Continuing Unsafe Sex: Assessing the Need for AIDS Prevention Counseling

ROGER A. ROFFMAN, DSW
MARY R. GILLMORE, PhD
LEWAYNE D. GILCHRIST, PhD
SONIA A. MATHIAS, RN, MSW
LEIGHA KRUEGER, MPH

Three of the authors are with the University of Washington. Dr. Roffman is Associate Professor of Social Work; Dr. Gillmore is Research Assistant Professor; and Dr. Gilchrist is Associate Professor and Associate Dean. Ms. Mathias is Health Educator/Trainer at Youth Care in Seattle, WA. Ms. Krueger is a Biostatistician with the AIDS Prevention Project, Seattle-King County Department of Public Health.

Tearsheet requests to Roger A. Roffman, DSW, School of Social Work, University of Washington, 4101 15th Ave., NE, Seattle, WA 98195.

Synopsis

To assess the need for acquired immunodeficiency syndrome (AIDS) prevention counseling for gay and bisexual men who were continuing to engage in unsafe sex, a nonprobability telephone survey—the data may not be generalizable to the population—was conducted in Seattle during March 1987. In a 4-week period, 141 callers phoned in response to local publicity and completed a 30-minute anonymous interview. This paper focuses on 106 male respondents who were behaviorally defined as gay (that is, sex during the past year exclusively with partners of the same sex, N = 74) or bisexual (sex with both men and women, N = 32).

The modal respondent was a never-married white male in his thirties who had some college education and was employed full-time in a white collar occupation. The gay men were more likely than the bisexual men to report that their family members and friends knew of their sexual orientation and to indicate that they were able to discuss their concerns about unsafe sex with someone close to them. Gay men were also more likely to use condoms and to have engaged in anonymous sex during the 3 months before to the interview. More gay men had engaged in unprotected receptive anal intercourse (27 percent) than had bisexual men (13 percent), and in considerably more insertive anal intercourse (42 percent versus 22 percent).

Of the gay men interviewed, 73 percent indicated that they needed help in changing their high-risk sexual behaviors compared with 61 percent of bisexuals. However, respondent preferences for the context of counseling (for example, sexual preference of the counselor, group versus individual counseling, type of agency) differed on the basis of the respondent's self-definition of sexual preference. Bisexual men expressed a preference for individual therapy delivered by a private practitioner who is a heterosexual. The authors conclude that men who are at risk of AIDS due to ongoing unsafe sex will require a diversity of counseling options.

SUBSTANTIAL CHANGES in sexual behavior (*1, 2*), knowledge about risk factors (*3*), and attitudes concerning unsafe sex (*4*) among gay and bisexual males have occurred in response to public education concerning acquired immunodeficiency syndrome (AIDS) risk factors. Nonetheless, there is considerable basis for concern as to both the scope and durability of risk reduction manifested in these data (*5–9*). The reduction in risky sexual behaviors has not been accompanied by an increase in "safe" sexual activities (*3*), and even in areas with the highest incidence of AIDS, a substantial minority of gay and bisexual men still engage in sexual behaviors believed to carry risk of AIDS (*10, 11*). (The Seattle-King County Department of Public Health, based on longitudinal data, estimates that 26 percent of men who have sex with other men continue to be unsafe. That number is comparable to findings reported for San Francisco.)

Data indicating that information campaigns have been only partially successful in promoting behavior change also demonstrate the need for increased behavioral research on the cognitive and psychosocial dimensions of sexual decision-making (*12, 13*). The development and testing of etiological models pertaining to continuing unsafe sexual behavior are also warranted (*14–16*). At present, insufficient data exist to guide educational, counseling, psychotherapeutic, legal, or other approaches for those persons who continue sexual activity that places them and others at risk of AIDS.

Among the unanswered questions concerning this phenomenon are the following: (*a*) How do persons who do not follow safe sexual practices define themselves in terms of sexual orientation? (*b*) Do these people perceive themselves as needing counseling to achieve and maintain safer sexual patterns? (*c*) Is this

perception differentially held by people of different demographic characteristics and sexual orientations? (*d*) What preferences for counseling are expressed, for example, regarding characteristics of the treatment setting, service provider, and counseling approach? (*e*) Are these preferences a function of sexual orientation or sociodemographic characteristics, or both? (*f*) Will stigma serve to obstruct the acceptance of counseling by persons in the gay community?

