting Your Sex Partner from HIV/AIDS?"

Partners' protection	Participants	Percent
Very important	27	93.1
Somewhat important	0	0.0
Not very important	0	0.0
I don't think about it	0	0.0
Declined to answer	2	6.8

Table 18

Participants' Responses to "Do You Always Use a Condom/Barrier?"

Always use a condom/barrier?	Participants	Percent
Yes	18	62.1
No	8	27.6
Declined to answer	3	10.3

While protecting their sexual partner was considered extremely important, 8 participants (27.6%) said that they did not use condoms/barriers every time. Three participants (10.3%) declined to answer the question. Table 19 lists the reasons given by the 8 participants as to why they did not use a condom.

Table 19

Participants' Reasons for Not Using A Condom

Reasons given for not using a condom	Participants	Percent
"I am not having sexual encounters that need a condom"	3	10.3
"We are faithful to each other"	1	3.4
"Both of us are HIV +"	2	6.8
"Too much of a 'rush, etc'"	1	3.4
Stated no, but gave no reason for not using a condom every time	1	3.4

"Do you use condoms for anal sex, but not for oral or vaginal sex?" elicited an equal number of positive and negative responses (n = 13). Three participants (10.3%) declined to answer the question. The written responses as to why condoms/ barriers were not used for oral sex are listed in Table 20.

Table 20

Participants' Responses to "Why Condoms Are Not Used for Oral Sex?"

Reasons	Participants	Percent
"They were not used for comfort and feel"	2	6.8
"Didn't like the taste of condoms"	1	3.4
"Oral sex has a lower chance of transmitting HIV than anal sex"	2	6.8
"That you can get it (HIV) only once"	1	3.4
"Because sperm never enter me orally"	1	3.4
Declined to answer	3	10.3

Table 21

Participants' Responses to "Do You Use Anal Sex as a Means of Birth Control?"

Anal sex as birth control?	Participants	Percent
Yes	1	3.4
No	26	89.6
Declined to answer	2	6.8

Drug Use and Risk Behavior

When asked, "Do you think using a specific drug affects needle-sharing behavior?" 16 participants stated "yes," 8 stated "no," and 5 did not answer the question. Table 22 contains the participants' responses to the question, "Why do people share needles?"

Table 22

Participants' Responses to "Why Do People Share Needles?"

Reasons people share needles	Responses	Percent
They don't understand it is dangerous	19	65.5
They lack the skill to clean their equipment	12	41.4
They do not have cleaning supplies	12	41.4
The do not have clean equipment	16	55.1
They do not know how to clean their equipment	14	48.2

All of these responses were listed on the survey and the participants were asked to check all of the boxes with responses that they believed were valid reasons for needle sharing behavior. Participants also were given a space to write in their own reasons. They responded as follows:

1. "In too much of a hurry to get high to act with intelligence."
2. "Lack of money, less money on equipment, more money for drugs."

3. "Too stoned to care."

4. "When a person is using in that style they stop caring, I did. Plus I wanted to die then."

5. "They are junkies and hopelessly addicted to their drug--they probably don't care."

6. "Addict desperation."

7. "When using drugs you do not think, all you think about is the high."

Table 23

Participants' Responses to "Does Using Drugs Affect Condom Use?"

Drug use affect condom use?	Participants	Percent
Yes	29	100
No	0	0
Declined to answer	0	0

Table 24

Participants' Responses to "Does Using Drugs Influence the Choice of Sexual Partners?"

Drug use effect partner choice?	Participants	Percent
Yes	23	79.3
No	6	20.7
Declined to answer	0	0.0

Table 25

Participants' Responses to "Does Using Drugs Affect Exchanging Sexual Favors?"

Drug Use Affect Exchanging Sex?	Participants	Percent
Yes	27	93.1
No	2	6.8
Declined to answer	0	0.0

Table 26

Participants' Responses to "Does Doing Drugs Affect the Selling of Sex?"

Doing drugs effect selling sex?	Participants	Percent
Yes	25	86.2
No	3	10.3
Declined to answer	1	3.4

The participants were asked if they had ever exchanged sexual favors for money. Of the 29 respondents, 8 reported that they had exchanged sex for money.

Table 27

Participants' Responses to "Have You Ever Sold Sex for Money?"

Sold sex for money?	Participants	Percent
Yes	8	27.6
No	21	72.4
Declined to answer	0	0.0

Participants were then asked, "If you have (sold sex for money), why?" Table 28 represents the list of answers from which the participants were asked to choose and to mark all of the responses that applied.

Table 28

Participants' Responses to "Why People Sell Sexual Favors for Money?"

Reasons people sell sex	Responses	Percent
To buy everyday items--food, clothes, and/or shelter	2	6.8
To buy medicine to treat an illness	1	3.4
To buy [recreational] drugs	3	10.4
To buy alcohol	3	10.4
To buy cigarettes	1	10.4

Table 29

Participants' Responses to "Would You Have Had Sex If You Had Not Done Drugs?"

Had sex if not done drugs?	Participants	Percent
Yes	15	52.0
No	7	24.1
Declined to answer	7	24.1

In the past, some of the participants had used drugs, as evidenced by the responses given. Also, 27% (n = 8) of the participants responded that they had sold sexual favors for daily subsistence items (food, shelter, or clothes), as well as for drugs, medicine, alcohol, and cigarettes.

Concerning the number of sexual partners PLWA report, the TDPH survey asked, "What do you think would help reduce the number of sexual partners a person has?" Table 30 displays the participants' suggestions for reducing the number of sexual partners.

Also concerned that many PLWA under-report the number of previous sexual partners, the TDH survey asked, "What influences the number of sexual partners a person reports?" Participants wrote in their answers and a number of them gave multiple reasons.

Table 30

Participants' Responses to Strategies for Decreasing Numbers of Sexual Partners

Strategy	Participants	Percent
[Better] morals, strong family orientation	2	6.8
Religion	2	6.8
Family values	2	6.8
Acceptance of gay/lesbian needs	1	3.4
Committed relationships	7	24.1
Same sex marriages	1	3.4
More open sexual mores so that people can find compatible partners easier	1	3.4
Less emphasis on "singles lifestyle"	1	3.4
[More] knowledge/education	7	24.1
Less mind altering substances	1	3.4
Declined to answer	6	20.7

Table 31

Participants' Responses to "What Influences the Number of Sexual Partners a Person Reports?"

What influences the number of partners reported?	Responses	Percent
Shame/embarrassment	5	17.2
Fear (of partner being contacted)	2	6.8
"Don't want to report (on them)"	1	3.4
Low self-esteem	2	6.8
High self-esteem (bragging)	2	6.8
Peer pressure/friends/social politics	3	10.3
Modesty	1	3.4
"Social acceptance of multiple partners (within the gay community)"	1	3.4
"Lifestyle and not being in a monogamus (sic) relationship"/"promisuous (sic) behavior"/"appetite"	4	13.8
Drugs	1	3.4
"(A person's) honesty, with themselves, too"	2	6.8
"Ignorance"	1	3.4
"I don't know"	1	3.4
Declined to answer	7	24.1

Because the incidence of HIV/AIDS is on the rise again (Bragi, 2001; Centers for Disease Control and Prevention, 2001c; Gayle, 2000), the present researcher wanted to know if the participants had any knowledge or beliefs about the increase in the incidence of HIV/AIDS. The final question of the survey was, "Are there other reasons, that were not asked in this survey, that contribute to the high number of new cases of HIV/AIDS and sexually transmitted diseases?"

Table 32

Participants' Responses to "Are There Other Reasons, That Were Not Asked in This Survey, That Contribute to the High Number of New Cases of HIV/AIDS and Sexually Transmitted Diseases?"

Are there other reasons?	Participants	Percent
Yes (but did not elaborate)	1	3.4
No	4	13.8
Left Question blank	12	41.4

Those who chose to respond contributed these responses. The participants stated:

1. "Apathy. The message is out there but I don't think people are paying attention."

2. "Pear (sic) presure (sic), access to health care, [the diagonise] (sic) [of HIV/AIDS] and condoms, needle access. Also $ [money]."

3. "Self-worth/value, It's usually low."

4. "Possibly rape, the lack of knowledge, not knowing what the disease and the maintenance is like for POZ people."

5. "At my age--I [did] not think it could happen to me."

6. "Some people think it is going to happen anyway."

7. "Rampant immorality."

8. "It appears that the younger generation think it is an 'older' problem."

9. "Education about HIV/AIDS/STDs are directed at only one or a few segments of the population. And [it is] not shown that anyone at any time [can get it]."

CHAPTER V

DISCUSSION

This chapter includes a brief discussion of the investigation, a summary of the data gathered, and the implications for practice. Also included is a discussion of the limitations of the study and recommendations for further investigation of the problem.

In descriptive research there often is no ability to control the randomness of the participants and there may not be a control group (Polit & Hungler, 1993). These types of studies frequently try to examine a situation after an event has happened; in this case, the perceptions of the participants after being diagnosed as HIV positive. In this type of research, there is no manipulation of interventions, no control groups, and there may not be statistical data. However, these types of studies are important "because not all problems are experimental in nature and because non-experimental studies are often high in realism and can be particularly efficient" (Polit & Hungler, 1993, p. 166). The main objective for this type of research is to accurately portray the characteristics of individuals, situations, and/or groups as they are now. The purpose of this study was to describe a group of people who were infected with HIV

who were infected with HIV and examine the social phenomena and motivations for behaving in ways that increased their risk for HIV infection.

