

Gentlemen Don't Speak: Communication Norms and Condom Use in Bathhouses

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ABSTRACT *The theory of reasoned action (TRA) focuses on attitudes, norms, behavior, and intentions in explaining a behavior. This study provides a qualitative, detailed description of TRA components applied specifically to condom use for STD prevention among men who have sex with men (MSM) in bathhouses. Using a detailed, semi-structured interview guide, MSM acknowledged an existing norm for condom use for all anal intercourse and reported perceiving that bathhouse sexual partners were more likely to be infected with HIV and other STDs than men met in other settings. They also, however, reported a norm for silence in bathhouse public areas; this norm facilitated efficient and anonymous sexual encounters but precluded the ability to negotiate condom use verbally. Condom use lapses were generally attributed to this silence norm. Norms regarding silence appeared more strongly related to condom use than attitudes toward condom use. Implications for prevention, practical applications, and future research are discussed.*

KEY WORDS: gay men, condom use, HIV prevention, norms, silence, Theory of Reasoned Action, MSM

HIV infection rates have increased again across the U.S. (Centers for Disease Control and Prevention, 2001a, b, c): More than 100 Americans become infected with HIV each day ("Report calls," 2000). In some communities, syphilis and gonorrhea have also re-emerged (Williams et al., 1996). Not surprisingly, public health researchers and practitioners are looking again for ways to prevent unprotected sexual behavior as the traditional public health approaches used earlier in the epidemic were ineffective (Sarver, 1983; Zimmerman & Vernberg, 1994).

One group that continues to be at risk of infection with HIV and other STDs is men who have sex with men (MSM). One reason for this risk is that MSM generally have sex more frequently with more partners than other at-risk groups

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(Sadownick, 1996; Stall, 1994; Williams et al., 1996). Among the first U.S. demographic groups in which HIV emerged, MSM responded to early interventions that encouraged condom use for anal intercourse (Kelly et al., 1991, 1997; Miller, 1995; Valdiserri et al., 1989). Nevertheless, the advent of protease inhibitors and a younger generation of gay-identified men unacquainted with early AIDS-related deaths influenced a laxity in condom use for anal sex (Lemp et al., 1994; Meyer & Dean, 1995; Morris, Zavisca, & Dean, 1995; Signorile, 1997). "Barebacking," the practice of condomless anal intercourse, is widespread among MSM (Goode, 2001; Goodroad, Kirksey, & Butensky, 2000).

One venue in which such risky behaviors occur is in bathhouses, commercial venues that provide easy access for sexual encounters among MSM (Elwood & Williams, 1998; Weinberg & Williams, 1975). Once this means of HIV transmission was identified, local officials moved to close bathhouses in many American cities (Shilts, 1987); however, bathhouses have re-emerged across the country and reports of unprotected sexual encounters have returned as well (Elwood, 1996, 1999a; Elwood & Williams, 1998; McCoy & Inciardi, 1995; Meyer & Dean, 1995; Signorile, 1997). Previous research has demonstrated that bathhouses per se do not compel their patrons to engage in risky behaviors (Elwood & Williams, 1998); nevertheless, some patrons' perceptions, or normative beliefs, regarding social behavior in bathhouses may preclude condom use for anal intercourse (Elwood, 1999a, 1999b). MSM in bathhouses comprise an understudied group that provides a unique and important context for studying HIV prevention communication. The present study examines MSM's communication patterns and norms for sexual risk and risk avoidance behaviors when they attend bathhouses. The Theory of Reasoned Action (TRA) (Ajzen & Fishbein, 1973, 1980) has been used to evaluate why people engage in risky behaviors and to create interventions to change those behaviors. TRA is reviewed next (including attitude and norm components), followed by sexual communication research.

The Theory of Reasoned Action, MSM, and Condom Use

TRA is a general model of predictors of behavior with the goal of determining what influences voluntary behavior. The most recent review indicates that TRA successfully explains variance in behavior (Hale, Householder, & Greene, 2002). TRA is particularly important in examining a potentially co-operative behavior such as condom use because it includes both individual and social factors, whereas many persuasion theories focus exclusively on individual features. TRA has been used in research on health communication behaviors and HIV (Greene, Hale, & Rubin, 1997; Kashima, Gallois, & McCamish, 1992; Pleck, Sonenstein, & Ku, 1990), particularly condom use (Boyd & Wandersman, 1991; Chan & Fishbein, 1993; Fisher, 1984; Kasprzyk, Montano, & Fishbein, 1998).