Both the efficacy of alternative interventions in achieving durable change and the acceptability of such programs in terms of the willingness of members of the target population to participate require empirical examination. Our study, an anonymous survey conducted with respondents who volunteered to be interviewed by telephone, was designed (*a*) to document the existence of a population of persons who wished to change their sexual activities to avoid AIDS but were having difficulty doing so, (*b*) to establish that members of this population would express willingness to engage voluntarily in treatment to modify their high-risk or inconsistently safe sexual practices, and (*c*) to assess their preferences regarding the format and auspice of such treatment. Clinical data from private and public counseling sites suggested that less than 50 percent of professional service slots available to assist clients to change to safer sex practices were actually used by the estimated population in need of such services. No information was available to contrast behavior, needs, and preferences for counseling of bisexual versus exclusively homosexual men.

Context for the Study

The survey was conducted in March 1987 in Seattle, WA. At that time, the Seattle metropolitan area was 13th in the nation in total number of AIDS cases reported. The region has a relatively large, openly gay population. In early 1987, more than 88 percent of all reported cases of AIDS and AIDS-related complex (ARC) were among gay or bisexual men. Less than 1 percent of reported cases had occurred among intravenous (IV) drug users who had not also engaged in high-risk sexual behavior. Of the total reported AIDS cases, 2 percent were among women. Heterosexual transmission rates were believed to be low.

For more than 2 years preceding the study, a federally funded AIDS prevention demonstration project lodged in the public health department, together with an active not-for-profit private foundation, had informed and stirred action in the community on issues related to human immunodeficiency virus (HIV) transmission and control. The region has anonymous antibody testing sites and a network of mental health professionals in public and private settings skilled in dealing with sexual behavior and providing services to sexual minority groups.

'Gay men were somewhat more likely than bisexuals (50 percent versus 41 percent) to have sought professional help regarding their high-risk sexual behaviors and were considerably more likely to have been tested for the HIV virus (42 percent versus 22 percent).'

Method

Plans for fielding the survey, including development of the questionnaire and wording of publicity notices, were reviewed by an advisory board composed of gay health and mental health specialists. Training of the eight telephone interviewers emphasized skills in taking sexual histories, sensitivity to the target population, and the capability of handling people in crisis. A list of AIDS resources was compiled to assist respondents who asked for referral advice. Public service announcements and paid advertisements in the local media were directed at adult respondents, without mention of gender or sexual orientation, who felt unable to avoid unsafe sex. Business-sized cards describing the survey were distributed to gay bars and baths, and flyers were stuffed in 1 week's edition of a local gay newspaper. Local health care workers, gay-affirmative physicians, and AIDS-related agencies were notified by letter about the survey. Volunteer respondents were asked to call a specific phone number to participate anonymously in a telephone interview if they were concerned that their sexual behavior was putting them or others at risk for contracting AIDS.

All interviews were conducted by telephone. Each potential respondent was read a statement that described the survey's purpose, auspices, and format, including the fact that sexually explicit questions would be asked and that the interview was completely anonymous. Next, the respondent's eligibility for participation was determined by asking whether he or she was finding it a struggle to limit unsafe sexual behavior that may be putting him or her at risk of AIDS or infecting others. Only respondents answering yes to this query were interviewed; the others were thanked and referred to other resources where appropriate. Eligible respondents were then interviewed and, if appropriate, referred to

Table 1. Sociodemographic characteristics of gay and bisexual male respondents (percentages)

Characteristics	Gay (N = 74)	Bisexual (N = 32)
Mean age (years)	35.7	38.2
Race:		
White	90.5	93.8
Black	1.4	6.3
Other	8.1	0.0
Current marital status:		
Never married	71.6	46.9
Married	8.1	34.4
Previously married	20.3	18.7
Education:		
College degree or higher	63.5	31.3
Some college	29.7	53.1
High school graduate	5.4	15.6
Less than high school graduate	1.4	0.0
Employed:		
Full-time	66.2	71.9
Part-time	13.5	9.4
Annual income $20,000 or more	58.4	50.0
Currently living with:		
No one	47.3	40.6
Spouse or lover	28.4	43.8
Other	24.3	15.7
Sexual orientation:		
Exclusively homosexual	75.7	9.4
Mostly homosexual	20.3	31.3
Equally homosexual and heterosexual	2.7	12.5
Mostly heterosexual	1.4	46.9
Sex of sexual partners past year:		
Same sex	100.0	0.0
Mostly same sex	0.0	43.8
Equally same and opposite sex	0.0	25.0
Mostly opposite sex	0.0	31.3
Know someone with AIDS or ARC	70.3	31.3
Have:		
AIDS	2.7	0.0
ARC	1.4	0.0

community resources. The interview took about 30 minutes.