Much of the data collected was in the form of descriptive narrative. Analysis of these data consisted, primarily, of sifting through the large amounts of narrative for themes, concepts, or key words. These provide the researcher with the concerns, attitudes, or beliefs of the participants. Although the researcher may establish beforehand what might be the concerns of the participants through a review of the literature, each group of participants establishes its own areas of concern. What the participants determine as their major concerns may, or may not, coincide with those that were pre-established by the researcher. These areas of concern, pre-established by the researcher, may be categorized as predisposing and/or enabling factors.

In this study, the participants were asked intimate questions about their sexual orientation and personal sexual behaviors. Answering such intimate questions was considered as a risk to the participants. As such, a mental health worker and a member of the staff of AIDS Services of North Texas agreed to work with the participants in the event of emotional stress resulting from participation in the study. One participant did appear to become upset while answering the questions and was calmly approached by the mental health worker and the researcher. The participant was assured that even though the questions were indeed sensitive, no harm had been intended and that he was under no obligation to complete or submit the survey. He was told that he could destroy his survey if that would make him feel more

comfortable. The participant calmed down and agreed to talk further with the mental health worker in her office. As he was leaving with the mental health worker, he put the survey into the collection box. The mental health worker reported later that the participant had agreed to work with a group to help him deal with his feelings.

Because many of the questions in this study were intimate in nature, it was not surprising that some of them were not answered. While many of the participants did not answer all of the questions, and many gave short and sometimes cryptic answers, the answers that were provided were insightful. They spoke of the fear and concern of rape, and issues of moral behavior. Despite their own personal efforts to protect themselves and their partners, rape was one instance over which they had no control and they knew first hand how devastating it could be. One of the participants was a rape victim. Some believed that the incidence of HIV was rising because people were having multiple partners, which they described as "loose morals." Some were aware of the effect of peer pressure to behave in unsafe ways, which relates to the handicap principle (Conniff, 2001). Some also showed concern about issues of age, in that older persons were unaware of the risks and younger persons believed that HIV/AIDS was a problem of older people. Their concerns also touched on apathy, poor social programs for HIV/AIDS prevention and treatment, and the problems with access to health care, partially due to monetary concerns.

Thirteen (45%) of the participants were unemployed, and of these 7 (24.1%) were disabled and unable to work. Men are especially prone to associate what they do

for a living with who they are as a person. They gain self-respect and self-worth from their work (Coles, 1978). Lack of earned income and the ability to be self-sufficient in today's society causes feelings of decreased self-worth, helplessness, and hopelessness.

Lastly, some participants evidenced concern over the stigma of the disease itself. Some reported experiencing feelings of decreased self-worth when they were required to self-reveal during state-mandated sexually transmitted disease reporting. They were uncomfortable having to name their partners and reveal their HIV status. One participant stated it as, "embarrassed--don't want to report [on them]." They feared that their partners would be contacted and were concerned about what others would think of them.

The Research Questions

The formal research questions were rephrased on the instrument into language that more closely resembled the lived experience and speech patterns of the anticipated participants. This procedure personalized the questions and required that the participants answer in the context of their own lived experiences and beliefs. In the discussion that follows, the research questions are stated formally, and then restated as they appeared on the instrument. Wherever a participant's answer is used as an example, it is quoted verbatim.

"Could it be that persons do not believe that AIDS is a deadly disease?"

This question was rephrased on the instrument to read, "Before you were diagnosed, did you truly believe that HIV/AIDS was a deadly disease?" Drawing on the personal perceptions construct of the HBM, the participants were asked to determine if they believed that AIDS was a deadly disease. Twenty-five of the 29 participants (86.2%) answered that they did believe that HIV/AIDS was a deadly disease. The fact that 2 participants said that they were not sure and 2 said they had not believed that HIV/AIDS was a deadly disease seems to imply that approximately 13.7% of the participants, prior to their infection, were unconvinced of the seriousness of the threat. Because the sample was small, it is unadvisable to generalize these percentages to the general public. A small percentage, 6.8%, of those who believed that HIV/AIDS was a deadly disease, reported behaving in ways that placed them at risk for infection. Even among those who believed HIV/AIDS to be a deadly disease, condoms were not always used during sex.

Several recent studies have raised controversial issues as to whether HIV/AIDS is still a disease to be feared (Bragi, 2001; D. Harris, 2000). Some of these reports discussed the negative effects the development of the antiviral cocktails and the promise of a vaccine and/or cure have had on prevention efforts (Centers for Disease Control and Prevention, 1998; Haney, 2001; M. Harris, 2000a). There are conflicting reports, some sponsored by reputable agencies, as to the validity of condom use (Connolly, 2001) and the safety of oral sex versus vaginal or anal sex (M. Harris,

2000a). Two participants stated that, "oral sex has a lower risk." These mixed messages contribute to the risk for infection. Individuals may choose to believe only those messages that support their risky behavior (M. Harris, 2000a).

"Is there some mechanism, such as optimum bias, that allows people to believe that they are not vulnerable to HIV infection?"

This question asked the participants to assess their own susceptibility to HIV/AIDS. Rephrased as, "Did you believe that you might get HIV/AIDS? If not, why not?" The participants were divided almost in half as to their belief that they would or would not contract HIV/AIDS. Fourteen participants (48.2%) responded "yes" and 13 participants (44.8%) responded "no." One (3.4%) person said that (he/she?) "did not consider it" and 1 (3.4%) person said "possibly." One participant wrote that, "being my age (53) [I] would not get it." Those who said "yes" seemed to indicate, from other responses, that they had engaged in risky behaviors and were aware of these risks. Of those who said "no" and gave a reason, 4 made statements that implied a belief in optimum bias, so aptly stated by this participant: "No, no one truly believes that it would happen to oneself." Others made statements that they were "too old," "didn't do drugs," and "I'm not gay." These responses imply an attitude of "it won't happen to me." Defensive denial is a form of distancing oneself from the problem. The element of defensive denial resides within optimum bias as it implies that, since the participants do not belong to the group in question, they are not affected (Kirscht et al., 1966; Weinstein, 1987). The participant who responded about

age implied that AIDS is a disease of the young. The participant who said, "I'm not gay" implied that "only gay persons" get AIDS. The participant who replied that they did not "do drugs" implied that only persons who used drugs were likely to get AIDS. Both Kirscht et al. (1966) and Weinstein (1982, 1984, 1987) have reported on the self-protective aspects of optimum bias. Within the present study, the theory of optimum bias was evidenced in approximately half (44.8%) of the participants.

As previously mentioned, optimum bias is the belief that bad things are more likely to happen to others than to one's self and one's friends (Weinstein, 1984). Optimum bias normally functions as an ego protector in most everyday situations. However, in preventable disease situations it may cause susceptible persons to ignore valuable cues to action and subsequent behavior that might help protect them (Kirscht et al., 1966).

AIDS Bias

Another optimistic, self-preservationist attitude also has risen from the antiviral treatment modality. Along with the attitude that, "it won't happen to me," is the corollary, "and if it does it will be OK. There will be some pill or there'll be something that I can take if I get it that I won't die" (Harris, D., 2000, p. 2). This overly optimistic attitude is called "AIDS optimism" and is directly related to the drug treatment regimens. This was evidenced by one of the participant's statements: "Yes I did believe that HIV/AIDS was a deadly disease, but a disease that could be treated and managed due to medication and good lifestyle." This is a common theme that

runs through many articles and government reports (Bragi, 2001; Centers for Disease Control and Prevention, 1998; D. Harris, 2000).

"What information or behavioral strategy might have helped to prevent the risk behaviors?"

This question relates to the structural variables within the modifying actions construct of the HBM. These constructs include variables such as knowledge and preventative measures performed by the individual. Unlike cues to action, these are specific behaviors that individuals might do to change their circumstances. This question was stated as, "What could have helped prevent the risk behaviors?" The answers to this question demonstrated the participants' knowledge about what they could have done in the past to protect themselves.

Despite self-efficacy, there are often things that one has no control over, such as a spouse or partner having an extramarital affair or using injectable drugs that increase the person's risk for HIV infection. One participant related that his wife had been a drug user in her youth. Another stated that his girlfriend had had a boyfriend who died from AIDS, but neither of them had known the ex-boyfriend was infected until his death. One participant reported the HIV infection was the result of a rape. In essence, this question provided a reality check. If the participants believed HIV/AIDS to be a deadly disease and they believed they might be susceptible to infection, what could they (should they) have done to decrease their risk?

Although one person declined to answer and two people stated that they did not know, the remaining participants were very knowledgeable about self-protection in the form of condom use (n = 11), not using drugs (n = 2), education (n = 6), monogamous relationships (n = 1), and more careful partner selection (n = 1). Others recommended safe sex education in the schools, enlightened public policies about sex education in the schools, and better access to health care. One person believed he would have benefitted by seeking help for emotional problems. The responses, though limited in number, indicated that a majority of the participants were aware of behaviors that could have protected them, demonstrating some level of insight.