There have been a number of critiques of TRA (see Hale et al., 2002; Sarver, 1983 for reviews). The theory is based on a rational process and assumes that people use available information in a reasonable manner to arrive at decisions (Sarver, 1983), perhaps least true in sexual interactions. However, clearly people have intentions regarding safer sex behaviors, a possible target for interventions. The theory also assumes that most socially relevant behaviors are under volitional control (Fishbein, Middlestadt & Hitchcock, 1994), and this would only

apply to one's own behavior and not necessarily the partner's. Clearly the theory does not apply to all behavior, particularly to spontaneous or routinized acts (Ajzen & Fishbein, 1973, 1980). Despite criticism, TRA has become a major model in the area of attitude and behavior relations. It has been used recently to study condom use, thus making it a good choice for the present study. The review of TRA begins with behavior, its predictor intention, and the predictors of intention attitude and subjective norm.

TRA maintains that the best predictor of a person's behavior is that person's behavioral intention (Fishbein & Ajzen, 1975). Understanding what affects behavior has implications because it would become possible to target interventions and campaigns more accurately. In order to change a specific behavior, one must change the intention to perform that behavior (Fishbein et al., 1994). In summarizing six meta-analyses of TRA, the relation between volitional behavior and behavioral intention ranged from .44 to .53 (Hale et al., 2002). To change MSM's failure to use condoms consistently, or request their partners to use condoms in casual encounters in bathhouses, campaigns could persuade them to intend to use (or have their partners use) condoms for anal intercourse in these circumstances. Behavioral intentions have been shown to be significantly associated with future condom use reported one month (Fisher, 1984), three months (Boyd & Wandersman, 1991), and four months later (van der Velde, van der Pligt, & Hookyaas, 1992). So, intention to use condoms is important in addition to condom use behavior itself. Thus, the first set of research questions asks about specific behavior and intentions among MSM in bathhouses:

RQ1A: What is the condom use behavior among MSM and their sexual partners in bathhouses?

RQ1B: What are the intentions to use condoms among MSM and their sexual partners in bathhouses?

Behavioral intent is affected jointly by two factors: the individual's attitude toward the behavior and subjective norm (that is, the perception that others think one should engage in the behavior). For MSM in bathhouses, it may be that the attitude or normative component is a stronger predictor (Fishbein & Ajzen, 1975), as the bathhouse setting is a specific situation that facilitates sexual encounters (Elwood, 1999c; Magnusson, 1981). In most research, the attitudinal component has been more strongly associated with behavioral intention than the normative component, even if both are significant (Farley, Lehmann, & Ryan, 1981; Hale et al., 2002). Attitudes and norms have both been found to be associated with likelihood of using condoms (Chan & Fishbein, 1993; Fisher, Fisher, & Rye, 1995; Godin & Kok, 1996; Jemmott & Jemmott, 1991; Kasprzyk et al., 1998; Sheeran & Taylor, 1999). Attitudes and subjective norms are explored next as predictors of behavioral intentions.

Attitudes as Predictors of Behavioral Intentions

According to the TRA framework, an attitude is a person's evaluation of performing or not performing a specific behavior. This is an individual factor, comprising an individual's feelings with respect to performing the behavior in question. The more people believe that performing a behavior will lead to positive outcomes (or prevent negative outcomes), the more favorable their

attitudes will be. For example, people may believe that using condoms during intercourse prevents possible transmission of infection but to openly discuss using them violates other social norms.

For behavior change through attitudes, a person must believe that the benefits of performing the behavior outweigh the costs (Fishbein, 1995). Attitudes toward condom use do predict intentions to use them (Boyd & Wandersman, 1991; Kashima et al., 1992; Pleck et al., 1990). In Sheeran and Taylor's (1999) meta-analysis of condom use and TRA, attitudes and intentions were correlated at .45 (see also Godin & Kok, 1996).