The interview contained primarily fixed-response questions but also some open-ended ones designed to elicit information about sociodemographic characteristics; sexual orientation; sexual behaviors; difficult to control nonsexual behaviors (for example, alcohol abuse); efforts made to seek knowledge of or change in high-risk sexual behaviors; preferences and objections regarding characteristics of programs aimed at AIDS risk reduction; and social support available to the respondent for changing high-risk behaviors.

Results

Of the 147 callers who met the eligibility criterion for inclusion in the study, 6 terminated the interview before its completion. These terminations did not appear to be related to the sensitive nature of some of the questions, since no one discontinued the interview immediately after the first explicit questions about sexual behavior were asked. In two cases, it appears that the callers may have been concerned about being overheard by someone. The data we present represent those men who were behaviorally defined as gay (that is, sex during the past year exclusively with partners of the same sex, $N = 74$) or bisexual (sex with both men and women, $N = 32$). The remaining subjects were either females or heterosexual males and are excluded from the analyses reported.

For both gay and bisexual men, the modal respondent was a never-married white male in his thirties who had some college education and was employed full-time in a white collar occupation (table 1). Gay men were somewhat more likely than bisexual men to be living alone (47 percent versus 41 percent). The vast majority of gay men viewed themselves as exclusively homosexual (76 percent) or as mostly homosexual (20 percent), though a few viewed themselves as equally homosexual and heterosexual (3 percent) and even fewer as mostly heterosexual (1.4 percent), despite the fact that they reported having engaged in sex during the past year exclusively with men. Conversely, only 9.4 percent of the bisexual men viewed themselves as exclusively homosexual (despite the fact that they had engaged in heterosexual sex during the past year). The majority of bisexual men viewed themselves as equally homosexual and heterosexual or as mostly heterosexual. No bisexual man saw himself as exclusively heterosexual. While the majority of gay men reported that most or all of their close friends (78 percent) and their families (82 percent) were aware of their sexual orientation, just the opposite was true of the bisexual men. The majority of bisexual men reported that few or none of their close friends (72 percent) and families (66 percent) knew of their sexual orientation.

A large majority of gay men reported that they knew someone with AIDS or ARC (70 percent), but less than a third of the bisexual men did. No bisexual man reported that he had AIDS or ARC, but about 4 percent of the gay men did. About two-thirds of the gay men and half the bisexual men felt that they were able to discuss concerns about their high-risk sexual behavior with someone close to them. Similarly, 61 percent of the gay men and 56 percent of the bisexual men indicated that they could expect a fair amount or a lot of support from others for changing their high-risk sexual behaviors. As might be expected, being able to discuss concerns about the behaviors that were putting one at risk of AIDS was positively and significantly related to the amount of support respondents expected to receive for changing these high-risk behaviors, but only for gay men. This relationship was not significant for bisexual men (table 2).

Table 2. Relationship of ability to discuss concerns about sex and support expected for changing high-risk sexual behaviors

Support for change	Gay men				Bisexual men			
	No		Yes		No		Yes	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Little or none	20	86.9	9	17.6	9	56.3	5	31.0
A lot	3	13.0	42	82.3	7	43.7	11	69.0
Total	23	100.00	51	100.00	16	100.0	16	100.0

NOTE: For gay men: $x^2 = 29.11$, $df = 1$, $P < 0.01$. For bisexual men: $x^2 = 1.14$, $df = 1$, P is not significant.

Risk-Taking Behaviors

Respondents were asked about their sexual partners and the types of sexual activities in which they had engaged during the 3 months preceding the interview. Table 3 presents these data for gay and bisexual males. (Four gay males had not engaged in sex during his time and are excluded from these analyses.) Although the median number of partners was five for bisexuals and seven for gay male respondents, there was enormous variation in the number of partners reported. Gay men, for example, reported from 1 to 150 male partners during this 3-month period. A higher proportion of the gay men (81 percent) when compared with bisexual men (67 percent) had engaged in anonymous sex during this period. Despite what appears to be a relatively high level of involvement in high-risk sexual activities during the 3-month period before being interviewed, 60 percent of the bisexual men and 36 percent of the gay men reported that they had never used condoms during this time. Interestingly, a higher proportion of gay male respondents reported using condoms at least some of time than bisexuals, suggesting that the latter may not be as well informed as exclusively gay people regarding condom use as prophylaxis against AIDS. However, in either case, condom use was irregular for the overwhelming majority of respondents.