"Was there a person who might have been able to dissuade the person from risk-taking behavior?"

This question addresses the psychosocial variables under the modifying actions construct of the HBM. These refer to peers, reference groups, and the social pressures for behavior that are imposed on the participant. Over time, these set individual values and behavioral expectations. The question also addresses the cues to action construct of the model, as well. Cues to action include media campaigns, newspaper and magazine articles and advertisements, advice from others, and the experience of an illness by oneself or a friend. This question was stated as, "To whom would you have listened about risk behaviors?"

The participants offered a wide variety of people to whom they might have listened. "Anyone with knowledge" was listed eight times, while "friends" and "health care professionals" was listed five times. "Persons in authority," "parents," especially mothers, and "family members" were listed approximately four times each. This information suggests that the participants would have been willing to listen to people they believed knew what they were talking about and were respected by the participant.

An interesting theme arose from some of the answers to this question. The participants primarily listed people in caregiver roles, who had a stated (parent/ family/friend) or implied (doctor/nurse) relationship to/with the person as someone to whom they might have listened for health protection information. This finding suggests that parents, family, and friends should talk with their children, other family members, and friends about practicing safe sexual behaviors and avoiding the use of drugs. Only one person responded that the "media" was a positive cue to action and one person suggested that "contact with persons who were HIV positive" might have dissuaded him/her. This seemed to imply that caring and knowledgeable persons, especially those in positions of respect or authority, are best suited to deliver the message for HIV/AIDS prevention.

"How could information have been presented that might have altered the risk taking behaviors?"

This question applies to cues to action and was stated as, "How could this information been presented to you that would have altered your behavior?" Of the five research questions, this question was left blank most often. Six participants (20.7%) declined to answer and a number of the answers given (17.2%) were not responsive to the question. From the responses given, it appears that some of the participants were elaborating on the previous question. Some of the responses were totally non-sequesters, apropos of nothing, and matched none of the questions asked.

Where answers were given, the participants believed that information should be provided early (before puberty). Forty-four percent of Americans, surveyed by the 1998 *National Survey of Americans on Sex and Sexual Health* (Kaiser Family Foundation, 1998), believed that young people are getting information on sex, birth control, and other sexual issues too late. In this study, teens (57% of 12- to 18-year-olds who were surveyed) said that the information they get from adults about sex and birth control comes too late (Kaiser Family Foundation, 1998). Approximately half (48.4%) of adolescents between grades 9 through 12 (roughly ages 14 to 19 years), interviewed in the CDC's Youth Risk Behavior Surveillance study, reported that they had had sexual intercourse within their lifetimes (Robinson & Telljohann, 1999). Early initialization of sexual behaviors is "significantly associated with

increased numbers of sexual partners and greater risk for STD infection" (Robinson & Telljohann, 1999).

One participant believed the information should be given in "graffic (sic) visual detail." The information should be presented honestly or, as one respondent termed it, "straight up--no holes (sic) bared (sic)." One participant wrote that presentations by gay persons, and those who were "HIV POZ," would be more believable.

The participants also believed that parents and family members should discuss the risk of HIV/AIDS infection, practicing safe sex behaviors, and not using drugs with their children. The majority of the participants' answers indicated that they understood the value of early safe sex education, and seemed clear on how to address the problem of prevention education.

Dr. David Satcher, the former U.S. Surgeon General, in a recent article, proposed the same strategies offered by the participants for prevention education. Dr. Satcher encouraged families, schools, and communities to, "Get past their nervousness about sex so that they could do a better job of preventing unwanted pregnancies and sexually transmitted diseases, especially HIV/AIDS" (Cable Network News, 2001b). For many teens, parents are a trusted source of information about sex (Kaiser Family Foundation, 2000). In the 2000 Kaiser Family Foundation's *National Survey of Teens on AIDS*, parents ranked second (35%) after teachers, school nurses, and in-school classes (65%) as trusted information sources.

In 1998, approximately 20,000 Americans under the age of 25 were diagnosed as HIV positive. AIDS has become the number one killer of adults between the ages of 25 and 44 years (Raymond, Tanner, & Eppright, 1998). Unfortunately, this indicates that many of these young adults were infected while in their teens and 20s. The youngest participant in this study was 22 years of age.

Are there other factors at work and, if so, what are those factors?

This question, though not officially one of the research questions, elicited some interesting responses from several of the participants. The responses seemed to imply a level of thrill seeking. A participant who referred to not always using a condom provided an example of thrill-seeking behavior. The participant stated, "Not having sex needing a barrier. But any risks taken are my own. I am not comfortable allowing a partner to take risks when having sex with me." Another stated, "Don't like the taste of condoms," while another responded, "[The] pleasure of toungue (sic) to flesh that [I] cannot seem to give up."

In several studies of the reasons why people take risks, the intimation is always that there are some intrinsic values gained by risk taking, either social status, mates/sexual partners, or other rewards (Conniff, 2001). Risk-taking seems to heighten the awareness and sense of pleasure for some people. The same area of the brain that responds to gambling seems to be involved in other forms of risk taking. This area of the brain also influences decision-making and addictive behaviors (Gately, 2001). Other studies investigating attention deficit hyperactivity disorder have

found genetic linkages to addiction and novelty seeking, both of which are related to risk-taking behaviors (Moyzis, 2001). Finally, a study of healthy teenage brains found that, during the later teen years and early 20s, a major growth spurt occurs in the brain in the area where decision-making, responsible behavior, and self-control occur (Vedantam, 2001). Could the lack of brain development, or the processes involved in that development, account for the impulsive, erratic, and sometimes irresponsible behavior exhibited by teens? As the brain matures, the physical changes are believed to mirror the cognitive changes (Vedantam, 2001). While this theory is still considered controversial, there is a need for further investigation of its application to risk behavior.

Condom dislike. As mentioned previously, condom use was not a favored choice for many of the participants and there were several statements that documented this attitude. "Don't like the taste," [Poor] "comfort and feel," and "pleasure of flesh to toungue (sic) that [I] cannot seem to give up" were three such statements. There is research to substantiate the discomfort and difficulty of use of condoms, as well as the taste and smell (Finger, 1998; Grady et al., 1999; Resource Center for Adolescent Pregnancy Prevention, 2001). However, different types of condoms, which are proving to be reliable, as well as flavored and scented condoms, are available (Resource Center for Adolescent Pregnancy Prevention, 2001).

Complacency. The participants reported complacency as a concern. They mentioned complacency among the gay community in the use of condoms. One

participant stated, "Apathy. The message is out there but I don't think people are paying attention." Several government studies, investigative reporters, newspaper, and research articles have reported that, due to complacency and the success of the drug cocktails, condom use is down, and risky sexual behaviors are up (Bragi, 2001; Centers for Disease Control and Prevention, 1998; Gayle, 2000; Haney, 2001; D. Harris, 2000; M. Harris, 2000b; Stahl, 2001).

The participants also mentioned complacency at the political levels in not providing education and public funding for HIV/AIDS care. One participant wrote, "More education to the public. Preferrably (sic) not having a bigot in the White House (Bush) (Reagan) during the 80's." Another wrote, "More public information and political support in the Reagan Admin." A third wrote, "It was not a public concern at the time." In a press conference, former Surgeon General Satcher (2001) offered a five-step program for sex education. Included in the program would be, "Increasing scientific research on sexual health," "Developing and disseminating educational materials that cover the full continuum of sexual development," and "Have these materials available for use by parents, clergy, teachers, and others" (Cable Network News, 2001b).

Drug use. Of the 48.2% of the participants who did believe they were susceptible to HIV/AIDS, 57% of those participants referred to behaviors done prior to, during, or just after using drugs. It is well documented that drug usage/abuse inhibits behaviors that are self-protective (Centers for Disease Control and Prevention,

2001c; Farrow & Arnold, 2001; Gayle, 2000; Muir, 1991; Otto-Salaj & Stevenson, 2001). Contraceptive behavior (condom use) has been shown to be negatively correlated with drug use, alcohol use, aggression, and delinquency (Robinson & Telljohann, 1999). One participant said, "When using drugs you do not think--all you think about is the high." Another responded, "In too much of a hurry to get high to act with intelligence." "Some drugs, such as cocaine, actually influence other risky behaviors and can affect the reproduction and spread of the HIV virus" (United Press International, 2002).

Moral issues/family values. Of the participants in this study, 55% (n = 16) were single, 10% (n = 3) were married, and 13% (n = 4) were partnered. Ten percent (n = 3) had significant others (SO), while 10% (n = 3) said that they had "no one special at the moment." From the information available, it appears that the majority of the participants were single and 10 (34.5%) had some form of committed relationship. Yet, the numbers of partners counted on the ethnicity question was 16.

The disparity between the numbers reported in this group and the numbers in the marital status group was because many relationships were not considered as more than "girlfriend/boyfriend level." Legally, they do not fall into the marital status category, but are simply agreements between the persons to have a relationship. The participants listed committed relationships (27.6%), family values (6.8%), or having religious convictions/being religious (6.8%) as being important. One participant

suggested that a way to decrease the number of sexual partners, a person had would be "encouraging same sex partnerships, something like marriage."