One component of attitudes toward condom use is specifically related to sexual communication. If people hold negative attitudes toward communicating about sex, they may be less likely to attempt to negotiate condom use. In fact, many heterosexual couples avoid discussing safer sex openly because of the stress it creates (Afifi, 1999; Buysse & Ickes, 1999; Lear, 1995), preferring to remain quiet about sexual issues (Faulkner & Mansfield, 2002). When couples do report discussing related issues, they talk about AIDS generally or sexual pleasure but not safer sex, HIV risk, or condom use (Cline, Johnson, & Freeman, 1992; Quina, Harlow, Morokoff, Burkholder, & Deiter, 2000). The more individuals talk about sex and condoms the more likely it is that condoms will be used in a sexual encounter (Bird, Harvey, Beckman, & Johnson, 2001; Catania et al., 1994; Rickman et al., 1994). Studies of heterosexuals find that women in particular find it awkward to ask partners to wear a condom (Metts & Fitzpatrick, 1992; Lear, 1995) in part because it conveys lack of trust (Metts & Fitzpatrick, 1992; Metts & Spitzberg, 1996).

There are many studies about attitudes and behaviors regarding sex and condoms; however, there is less extant research regarding communication, sex, and HIV prevention. Consequently, the second set of research questions ask about MSM's attitudes regarding sex, risk avoidance behaviors and communication when they attend bathhouses:

RQ2A: What are the attitudes regarding sex and HIV prevention behaviors among MSM who attend bathhouses?

RQ2B: What are the attitudes about communication regarding sex and HIV prevention behaviors among MSM who attend bathhouses?

Subjective Norms as Predictors of Behavioral Intentions

In addition to attitude, a normative component predicts behavioral intention. Subjective norm is a person's perception that important others support a specific behavior (Hale et al., 2002). The subjective norm is determined by the degree to which others perceive that a given behavior should be performed, combined with how strongly the individual is motivated to comply with these wishes.

Perceptions of condom use norms (especially for partners) predict intentions to use condoms (Boyd & Wandersman, 1991; Jemmott & Jemmott, 1991; Kashima et al., 1992). In Sheeran and Taylor's (1999) meta-analysis, the effect of subjective norms on condom use intentions was .42 (see also Godin & Kok, 1996). What others think about a behavior such as condom use could influence a person's behavior, but only if the person thought it was important to comply with the attitudes of these others. In the case of condom use or communication about sex,

the norms of the partner may be more salient than in instances that are not cooperative or involving both parties (for example, starting an exercise program). The strongest normative influence by far on intent to use condoms is the sexual partner (Sheeran & Taylor, 1999), but casual and long term partners may have different effects. For example, Greene, Derlega, Yep, and Petronio (2003) summarize differences in disclosure of HIV to casual and long term partners by focusing on how the relationships and relational responsibilities are perceived differently. The normative effects of casual partners such as those in bathhouses may not be as strong as long term partner effects.

Individuals may also maintain positive attitudes toward a behavior but not act on them because of the disapproval of others. On the other hand, individuals with negative attitudes still may perform a behavior because of the influence of important others. It might also be possible that a MSM could have a high motive to comply with others but not know what to do (no clear expectations). In view of that, the third set of research questions attempts to delineate the perceptions of condom use and communication norms and other prevention behaviors among MSM who patronize bathhouses:

RQ3A: What are the perceived norms regarding sex and HIV prevention behaviors among MSM who attend bathhouses?

RQ3B: What are the perceived norms about communication regarding sex and HIV prevention behaviors among MSM who attend bathhouses?

The research described up to this point identifies an area for exploration, specifically the relationship among communication about sex, attitudes and norms in explaining condom use behavior, and intentions. Toward that end, transcripts from interviews with MSM on these issues are explored.

Method

In-depth, semi-structured dyadic face-to-face interviews were conducted in 1996 and 2001 with 101 men, each reporting having recently had sexual contact with another man in a bathhouse. In 1996, 41 men were interviewed in Houston. The study was extended¹ using the same interview guide with 40 participants in Key West, FL, and 20 men in and around New York, NY and New Jersey. The Houston sample consisted of men mostly in their 30s, although ages ranged from 18 to 58; these men were predominantly white/Anglo, including three African American and seven Latino men. The Key West sample consisted of men mostly in their 30s, although ages ranged from 22 to 89. There were 20 white/Anglo, 10 African American, and 10 Latino participants in Key West. The New York/New Jersey area sample consisted of men mostly in their 30s; ages ranged from 19 to 51. There were seven white/Anglo, five African American, six Latino, and two Asian American men. For the entire sample, most of the men were employed, often in managerial positions. Only four men reported being in committed romantic relationships and 17 men reported being infected with HIV.