Of the respondents who had been sexually active during the 3 months before the interview, the majority reported engaging in at least three different sexual behaviors thought to carry some risk of AIDS. As is evident in table 3, about one-third of both gay and bisexual men had performed unprotected oral sex. More gay men had engaged in unprotected receptive anal intercourse (27 percent) than had bisexual men (13 percent) and in considerably more insertive anal intercourse than bisexuals (42 percent versus 22 percent). Similarly more gay men (47 percent) had been "fisted" (defined as a partner's fingers or hand inserted in the respondent's rectum) than had bisexuals (34 percent).

Table 3. Sexual practices of gay and bisexual men during 3-month interval before interview (percentages)

Sexual practices	Gay men (N = 70)	Bisexual men (N = 32)
Anonymous sex	81.2	66.7
Condom use:		
Never	35.7	60.0
Sometimes	60.0	30.0
Always	4.3	10.0
Performed oral sex	33.8	37.5
Receptive anal intercourse	27.0	12.5
Insertive anal intercourse	41.9	21.9
Receptive fisting[1]	47.3	34.4
Vaginal intercourse	0.01	15.6
Rimmed partner[2]	29.7	18.8
Rimmed by partner	45.9	25.0
Shared sex toys	9.5	15.6

[1] Fisting refers to insertion of hands or fingers in rectum.

[2] Rimming refers to any type of oral-anal contact.

NOTE: Median number of partners for gay men = 7, range 1–150; and for bisexual men, 5 with a range of 1–18.

Significant minorities of both gay and bisexual subsamples reported "rimming" (oral-anal contact) their partners, though this activity was somewhat more prevalent among gay men (30 percent versus 19 percent). Nearly twice as many gay men (46 percent) as bisexuals (25 percent) had been rimmed by partners.

Only three gay men and one bisexual man reported that they had engaged in sex with partners who had AIDS or ARC. Only four gay men had had sex with persons who were needle users. Four gay men and one bisexual man had received money in exchange for sex, although seven gay men had paid to have sex with a partner as had three bisexual men. No bisexual men and only one gay man reported having shared a needle to inject IV drugs during the 3 months before the interview. Noteworthy is the fact that half the bisexual men and 49 percent of the gay men indicated that recreational drug and alcohol use played a role in the difficulty they were experiencing in trying to limit unsafe sex.

Table 4. Percentage distribution of perceived need for help and efforts made to reduce risk of AIDS

Question	Gay men (N=74)	Bisexual men (N=32)
Perceived need for help to modify sexual behaviors	72.6	61.3
Likely to seek help to change sexual behaviors	72.6	75.0
Sought professional help in past to change sexual behaviors	50.0	40.6
Ever tested for HIV virus	41.9	21.9
If tested, result:		
Positive	31.3	0.0
Negative	65.6	100.0
Unknown	3.1	0.0

Table 5. Percentage distribution of treatment preferences and objections

Characteristics	Gay men (N=74)	Bisexual men (N=32)
Type treatment preferred:		
1. Therapist led small group	18.9	18.8
2. Therapist-client (1:1)	25.7	37.5
3. Combination of 1 and 2	40.5	21.9
4. Self-help group	4.1	9.4
5. No preference	10.8	12.5
Sexual orientation of therapist preferred:		
Heterosexual male	5.4	25.0
Homosexual male	44.6	21.9
Heterosexual female	2.7	0.0
Homosexual female	6.8	6.3
No preference	40.5	46.9
Treatment facility preferred:		
Agency	13.7	23.3
Private practitioner's office	41.1	53.3
No preference	45.2	23.3
Agency preferred:		
Agency for sexual minorities	46.6	28.1
General agency	16.4	28.1
No preference	37.0	43.8
Object to:		
1. Treatment in small groups	15.1	29.0
2. Individual (1:1) treatment	8.1	3.1
3. Combination of 1 and 2	12.2	25.8
4. Heterosexual male therapist	39.2	22.6
5. Homosexual male therapist	9.5	15.6
6. Heterosexual female therapist	32.9	18.8
7. Homosexual female therapist	20.5	18.8
8. Treatment in agency for sexual minorities	12.2	25.0
9. Treatment in general agency[1]	43.8	22.6

[1] Agency not specifically for sexual minorities.