Self-efficacy. With regard to self-efficacy, none of the participants implied that they were unable to perform the tasks necessary to protect themselves. Two participants believed that they had been infected at the very beginning of the epidemic, when there was no threat of HIV/AIDS and people only had to worry about other STDs. As mentioned previously, 1 participant had become infected during a rape, 1 participant was unknowingly infected by his girlfriend, and 2 participants had unprotected sex with previous drug users. One participant received HIV-contaminated blood. These situations provide examples of situations in which the best of intentions and the highest level of self-efficacy cannot prevent HIV infection.

Other emotional issues. Throughout the responses, participants mentioned issues of self-esteem, low self-worth, or self-value. One person reported that he had been suicidal and had tried to "get AIDS as a means of committing suicide." He stated, "I am not currently suicidal, this was over 10 years ago."

The question that drew the most frequent statements about self-esteem and self-worth was, "What influences the number of sex partners a person reports?" This question was from the TDPH and refers to the required practice of reporting sexual contacts and notifying persons that they have been exposed to a sexually-transmitted disease.

Seven (24.1%) declined to answer the question. One (3.4%) said that he/she? didn't know. Five (17.2%) said "shame or embarrassment," 2 (6.8%) said "fear," 2 (6.8%) said "low self-esteem," and 2 (6.8%) said "high self-esteem" (bragging). Because of the wording of the question, it is difficult to relate the feelings to the persons' usual feelings about themselves, or were the feelings engendered during a process that caused the person to self-reveal sexual behavior, having multiple partners, to others during the reporting process.

Limitations of the Study

The major limiting factors of the study are the design, as it addressed only one moment in time; the lack of a control group, which allows for no comparison between groups; and multiple threats to validity, both internal and external. Despite these flaws, descriptive studies are designed to gain information about the characteristics within a particular field of study. Their purpose is to provide a picture of a situation. The descriptive design may be used to "develop theory, identify problems with current practice, justify current practice, make judgments, or determine what people in similar situations are doing" (Burns & Grove, 1993, p. 293). This type of investigation can produce a large amount of informative data concerning the attitudes, knowledge, and beliefs of a group.

Several other factors affected the generalizability of the results of this study. The sample size was small ($N = 29$) which is restrictive to the generalizability of the results. All of the participants were HIV positive. The participants were all from the

North East Texas Area and recipients of care at the same mobile clinic. Therefore, the sample was very localized. Only persons who came to the clinic were available to participate and only those who were amenable to participating chose to fill out the survey. The study was retrospective in nature. A disadvantage of using the self-report survey is the potential for low response rate of the survey and/or the questions (McDermott & Sarvela, 1999).

Lack of Diversity

There was little diversity in the ethnic groups represented. Caucasians, Black/African Americans, Hispanics, and Jamaicans were represented in the study. American Natives were represented only in conjunction with other ethnic groups. There were no Asian/Pacific Islanders, or Alaskan Natives represented, nor were there any individuals of the Near East or the Indian Subcontinent.

Limited Gender Representation

The participants were predominantly male. Females living with AIDS were under-represented. A recent study indicated that women of color have the fastest rising incidence of HIV/AIDS (Haney, 2001). The 4 female participants made up only 13.79% or approximately one-seventh of the sample. The Division of HIV/AIDS Prevention Surveillance and Epidemiology released a study in 2001, which stated that "40% of women with AIDS were infected in a heterosexual relationship with a drug user or partner who had M/M/F sexual encounters" (Lansky, Fleming, Byers, Karon, & Wortley, 2001; Lehrer, 1999).

Limited Age Representation

Only 4 participants (13.9%) were between 18 and 29 years of age, with the majority of participants (79.3%) between 31 and 47 years of age. Only 2 (6.8%) persons were over 50 years of age. However, the trends indicate that HIV/AIDS infection is rapidly increasing among those under 25 (Centers for Disease Control and Prevention, 2001c) and those over 50 (Centers for Disease Control and Prevention, 2001f).

Limited Time

The advertisement time for the study was only a week prior to the beginning of data collection. This may not have been enough time for a larger population to become aware of the study. The data collection time was quite short, only 32 days, from January 28 to February 28, 2002. Despite the limited data collection time, 29 persons participated. This number was well within the 20 to 30 participants suggested by the Institutional Review Board for this study.

Implications for Health Studies Practice

The participants suggested that parents and family members talk to their children about HIV/AIDS/STDs. Health Promotion/Education specialists could provide culturally sensitive programs within the community for parents. These programs could provide parents with educational materials and communication skills to improve their children's understanding of the dangers of HIV/AIDS, drug usage, and the need to practice safe sex. The participants' responses implied that a caring

relationship with the educator is as important as the message. A continuing study is investigating the benefits of clinician-delivered interventions that reduce HIV risk behaviors by utilizing the close patient-clinician relationship as a medium of information exchange (Fisher, 2001).

Competent Safe Sex Education

Sex education for young adults. Young adults, under the age of 25, are among the fastest growing groups of HIV-infected individuals. Sex education and safe sex should be taught in the schools and at a younger age than is now offered. According to a recent study, sex education does not encourage earlier initiation of sex or increased sexual behavior (Cable Network News, 2001a; Kaiser Family Foundation, 2000). Young people who have had comprehensive sex education in the schools become sexually active at an older age and report having fewer sex partners (Kaiser Family Foundation, 2000; Sykes, 2001).

Safe sex for those over 50. Older adults need to be made aware of the risk of unprotected sexual behaviors. The Centers for Disease Control and Prevention, in a press release dated March 19, 2001, indicated that the rate of incidence for HIV infection in those over 50 is increasing at twice the rate for younger people (Centers for Disease Control and Prevention, 2001f). Many people over 50 equate the use of condoms with birth control and do not use them (Centers for Disease Control and Prevention, 2001f). "Older adults may be at risk for HIV infection by engaging in sex- or needle-related behaviors and may need counseling and testing" (Linsk, 2000,

p. 430). Health care providers should include a sexual history for adults over 50 in their initial visits and provide safe sex and HIV education as needed throughout the continuum of care (Linsk, 2000).

Cultural Competence/Social Sensitivity

Safe sex presentations need to be culturally sensitive and age appropriate for the audience. Culturally competent instructors should make the presentations. Peers, people living with AIDS (PLWA), or others who are perceived to be knowledgeable and respected within the population should be the instructors. One participant suggested that the information needed to be presented from "a minority perspective." Some of the participants suggested that the information needed to be presented in a straightforward, honest, and truthful manner.

Socially Sensitive Language

Many bisexual Black/African American and Hispanic males who have sex with males identify themselves as heterosexuals and do not perceive themselves at risk (Centers for Disease Control and Prevention, 2001c; Feig, 2001; Haney, 2001; Humphries, 2000). Therefore, using the terms "men who have sex with men" or "M/M sex" are socially appropriate. This group is among those who need to be targeted for culturally sensitive and competent safe sex education, as they are often marginalized in society. These men often experience low education levels, joblessness, and poverty, which often leads to decreased access to health care and

health promotion education (Centers for Disease Control and Prevention, 2001c; Gayle, 2000).

Enlightened Public Policies

In order to provide this education, public policy regarding sex education in the schools needs to be re-evaluated. Former Surgeon General Satcher has presented a five-step program for sex education, research, and sexual health promotion programs that would be widely available (Cable Network News, 2001b). As of 1995, only 37 states and the District of Columbia required schools to provide education on STDs and HIV. Of those, 22 states also required sexuality education. The other states may provide sex education programs, but they are not mandated to do so. Twenty-six states require abstinence instruction and of those, only 14 require inclusion of information on contraception, pregnancy, and disease prevention (National Abortion and Reproductive Rights Action League, 1995). At the present time, due to government policy, millions of highway dollars are attached to a sex education policy that promotes abstinence only. Unfortunately, this is a program that, when used alone, does not adequately address the problem (Livni, 2000; Sykes, 2001).

Active Advocacy for Health

Health promotion/education specialists should be active within their communities to promote positive change in the health policies that impact the overall health of the people. Program evaluations and other types of research that investigate the long-term outcomes of existing programs, should be conducted to determine

program effectiveness (McDermott & Sarvela, 1999). Programs that have been shown to be ineffective should be changed for others that have offered success (Leutwyler, 1993).

Community-based Health Care

Communities need to upgrade education efforts, improve access to health care, and provide outreach and counseling programs for those at risk (Centers for Disease Control and Prevention, 2001c). The participants of the study suggested that education provided within the homes, the schools, and the communities by caring individuals could have an extremely beneficial outcome. Safe sex and HIV/AIDS education needs to be targeted to all societal groups and to all ages in the life continuum.

Recommendations for Further Research

The researcher suggests that this study, or one similar to it, be repeated with several, more widely dispersed groups to give a broader base for data collection. This would provide access to participants who more closely represent the overall population of PLWA.

Because the majority of the respondents in this study were male (86.2%), a similar study of women might reveal different issues of concern. This might also be true of a related study with those over the age of 50.

In order to strengthen the study, a component addressing the issue of self-efficacy could be added. Because one person described feelings of depression and

of having been suicidal in the past, it might be of value also to add a depression scale or quality of life measure.