Procedure and Coding

Candidates for the study were recruited through advertisements in local

newspapers and by referral from men already participating in the study (for descriptions of snowball sampling and hidden populations, see Patton, 1990; Watters & Biernacki, 1989). Advertisement and participant referrals asked men to call one of the authors to determine study eligibility. During the initial phone conversation, participants were screened to meet the following criteria: at least 18 years of age, reported having had sex with another male in a bathhouse in the previous six months, and gave verbal consent to be interviewed and recorded. For participants who met the criteria, an appointment was set for an individual interview in person at a later date.

Data were collected using an interview guide² that followed the principles of TRA and included questions concerning sociodemographics and life history. The guide also included questions on participants' attitudes toward condoms and condom usage, intentions for condom use during sex, as well as their peers' attitudes, intentions, and behaviors regarding the same topics. Also included were sequences that obtained descriptions of verbal and nonverbal communication regarding sex and condom use in bathhouses—both our research participants' observations as well as their personal recounts. Although the questions served as a prompt and guide for the interviewer, participants were encouraged to elaborate on topics that appeared relevant to the study. Interviews generally lasted two hours (range 45 minutes to 3 hours), were audio taped and transcribed verbatim into text files. In turn, text files were content coded using objective analytical codes derived from TRA and research questions. Codes included men's perceptions of bathhouses (for example, sexual nature, community center), attitudes toward condom use (for example, effectiveness, comfort), intentions to use condoms during future sexual encounters (for example, by specific behavior and type of partner), sexual behaviors (for example, fellatio with condom, unprotected anal sex to ejaculation) and perceived subjective norms regarding condom use (including expectation of others such as friends, partners, family members and motivation to comply). Other predetermined codes included accurate knowledge about HIV and AIDS and communication norms and patterns (verbal and nonverbal) within the bathhouse setting. Additional examples include alcohol and other specific drug use, affinities for types of sexual partners, and types of emotional regard for others. Given the use of both inductive and deductive approaches to these data, other codes also arose inductively during the process (for example, silence and arousal).

The transcribed interviews were coded by one of the authors or a research assistant. Coders examined 10% in common. Both coders searched transcripts looking for instances of the five major variables (behavior, behavioral intention, attitudes, subjective norms, communication). Each coder identified the presence of a variable in a description and also coded for direction (for example, behavioral intention was coded as positive or negative regarding condom use, and that was different from intention to engage in anal sex generally). Kappas were calculated for presence/absence and positive/negative (range .92 to .97; $M = .95$). Disagreements were discussed between coders until 100% agreement was reached. Data that best illustrate analytical patterns were excerpted for presentation below.

Results

Condom Use Behavior and Intention

To begin, participants generally expressed intentions to engage in sex at bathhouses. For example, one male posed the rhetorical question, "Why do you go to an art museum if you don't like art? Why go to a restaurant if you're not going to eat? Why go to the baths if you don't want to have sex? That's why they're there." More frankly, he said, "It's sort of like the blow-job store. I just go there to meet my need." Unlike going on a date or patronizing a bar, bathhouses provide "a sure thing; whereas, I've been out at a bar all night and gone home alone." Some men expressed the intention of having sex in bathhouse open areas to simulate the experience of sex in public places, which would place them at risk of arrest if they had sex in spaces like parks or health clubs. According to another participant,

There're things I'd do there that I wouldn't do elsewhere. It's just more open. You can have sex wherever you want. . . . outdoors without the risk of getting caught. You can have sex outdoors on the patio if you want. You can have sex in the steam room with other people watching and not participating. You can have sex almost anywhere and have even 20 people come and join you. Things like that.

Indeed, the man who likened a bathhouse to a blow-job store said, "I tend to do group sex, just at the bathhouse." For some men, the bathhouse is a setting in which "you do drugs and drink, if you bring anything with you, and have sex. It's a place to be free and have sex." In this sense, to engage in sexual acts while watched by others, or to engage in sex with multiple concurrent partners is a desirable risky act that could not be performed in one's home or in public spaces without possible reprisal. Bathhouses provide the setting in which to engage in these acts of fantasy without the repercussions of offending others or being arrested for indecent exposure or lewd behavior. Thus, participants generally expressed intentions to engage in, and engaging in, sex at bathhouses.