Respondents were asked what steps, if any, they had taken in attempting to reduce their risk of getting or transmitting AIDS, and whether they perceived a need for help to modify their high-risk behaviors (table 4). Gay men were somewhat more likely than bisexuals (50 percent versus 41 percent) to have sought professional help regarding their high-risk sexual behaviors and were considerably more likely to have been tested for the HIV virus (42 percent versus 22 percent). Of the gay men who had been tested for the HIV virus, nearly one-third were positive while none of the bisexual men who had been tested were positive. This difference should be interpreted very cautiously since only 11 persons in the entire sample tested positive.

Interestingly, while 73 percent of the gay men interviewed indicated that they needed help in changing their high-risk sexual behaviors, somewhat fewer bisexuals perceived this need (62 percent). Gay and bisexual men were about equally likely to indicate that they would be inclined to seek such help. In attempting to understand better those respondents who had, on the one hand, indicated that they were finding it a struggle to limit their high-risk sexual behavior, while on the other hand indicating that they would not be likely to seek professional help to change these behaviors, we conducted a set of additional analyses. Except for age, we found no significant differences in the socio-demographic characteristics of those gay men who were likely to seek help compared with those who said that they would not be likely to seek help in modifying their risky sexual behavior. Older gay respondents were less likely to seek help than younger ones. The numbers for bisexual men were too small to permit a comparable analysis.

One possible reason that some respondents may not be willing to seek help for changing behavior is that they are engaging in fewer high-risk sexual behaviors than those who say they would be likely to seek help. To explore this possibility, the help-seeking intention of gay men was cross-tabulated with several indices of their high-risk sexual behaviors (condom use, unprotected anal intercourse, unprotected oral sex, fisting, rimming, and shared sex toys). No significant differences emerged. (Again, the numbers were too small to perform the same analysis with bisexual men.)

Gay men who had been tested for the HIV were more likely to say that they would seek help than those who had not been tested.

	Not tested for HIV		Tested for HIV	
Likely seek help	Number	Percent	Number	Percent
Very likely	26	61.9	27	87.1
Not likely	16	38.1	4	12.9
Total	42	100.0	31	100.0

NOTE: $\chi^2 = 4.49$, $df = 1$, $P < 0.04$.

This is not surprising since choosing to be tested may be an action taken in the direction of help-seeking.

However, for gay men who had never been tested, the perception that one is HIV positive or negative was not significantly related to help-seeking intentions. Generally, gay men who were less likely to say that they would seek help to change the behaviors that may be putting them at risk of AIDS tended to be older, had not been tested for AIDS, and did not feel that help was needed to change these behaviors, relative to those who indicated that they would be likely to seek help. (The number of bisexual men was too small to permit comparable analyses.)

Preferred Treatment Characteristics

All respondents, regardless of whether they thought they might actually seek professional help in changing their sexual behavior, were asked to indicate the characteristics of the treatment that they would prefer should they seek such assistance (table 5). Both gay and bisexual men indicated a preference for one-to-one treatment with a therapist or for one-to-one treatment in combination with therapist-led small group sessions relative to other treatment modalities. A higher proportion of bisexuals than homosexuals preferred one-to-one treatment, and considerably more gay men preferred the combination of small group and individual treatment. Few of either group had no preferences regarding treatment format, and fewer still desired treatment in self-help groups. A much higher proportion of gay men (45 percent) than bisexuals (22 percent) preferred treatment from a homosexual male, and conversely, bisexuals were almost five times as likely as gay men to prefer treatment from a heterosexual male. Few gay or bisexual men preferred treatment from a heterosexual female, but it is important to note that more than 40 percent of both groups expressed no preference regarding the sexual orientation-gender combination of the therapist. More than half the bisexuals preferred treatment in a private practitioner's office while a higher percentage of gay men had no preference concerning the treatment facility. Gay men had a distinct preference for treatment in an agency designed specifically for sexual minorities as opposed to a general agency. Bisexuals did not express strong preferences between such agencies and general agencies.

When asked what treatment characteristics they would object to (table 5), a higher proportion of bisexuals than gay men expressed objections to treatment in small groups, to treatment delivered by a homosexual male, and to treatment in an agency specifically designed for sexual minorities. Gay men were more likely to object to treatment by a heterosexual male and to treatment delivered in a general agency (that is, an agency not explicitly for sexual minorities).

Discussion

This study clearly demonstrates the existence of a population subgroup that continues to be at risk for AIDS despite intensive educational campaigns. The very high percentage of gay and bisexual respondents is not surprising given the epidemiology of AIDS in the survey area. AIDS was and continues to be an issue of major concern in this population subgroup. It is not clear that other populations at high risk of HIV infection would so readily identify themselves and thus respond to the recruitment procedure used in this needs assessment study.