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APPENDICES

Appendix A

Institutional Review Board Letter

TEXAS WOMAN'S UNIVERSITY

INSTITUTIONAL REVIEW BOARD
P.O. Box 425619
Denton, TX 76204-5619
Phone: (940) 898-3375
Fax: (940) 898-3416
e-mail: IRB@twu.edu

January 9, 2002

Ms. Helen Hughes

Dear Ms. Hughes:

Re: Why Adults Indulge in Behaviors That Increase the Risk of HIV/AIDS Infection

The above referenced study has been reviewed by a committee of the Institutional Review Board (IRB) and appears to meet our requirements in regard to protection of individuals' rights.

If applicable, agency approval letters obtained should be submitted to the IRB upon receipt prior to any data collection at that agency. Because you do not utilize a signed consent form for your study, the filing of signatures of subjects with the IRB is not required.

This approval is valid one year from the date of this letter. Furthermore, according to HHS regulations, another review by the IRB is required if your project changes. If you have any questions, please feel free to call the Institutional Review Board at the phone number listed above.

Sincerely,

Gail Davis

Dr. Gail Davis, Chair
Institutional Review Board - Denton

enc.

cc Dr. Susan Ward, Department of Health Studies
Dr. Kristin Wiginton, Department of Health Studies
Graduate School

Appendix B

Agency Approval Letter

AIDS SERVICES OF NORTH TEXAS

Creating healthier futures for North Texans living with HIV/AIDS.

26 July 2001

To Whom it May Concern:

Helen E. Hughes has requested and received permission to conduct her study entitled "A Qualitative Study of Why Adults Indulge in Behaviors that Increase the Risk of HIV/AIDS Infection" utilizing clients of the mobile primary care clinic who agree and are currently receiving services at AIDS Services of North Texas. She has agreed to abide by our confidentiality and other pertinent guidelines in her study. If clients should become distressed by the interview content, counseling is available on site here at ASNT.

It is a pleasure to work with Helen Hughes and we are confident that the study will be a valuable addition to the field.

Sincerely,

Ronald G. Aldridge, Ph.D.
Executive Director

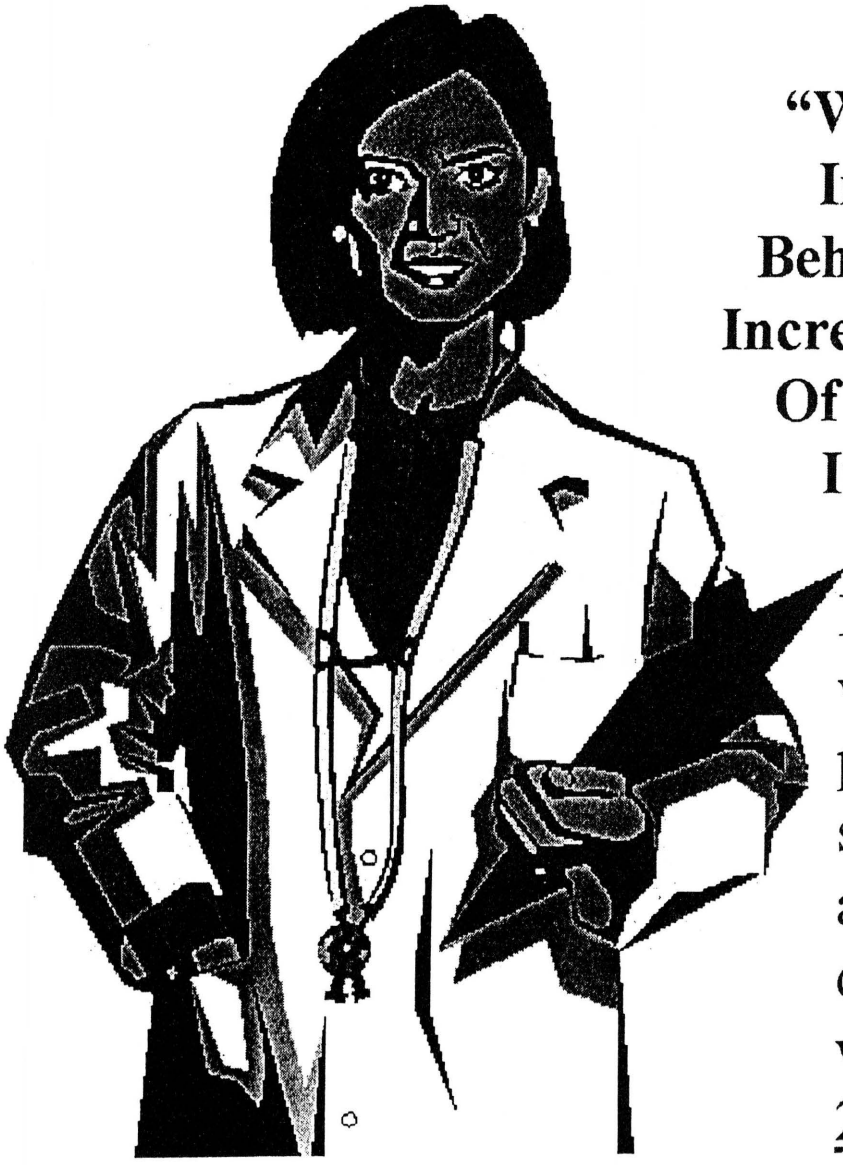
Main Center
616 Fort Worth Drive · Dallas TX 76201
Toll-Free (800) 974-AIDS
Telephone (940) 381-1501 · Fax (940) 566-8059

Outer Metro Center
1316 14th Street · Plano TX 75074
Toll-Free (800) 339-AIDS
Telephone (972) 424-1480 · Fax (903) 455-9292

Rural Center
3506 Texas Street · Greenville TX 75401
Telephone/Metro (903) 450-4018
Fax (903) 455-3737

Appendix C

Recruitment Poster



"Why Adults Indulge In Behaviors That Increase The Risk Of HIV/AIDS Infection"

If you would be willing to participate, the surveys will be available during the weeks of **Jan 28** thru **Feb 28.**

Your insights may help others!

Helen Hughes, R.N., MSN

Appendix D

Study Instrument

WHY ADULTS INDULGE IN BEHAVIORS THAT INCREASE THE RISK OF HIV/AIDS INFECTION

Thank you for taking the time to complete this survey.
Investigator: Helen E. Hughes, R.N., MSN . . . . . .
Advisor: Kristin Wiginton, Ph.D. . . . . .

You are being asked to participate in a research study for Mrs. Hughes' dissertation at Texas Woman's University. The purpose of this study is to identify some of the internal motivations that lead people to indulge in behaviors that place them at risk for HIV/AIDS infection. You will be asked to answer some questions about yourself and then write out the answers to five questions. If you feel that a question is one that you would rather not answer there is a place for you to indicate this. This will indicate that you chose not to answer that question rather than you missed that question. It will take about 20 to 30 minutes to complete the survey. Surveys will be collected in a sealed container.

This is an anonymous survey. There will be no identifying marks on the surveys. No signed consent form will be asked for to insure your privacy. Your confidentiality will be protected to the extent that is allowed by law. The return of your completed questionnaire constitutes your informed consent to act as a participant in this research.

These are some of the risks that you may encounter if you choose to participate in the research and the steps that will be taken to minimize those risks.

Loss of confidentiality

You will self-select survey sheets and deposit them in a sealed container upon completion. Only the researcher will have access to the raw data. For purposes of data entry for analysis each survey will be given a number just prior to its entry. During analysis the surveys will be kept in a locked file cabinet in the home of the researcher.

Loss of privacy/Self-disclosure/Sensitive nature of the questions/Embarrassment.

You are not required to answer any question you might feel is too sensitive or revealing. You will complete the survey in a private place. There will be no identifying marks on the survey.

Introspection/feelings of guilt/regret.

A Licensed Mental Health counselor will be available to discuss these feelings with you.

Interacting with a stranger.

The Researcher is a volunteer at the clinic in order to establish a level of comfort and trust with the clients.

The researchers will try to prevent any problem that could happen because of this research. You should let the researchers know at once if there is a problem and they will help you. However, TWU does not provide medical services or financial services for injuries that might happen because you are taking part in this research. Participation in the survey is on a purely voluntary basis. There will be no rewards or personal benefit to you except the knowledge that you have helped the health care profession to better understand people's reasons for why they behave the way they do. Your honest answers may help someone else avoid acting in ways that may be harmful to themselves or to their loved ones.

If at any time you feel that you do not wish to continue, for any reason, you may stop. If you decide not to complete the survey, please place it in the sealed container. There is no penalty for not completing the survey.

The results of the survey will be used to write a dissertation and a report for AIDS Services of North Texas, which will be available to you through AIDS Services of North Texas. If you have questions about the report you may contact the investigator at or by e-mail at hehughes@flash.net.

If you have any questions about the research study, you should ask the researchers: their phone numbers are at the top of this form. If you have questions about your rights as a participant in this research or in the way this study has been conducted, you may contact Ms. Tracy Lindsay in the Office of Research & Grants Administration at 940-898-3377 or e-mail IRB@TWU.edu

Your confidentiality will be protected to the extent that is allowed by law. The return of your completed questionnaire constitutes your informed consent to act as a participant in this research.

Demographics

1. What is your age? _____

2. What was the highest grade of school that you completed? _____

3. What is your gender? ☐Male ☐Female ☐Transgendered

4. Would you share with us your sexual orientation? Please "x" your choice.
☐Male/Male ☐Female/Female ☐Male/Female ☐Bi
☐Do not wish to share this information

5. How would you describe your race and/or ethnicity? Please "x" your choice.
☐Asian ☐Black/African American ☐Hispanic/Latino
☐Caucasian/white ☐Don't know
☐Other (Please write in your choice) _____
☐Do not wish to share this information

6. Are you:
☐Married ☐Single ☐Partnered
☐Significant Other ☐No one special at the moment

7. How would you describe your /Wife's/Husband's/Partner's/Significant Other's race and/or ethnicity? Please "x" your choice.
☐Asian ☐Black/African American ☐Hispanic/Latino
☐Caucasian/white ☐Don't know
☐Other (Please write in your choice) _____
☐Do not wish to share this information

8. What is your occupation? _____

9. Are you working at the present time? ☐Yes ☐No

10. If you are working now, or when you worked in the past, at your chosen profession, what was your salary range? Please "x" your choice.

☐$10,000-20,000	☐$31,000-40,000	☐$51,000-60,000	☐$71,000-80,000
☐$21,000-30,000	☐$41,000-50,000	☐$61,000-70,000	☐Over $81,000

Your confidentiality will be protected to the extent that is allowed by law. The return of your completed questionnaire constitutes your informed consent to act as a participant in this research.

Research Questions

1. Before you were diagnosed, did you truly believe that HIV/AIDS was a deadly disease?

2. Did you believe that you might get HIV/AIDS? If not, why not?

3. What could have helped prevent the risk behaviors?

4. To whom would you have listened about risk behaviors?

5. How could this information have been presented to you that would have altered your behavior?

Your confidentiality will be protected to the extent that is allowed by law. The return of your completed questionnaire constitutes your informed consent to act as a participant in this research.

Knowledge of Risk Behavior

1. Is reducing the risk of getting HIV/AIDS important?
   ☐Yes ☐No

2. Is HIV/AIDS and sexually transmitted disease prevention important to you?
   ☐Yes ☐No

3. How important, on a daily basis, is protecting your sex partner from HIV/AIDS?
   ☐Very important ☐Somewhat important ☐Not very important
   ☐I don't think about it

4. Do you always use a barrier/condom? ☐Yes ☐No

5. If **NO**, why are barriers/condoms **NOT** used?

   _____

   _____

6. Do you have sex with both women and men? ☐Yes ☐No

7. Do you use condoms for anal sex, but not for oral or vaginal sex?
   ☐Yes ☐No

8. If YES, Why?

   _____

   _____

9. Do you use anal sex as a means of birth control? ☐Yes ☐No

10. Do you think using a specific drug affects needle-sharing behavior?
☐Yes ☐No

11. Why do people share injectable drug equipment (needles, syringes, spoons, etc.)? Please place an "x" in **ALL** the boxes that apply.
☐Lack of knowledge that sharing is dangerous.
☐Lack of skill at cleaning equipment.
☐Lack of cleaning supplies.
☐Lack of clean equipment.
☐Lack of knowledge about how to clean the equipment.
Some other reason (write in your answer).

_____

_____

12. Does using drugs affect condom use or risk reduction behaviors?
☐Yes ☐No

13. Does using drugs affect the choice of sexual partners?
☐Yes ☐No

14. Does using drugs affect exchanging sexual favors?
☐Yes ☐No

15. Does using drugs affect selling sex? ☐Yes ☐No

16. Have you ever sold sexual favors? (Had sex for money)?
☐Yes ☐No

17. If you have, why?
☐To buy every day items...food, clothes, &/or shelter.
☐To buy medicine to treat an illness or condition.
☐To buy drugs.
☐To buy alcohol.
☐To buy cigarettes.

18. Would you have had sex if you had not done drugs? ☐Yes ☐No

19. What do you think would help reduce the number of sexual partners a person has? _____

20. What influences the number of sex partners a person reports?

_____

_____

21. Are there other reasons, that are not asked about in this survey, that contribute to the high number of new cases of HIV/AIDS and Sexually Transmitted Diseases?

_____

_____

Appendix E

Demographic and Multiple Choice Responses

Demographic and Multiple Choice Data 1

Participant	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	**sub**
Age	31	45	38	38	36	44	40	39	28	39	37	39	44	53	52	
Highest Grade completed																
Jr.High(7-9)		x													x	**2**
High(10-12)	x				x	x	X	x		x		x				**7**
Technical			x								x		x	x		**4**
BS									x							**1**
MS				x												**1**
PhD																**0**
Participant's Gender																
Male	x	x	x	x	x	x	x	x	x	x	x	x				**12**
Female													x	x	x	**3**
Transgendered																
Participant's Sex Orientation																
Male/Male	x	x	x	x	x	x	x		x		x	x				**10**
Female/Female																**0**
Male/Female								x		x			x	x	x	**5**
Bisexual																**0**
won't say																**0**
Participant's Race																
Caucasian	x	x	x	x		x		x	x		x	x				**9**
Asian																**0**
Afr.Amer					x										x	**2**
Hispanic										x			x			**2**
Not know																**0**
Other							x							x		**2**
won't say																**0**
Participant's Martial Status																
Married													x	x		**2**
Single			x		x	x	x	x		x					x	**7**
Partnered				x							x	x				**3**
Sig.Other	x								x							**2**
None		x														**1**

Demographic and Multiple Choice Data 2

Participant	16	17	18	19	20	21	22	23	24	25	26	27	28	29	Tot	%
Age	22	44	47	37	36	44	41	29	43	40	42	38	46	28		
Highest Grade completed																
Jr.High(7-9)															**2**	**6.9%**
High(10-12)	x	x	x		x			x			x				**13**	**44.8%**
Technical				x		x	x		x	x		x	x		**11**	**37.9%**
BS														x	**2**	**6.9%**
MS															**1**	**3.4%**
PhD															**0**	**0.0%**
Participant's Gender																
Male		x	x	x	x	x	x	x	x	x	x	x	x	x	**25**	**86.2%**
Female	x														**4**	**13.8%**
Transgendered															**0**	**0.0%**
Participant's Sex Orientation																
Male/Male			x	x	x		x		x		x	x			**17**	**58.6%**
Female/Female															**0**	**0.0%**
Male/Female	x	x				x		x						x	**10**	**34.5%**
Bisexual										x					**1**	**3.4%**
won't say													x		**1**	**3.4%**
Participant's Race																
Caucasian	x		x		x	x		x				x	x		**16**	**55.2%**
Asian															**0**	**0.0%**
Afr.Amer		x		x						x	x			x	**7**	**24.1%**
Hispanic															**2**	**6.9%**
Not know															**0**	**0.0%**
Other							x		x						**4**	**13.8%**
won't say															**0**	**0.0%**
Participant's Martial Status																
Married						x									**3**	**10.3%**
Single	x	x	x					x	x	x	x		x	x	**16**	**55.2%**
Partnered							x								**4**	**13.8%**
Sig.Other												x			**3**	**10.3%**
None				x	x										**3**	**10.3%**

Demographic and Multiple Choice Data 3

Participant	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	sub
Participant's Partner's Race																
Caucasian	x			x				x	x		x	x	x			7
Asian																0
Afr.Amer															x	1
Hispanic																0
Not know																0
Other														x		1
won't say		x	x		x	x	x			x						6
Are You Currently Working																
Yes				x	x				x	x						4
No	x	x	x			x	x	x			x	x	x	x	x	11
Highest Salary You Last Earned																
<=$20,000	x				x	x			x	x		x		x		7
$21,000-$30,000											x					1
$31,000-$40,000			x													1
$41,000-$50000																0
>$51,000		x		x												2
won't say							x	x					x		x	4
Reduce Risk																
Yes	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	15
No																0
Preventation																
Yes	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	15
No																0
Protect partner																
Very much	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	15
somewhat																0
Not very																0
won't say																0
Use Condom																
Yes	x	x		x		x	x	x	x	x				x	x	10
No			x		x						x	x				4
won't say													x			1

Demographic and Multiple Choice Data 4

Participant	16	17	18	19	20	21	22	23	24	25	26	27	28	29	Tot	%
Participant's Partner's Race																
Caucasian			x		x	x	x								11	37.9%
Asian															0	0.0%
Afr.Amer		x										x		x	4	13.8%
Hispanic															0	0.0%
Not know				x											1	3.4%
Other															1	3.4%
won't say	x							x	x	x	x		x		12	41.4%
Are You Currently Working																
Yes	x	x			x	x		x			x	x		x	12	41.4%
No			x	x			x		x	x			x		17	58.6%
Highest Salary You Last Earned																
<=$20,000	x	x	x			x		x			x			x	14	48.3%
$21,000-$30,000				x					x	x		x			5	17.2%
$31,000-$40,000					x										2	6.9%
$41,000-$50000															0	0.0%
>$51,000															2	6.9%
won't say							x						x		6	20.7%
Reduce Risk																
Yes	x	x	x	x	x	x	x	x	x	x	x	x	x	x	29	100%
No															0	0.0%
Preventation																
Yes	x	x	x	x	x	x	x	x	x	x	x	x	x	x	29	100%
No															0	0%
Protect partner																
Very much	x	x	x	x	x	x	x		x	x	x	x		x	27	93%
Somewhat															0	0%
Not very															0	0%
won't say								x					x		2	7%
Use Condom																
Yes	x	x	x			x	x		x	x				x	18	62%
No				x	x						x	x			8	28%
won't say								x					x		3	10%