As researchers in other locations have also found, most of the gay and bisexual male respondents in this study have attempted to change deeply ingrained lifestyle patterns in order to protect themselves and others from HIV infection. Such changes, however, are difficult to make and to maintain. Although about half the sample had sought previous help to modify their sexual behaviors, virtually all continued to engage in high-risk sexual activities. The help provided was apparently not adequate to initiate or maintain the desired changes. The majority of both gay and bisexual men in this study wanted professional help to enhance a consistent transition to safer sex practices.

Respondents expressed a number of reservations about the format and auspice of such help that would limit their use of some existing professional resources. These preferences and reservations varied somewhat, depending upon whether the respondent was gay or bisexual. Bisexual men expressed a preference for one-to-one counseling provided by a heterosexual male in a private practitioner's office. Gay men preferred a combination of one-to-one and therapist-led group counseling by a gay male therapist in an agency for sexual minorities. The conclusion to be drawn is that outreach efforts to assist gay and bisexual men seeking help with their transitions to safer sex should be offered in several formats. Each format will appeal to and be used by different segments of what on the surface may appear to be a reasonably homogeneous group.

It became clear to us that there is a need for counseling and mental health services that allow participants to remain anonymous. Fears regarding public exposure were voiced by the majority of respondents. Telephone counseling and structured self-help strategies may help reduce fears regarding the confidentiality of counseling services. Finally, additional research is needed on ways to reach the 30 percent of respondents who indicated that, although they recognized their need for help in initiating and maintaining safer sex practices, they were highly unlikely or unwilling to seek such help regardless of format.

References

1. McKusick, L., Horstman, W., and Coates, T. J.: AIDS and sexual behavior reported by gay men in San Francisco. Am J Public Health 75: 493–496 (1985).
2. Puckett, S. B., Bart, M., Mye, L. L., and Amory, J.: Self-reported behavioral change among gay and bisexual men—San Francisco. MMWR 34: 613–615, Oct. 11, 1985.
3. Coates, T.J., et al.: AIDS: a psychosocial research agenda. Ann Behav Med 9: 21–28 (1987).
4. Valdisseri, R. O., et al.: The effect of group education on improving attitudes about AIDS risk reduction. NY State J Med 87: 272–278, May 1987.
5. Handsfield, H.: Letter to the editor. Am J Public Health 75: 1449 (1985).
6. Handsfield, H. H.: Decreasing incidence of gonorrhea in homosexually active men—minimal effect on risk of AIDS. West J Med 143: 469–470 (1985).
7. Doll, L.S.: Self-reported changes in sexual behaviors in gay and bisexual men from the San Francisco city clinic cohort. Paper presented at the Third International Conference on AIDS, Washington, DC, June 1987.
8. McKusick, L., Coates, T., and Horstman, W.: HTLV-III transmitting behavior and desire for HTLV-III antibody testing in San Francisco men at risk for AIDS 1982–1985. Paper presented at the Third International Conference on AIDS, Washington, DC, June 1987.
9. Martin, J. L.: The impact of AIDS on gay male sexual behavior patterns in New York City. Am J Public Health 77: 578–581 (1987).
10. Martin, J. L.: AIDS risk reduction recommendations and sexual behavior patterns among gay men: a multifaceted categorized approach to assessing change. Health Educ Q 13: 347–358 (1986).
11. Research and Decisions Corporation: A report on: designing an effective AIDS prevention campaign strategy for San Francisco: results from the third probability sample of an urban gay male community. The San Francisco AIDS Foundation, San Francisco, 1986.
12. Kelly, J. A., and St. Lawrence, J. S.: Behavioral intervention and AIDS. Behav Therapist 6: 121–125 (1986).
13. Kelly, J. A., and St. Lawrence, J. S.: The prevention of AIDS: roles for behavioral intervention. Scand J Behav Ther 16: 5–19 (1987).
14. Coleman, E.: Sexual compulsivity: definition, etiology, and treatment considerations. J Chem Depend Treat 1: 189–203 (1987).
15. Quadland, M. C.: Compulsive sexual behavior: definition of a problem and an approach to treatment. J Sex Marital Ther 11: 121–132 (1985).
16. Quadland, M. C., and Shattls, W. D.: AIDS, sexuality, and sexual control. J Homosexuality 14: 277–298 (1987).