Demographic and Multiple Choice Data 5

Participant	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	sub
Sex with M & F																
Yes																0
No	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	15
won't say																0
Condom Anal Only																
Yes	x	x	x	x	x		x		x							7
No						x		x		x	x	x	x		x	7
won't say														x		1
As birth control																
Yes																0
No	x	x	x	x	x	x	x	x	x	x		x	x	x	x	14
won't say											x					1
Drugs & Needle-sharing																
Yes	x		x				x	x			x	x		x		7
No		x		x	x	x									x	5
won't say									x	x			x			3
Why share Needles																
No knowledge		x		x	x	x	x	x	x	x	x	x	x		x	12
No cleaning skill	x	x	x		x	x	x		x	x	x	x				10
No supplies	x	x	x	x	x	x	x		x	x	x	x				11
No equip.	x	x	x		x	x	x		x	x	x	x				10
Don't know how	x	x	x	x	x	x	x		x	x	x	x				11
won't say														x		1
Do Drugs affect Condom use																
Yes	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	15
No																0
won't say																0
Do Drugs affect sex partner choice																
Yes		x	x	x	x		x		x	x	x	x	x	x	x	12
No	x					x		x								3
won't say																0

Demographic and Multiple Choice Data 6

Participant	16	17	18	19	20	21	22	23	24	25	26	27	28	29	Tot	%
Sex with M & F																
Yes										x					1	3%
No	x	x	x	x	x	x	x	x	x		x	x		x	27	93%
won't say													x		1	3%
Condom Anal Only																
Yes		x	x	x	x					x	x				13	45%
No	x					x	x		x			x		x	13	45%
won't say								x					x		3	10%
As birth control																
Yes			x												1	3%
No	x	x		x	x	x	x	x	x	x	x	x		x	26	90%
won't say													x		2	7%
Drugs & Needle-sharing																
Yes		x	x	x	x	x	x		x	x	x				16	55%
No	x												x	x	8	28%
won't say								x				x			5	17%
Why share Needles																
No knowledge	x	x	x				x			x		x	x		19	
No cleaning skill							x			x					12	
No supplies				x			x			x					14	
No equip.			x	x		x	x			x				x	16	
Don't know how							x			x				x	14	
won't say					x			x	x		x				5	
Do Drugs affect Condom use																
Yes	x	x	x	x	x	x	x	x	x	x	x	x	x	x	29	100%
No															0	0%
won't say															0	0%
Do Drugs affect sex partner choice																
Yes		x	x	x	x	x		x	x	x	x	x		x	23	79%
No	x						x						x		6	21%
won't say															0	0%

Demographic and Multiple Choice Data 7

Participant	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	**sub**
Do Drugs affect sex favors																
Yes	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	**15**
No																**0**
won't say																**0**
Do Drugs affect selling sex																
Yes	x	x	x	x	x	x	x		x	x	x	x	x	x	x	**14**
No								x								**1**
won't say																**0**
Have You Ever Sold Sex																
Yes			x	x	x											**3**
No	x	x				x	x	x	x	x	x	x	x	x	x	**12**
won't say																**0**
If Sold Sex; to buy what																
Food,clothes				x												**1**
medicine																**0**
drugs																**0**
alcohol				x	x											**2**
cigarettes					x											**1**
won't say			x													**1**
Sex w/o drugs																
Yes	x		x	x	x	x		x		x	x	x		x		**10**
No		x					x								x	**3**
won't say									x				x			**2**

Demographic and Multiple Choice Data 8

Participant	16	17	18	19	20	21	22	23	24	25	26	27	28	29	Tot	%
Do Drugs affect sex favors																
Yes		x	x	x	x	x	x	x	x	x	x	x		x	**27**	**93%**
No	x												x		**2**	**7%**
won't say															**0**	**0%**
Do Drugs affect selling sex																
Yes		x	x	x	x	x	x	x		x	x	x		x	**25**	**86%**
No	x												x		**3**	**10%**
won't say									x						**1**	**3%**
Have You Ever Sold Sex																
Yes		x	x	x	x			x							**8**	**28%**
No	x					x	x		x	x	x	x		x	**20**	**69%**
won't say													x		**1**	**3%**
If Sold Sex; to buy what																
food,clothes					x										**2**	
medicine		x													**1**	
drugs			x	x	x										**3**	
alcohol					x										**3**	
cigarettes					x										**2**	
won't say															**1**	
Sex w/o drugs																
Yes	x				x			x	x					x	**15**	**52%**
No		x	x	x							x				**7**	**24%**
won't say						x	x			x		x	x		**7**	**24%**

Demographics

Question 5. Self- Other Ethnicity (Write in)

Subject	Ethnicity listed
7	We're all one color in varying degrees
14	Jamaican
22	Native American (Cherokee)
24	Human
25	Black/African American/Native American

Question 7. Partner's Other Ethnicity (Write in).

Subject	Ethnicity listed
14	Jamaican

Question 8. What is your occupation? (Write in).

Subject	Occupation listed
1	N/A (unemployed)
2	Unemployed
3	Disabled, was Computer Programmer/Technician
4	Corporate trainer
5	Management
6	Disabled/unemployed
7	N/A (unemployed)
8	None
9	Self employed
10	Retail worker
11	Disability
12	Disabilited (sic)
13	Wife house
14	Nurse's Aide
15	Left blank
16	Subway (food preparer in a sandwich shop)
17	Machinist
18	Disable - mover for a co
19	Disable (sic)
20	Management
21	Amid. (sic) Asst. (Administrative Assistant)
22	Cosmetologist
23	Delivery driver
24	Unemployed
25	Not Working
26	Stylist
27	Apartment Manager
28	Disabled
29	Warehouse

Left blank =1, Unemployed =13, Employed = 15, Disabled =7, Self-employed =1, Management =3, Skilled =6, Unskilled =7

Research Questions

1. Before you were diagnosed, did you truly believe that HIV/AIDS was a deadly disease?

Subject	Statement
1	Yes
2	Yes
3	I was diagnosed in 1985. At that time the virus HTLV III now called HIV had just been discovered and tests for their antibodies through ELISA were just being released. I did believe it was a deadly disease because by this time I had already lost many friends.
4	Yes
5	Yes
6	Yes
7	Yes
8	Yes
9	No
10	Yes I did believe that HIV/AIDS was a deadly disease but a disease that could be treated and managed due to medication and good lifestyle.
11	Yes
12	Yes
13	To some point
14	Yes
15	No
16	Yes
17	Yes
18	I heard about it when I live in Dallas. I really didn't know I had it until I moved to (town name deleted to maintain privacy), Tx. That is when I had it
19	Yes
20	Yes, however I believe I was Positive before I learned about HIV, like age 17, year 1982.
21	Yes
22	Yes
23	Yes
24	Yes
25	Yes
26	Yes & No
27	Yes
28	Yes
29	Yes

Yes =25, No =2, Questionable =2

2. Did you believe that you might get HIV/AIDS? If not, why not?

Subject	Statement
1	No
2	Yes
3	Yes, because I had either had sex with or shot drugs with or both with many people who were dying. I fully expected to be found HIV positive when I took the test 17 Nov 85.
4	Yes
5	Yes
6	Yes
7	Yes
8	No because I am not gay. I thought it was a gay deises (sic.
9	No, because I had protected sex and avoided any at risk behaviors
10	I believe I could if I engaged in risky behavior
11	No, because that happens to other people
12	It was possible
13	Left blank
14	No, didn't do drugs. Misunderstood about it.
15	No, never did things to get AIDS. Not used protection-at my age didn't think about it.
16	No-honestly I thought that it couldn't happen to me
17	No / Because I am very safe and my ex wife had contracted it through a ahic (sic) she dated who die from AIDS
18	No I didn't becaue (sic) I didn't pay it any mind of it
19	Yes
20	Yes
21	No
22	Yes, My first partner died from AIDS
23	Yes. In some sense I was looking to get HIV/AIDS because I was suicidal at the time-> so, in all honesty I set out to get the disease.
24	Never thought about it
25	Yes
26	No, No one believe truly that it would happen to one self
27	Possibly
28	No
29	No

Yes =14, No =13, Maybe =1, Didn't consider it =1

3. What could have helped prevent the risk behaviors?

Subject	Statement
1	Use of condoms
2	Ware (sic) condom
3	I could have not shot drugs. I knew there were risks involved in shooting drugs but HIV was not one I was aware of. At the time of my infection I was not aware of a sexually transmitted disease that couldn't be fixed with a dose of antibiotics and rubbers were for stopping pregnancy.
4	More education to the public. Preferrably (sic) not having a bigot in the White House (Bush) (Reagan) during the 80's.
5	Condoms, education
6	More public information and political support in the Reagan Admin.
7	Psychotherapy, safe (sex-heh)
8	Play safe, use condoms
9	Knowledge
10	Having a relationship with one partner
11	I knew the behaviors
12	Protection and education
13	Sex protection
14	Better testing of blood donors, got bad blood transfusion.
15	Used [condoms], protected sex
16	Be more responsible & keep protection from it
17	I really don't know, just don't trust anybody
18	I tell people about it. Take care of the virus. It is Every real.
19	Safer sex
20	I don't believe anything, [This was] before medical professionals even knew what was going on
21	Killed my wife (Wife had used drugs-written response to another quest. heh)
22	Left blank
23	I suppose me reaching out to my friends for help to deal with the depression and suicidal thoughts
24	It was not a public concern at the time
25	Better education on transmission
26	Not or being choosy of who you sleep with yet when you're young every krotch (sic) count
27	Safer sex
28	Question mark ?
29	I don't know

Left blanks =1, Don't know =2, Education =6, Condom use =11, Committed relationship =1, Clean blood supply =1, + public policy =2, Not using drugs =2, seeking help =1, Ill before recognized as a threat =2, Abstinence =1, Careful partner selection =1

4. To whom would you have listened about risk behaviors?

Subject	Statement
1	Left blank
2	I don't know. I thought I was being "careful"
3	Anyone who had some definitive answers
4	CDC, President, teachers, anyone I felt as a superior
5	Friends
6	Friend, Public Forum, Parents
7	Medical professionals (1980's) Now > qualified people
8	Someone you [knew] was HIV +. If I would have met someone with this
9	Educators, General Practitioner
10	My family, especially my mother, also friends
11	N/A
12	Friends and common sense
13	Left blank
14	Doctors
15	Daughter's very close-might have listened to her. Doctors, nurses
16	My father
17	Anyone with knowledge
18	Friends, family members
19	Family
20	Peers, news & medical professionals
21	Anyone
22	Left blank
23	I've understood that using condoms reduces the risk of contracting the virus; I suppose if I had really wanted help out of committing suicide in this way I would not have done the "risky" behaviors in the first place. P.S. I am not currently suicidal...this was over 10 years ago.
24	Any knowledgeable authority
25	Anyone that approached me with information
26	My mother
27	Left blank
28	At that point, no one
29	Anyone?

Left blank =4, Don't know =1, No One =1, Friends =5, Peers =1, Parents =4, Family=3, Dr./Nurse =5, Person in authority =4, Media =1, HIV + person =1, Anyone with knowledge =8, used common sense =2

5. How could this information been presented to you that would have altered your behavior?

Subject	Statement
1	Left blank
2	None
3	In any manner from an official source.
4	Strait (sic) forward (sic) no holes (sic) barred
5	Don't know
6	Early information, prior to exposure
7	Graffic (sic) visual detail
8	Telling about [in] schools
9	Classes, seminars discussing the diseases related to HIV/AIDS, the deterioration of POZ people medically and mentally
10	I don't think information about HIV/AIDS could have been presented in any other way that could have altered my behavior
11	N/A
12	To see a real aids patient
13	Left blank
14	Didn't do anything
15	My friend, he had had protection, he was on drugs and stuff
16	Because he has the virus
17	I would have to inquire more about his deteriating (sic) condition-But she claims she really didn't know until she got his death certificate
18	Be aware of it
19	Family discussion
20	In the gay world. Or from other gay people.
21	Informal/confidential
22	Left blank
23	I needed help- I don't think I am answering this survey the way you are asking the questions/. I can say I understand what behaviors to avoid and how to better protect myself.
24	It comes across more poignantly through friends and peers with direct experience
25	If it was presented from a minority viewpoint
26	To be honest I'm not sure
27	Left blank
28	I don't know
29	In school

Left blanks = 5, N/A =1, Don't know =2, Early information =1, graphic details and straight up =2, From other gays =1, Seeing a POZ person =1, In schools =2, Informal/confidential =1, family discussion =1, Friends & peers who were ill =1, Culturally appropriate information =1, Answers that weren't responsive to question = 5

KNOWLEDGE OF RISK BEHAVIOR

Question 5. If No, why are barriers/condoms Not used?

Subject	Statement
3	Not having sex needing a barrier. But any risks taken are my own. I am not comfortable allowing a partner to take risks when having sex with me.
5	Rush, etc.
12	We are both faithful to each other
19	Not always having that kind of sex
20	Depends on the activity, risk to my partner, and their status. Also, what we have discussed about having HIV
26	Because both of us are infected already. Lame excuse yet true
27	We are both HIV +

Question 8. If YES, Why?

Subject	Statement
1	Comfort and feel.
2	Didn't like taste of condoms
3	Oral sex has a lower chance of transmitting HIV than anal sex.
5	Don't know
7	Pleasure of flesh to toungue (sic) that cannot seem to give up
9	To lessen the risk of transmitting to my partner
18	That you can get it only once
19	Prevent Infection
20	The risk factor for oral is so low. However, I don't let a partner do me without one
25	Because HIV/AIDS can be transmitted either way
26	Because sperm never enter me orally

Question 11. Some other reason? (Write in).

Subject	Statement
3	In too much of a hurry to get high to act with intelligence
4	Lack of money, less money on equipment more money for drugs
7	Too stoned to care
20	When a person is using in that style they stop caring, I did. Plus I wanted to die then
23	They are junkies and hopelessly addicted to their drug – they probably don't care
24	Addict desperation
26	When using drugs you do not think all you think about is the high

Question 19. What do you think would help reduce the number of sexual partners a person has?

Subject	Statement
1	Left blank
2	Commited (sic) relationship
3	Encouraging same sex partnerships, something like marriage
4	Morals, education, strong family orientation growing up
5	Knowledge/Love
6	Morality, religion, personal choice
7	Psychotherapy & self worth/value
8	Advertisement on TV [about] the risk of HIV
9	The personal upbringing of the individual & outside other places other than bars that individuals can get to know one another, ie. – organizations, church groups
10	Having a monogamus (sic) relationship with one person. Education
11	Knowledge, need to know more about relationships
12	to find the right person
13	Left blank
14	Sticking to one person
15	Caring relationship
16	I really don't think anything but maybe letting people know the dangers
17	A relationship
18	Take care of it
19	Committed relationships
20	Less mind altering substances
21	Left blank
22	Left blank
23	Jesus

24	More open sexual mores so that people can find compatible partners easier
25	If there were more emphasis on being monogamous and less on being "young, single and free"
26	Knowing the real dangers of AIDS
27	Left blank
28	Left blank
29	Better awareness

Left blank =6, Morals =2, Religion =2, Family values =2, Committed relationships =7, Same sex marriage=1, Knowledge/education =7, less drugs =1, Acceptance of gay needs =1, Less emphasis on singles lifestyle =1

Question 20. What influences the number of sex partners a person reports?

Subject	Statement
1	Left blank
2	Fear of partners being contacted
3	Drugs, self-esteem, peer pressure, shame
4	In my case nothing
5	Low self esteem, friends, modesty
6	Sham (sic) (shame-heh)
7	Social politics
8	If guy(s) make you feel good about the more you get you can brag to buddies
9	Honesty
10	Lifestyle and not being in a monagamus (sic) relationship
11	In my case, it could be the gay community. Some think it is all about sex its (sic) not
12	Left blank
13	Left blank
14	Ashamed
15	Embarrassed-don't want to report [on them]
16	That persons lifestyle
17	Promisuous (sic) behavior
18	Left blank
19	Appepitite (sic)
20	Honesty, with themselves too
21	Fear/(unreadable word)/self blame
22	Left blank
23	I have no idea, maybe shame
24	Ignorance
25	Social acceptance of multiple partners
26	You [the person]
27	Left blank
28	Left blank
29	I don't know

Left blanks =7, Don't know =1, Shame/embarrassment =5, fear =2, self-esteem/low =2, self-esteem/high =2, Ignorance =1, Social acceptance of multiple partners =1, Person's honesty =2, Drug usage=1, Lifestyle =4, Social pressures = 3

Question 21. Are there other reasons, that are not asked in this survey, that contribute to the high number of new cases of HIV/AIDS and Sexually Transmitted Diseases?

Subject	
1	Not that I can think of
2	Left blank
3	Apathy. The message is out there but I don't think people are paying attention
5	Yes (gave no reasons)
6	Pear (sic) presure (sic) access to health care (diagonise) (sic) and condoms, needle access. ($) (money-heh)
7	Psychotherapy & self worth/value (double headed arrow drawn between questions 19 & 21- heh)
8	Left blank
9	Possibly rape, the lack of knowledge, not knowing what the disease and the maintenance is like for POZ people
10	Left blank
11	No
12	Left blank
13	Left blank
14	Left blank
15	At my age- I [did] not think it could happen to me
16	Left blank
17	Left blank
18	Yes
19	Fear
20	Some people think it is going to happen anyway
21	No
22	Left blank
23	Rampant immorality
24	It appears that the younger generation thinks it is an "older" problem
25	Education about HIV/AIDS/STD's are directed at only one or a few segments of the population. And not shown that anyone at any time [can get it]
26	No
27	Left blank
28	Left blank
29	Left blank

Left blank =12, No's =4, Yes, but no reasons =1, Optimum bias =1, Helplessness =1, Fear =1, Apathy =1, Self-worth =1, Psychotherapy =1, Peer pressure =1, Access to health care, condoms, needles =1, The diagnosis =1, Rape =1, Lack of knowledge about disease and LWA =1, Immoral behavior =1, Issues of age =2, Population specific information =1