Research questions 1A and 1B asked: What are the condom use behaviors and intentions among MSM and their sexual partners in bathhouses? We have established that MSM perceive bathhouses to be expressly sexual settings. Now we turn to MSM's specific condom use intentions and behaviors. Perhaps because bathhouses provide the opportunity for sex with multiple partners, participants recognized that HIV transmission is a possibility in bathhouses.

Participants reported inconsistent condom use behavior. Although only 45% reported using condoms consistently, 73% reported using condoms on occasion. One man reported, "Most of the time I use them [condoms] at the bathhouse." Another was more graphic in describing his behavior: "Hell, yeah, I keep it covered and so does any partner." Some men reported engaging in unprotected insertive anal sex with other men in bathhouses: "Yeah, I've penetrated men without protection at the bathhouse. He didn't say anything so I did it." Men may have reported using condoms unthinkingly for anal sex; one behaviorally bisexual man reported wearing a condom in a bathhouse regardless of his activities. Men were more willing to report insertive anal sex without condoms than receptive anal intercourse without condoms. Many participants also reported they had condoms with them at the bathhouse or knew where to get them, but this was not always the case. Participants reported that free condoms were

available at some bathhouses. One establishment had an open bowl inside the entrance, and patrons could serve themselves. Another provided condoms "if you go up to the window and ask" an attendant. Men who patronized other bathhouses reported even easier access—including baskets of condoms throughout the facility and placed on pillows in cubicles that are rented for a fee. Additionally, some men brought their own condoms and lubricant, preferring a particular brand or style.

Participants described how a sexually-oriented establishment like a bathhouse attracts people with HIV and other STDs. For example, one participant recounted, "At the baths, if I've ever allowed them to penetrate me, then they've always had to have a condom. Because that person has done many other people there and it's a million times greater that I'm going to get HIV at that point." Another patron reported, "When I'm there, I actually am more conscious to think about HIV." Accordingly, men who perceived bathhouses as also involving the risk of HIV and other STD transmission reported eschewing high-risk activities there altogether and only engaging in mutual masturbation, or always using condoms for anal sex. For example,

Participant: I think I'm pretty hard-line on using condoms, compared to some people.

Interviewer: So gay men are just as wishy-washy outside the baths as they are inside?

Participant: Probably, people are less likely to use condoms outside the baths.

Interviewer: Really? Why do you think that is?

Participant: I think because when men decide they're going to go to the baths, they think they're going to meet a different quality of people.

Interviewer: A separate quality of people?

Participant: Yeah, I mean, I think they go there with the expectation that there's a chance of catching something from the kind of people who go to the baths.

Another participant who both intends to use, and uses, condoms regularly stated this idea more succinctly, "They can have all sorts of diseases that I might pick up." In fact, at least three participants reported contracting sexually transmitted diseases at bathhouses.

Although the condom use behaviors of these bathhouse patrons were inconsistent, the intentions (research question 1B) were much more consistent: 87% of participants reported intentions to use condoms for receptive anal sex (higher than for insertive anal sex). As one man stated, "Of course I plan to use condoms, that's the safe thing to do. Sometimes it happens and sometimes it doesn't, but I always go there with the idea that I'll be safe."

In summary for research question 1, participants stated that bathhouses are expressly sexual settings that consistently provide opportunities for sex between men and for types of sex that MSM might not find elsewhere. This perception leads some men to believe that the men they meet in bathhouses are more likely to be infected with sexually transmitted diseases, including HIV, than men they meet in other settings. MSM in this study generally intend to use condoms but do not always use them.

Condom Use Attitudes and Communication

Research questions 2A and 2B asked: What are MSM's attitudes regarding sex, HIV prevention behaviors and communication at bathhouses? Some men reported negative attitudes toward bathhouses themselves. Such attitudes appeared related to the almost certain opportunities for sex or sexual encounters unavailable elsewhere, and that the sexually-oriented setting may attract a greater percentage of MSM infected with HIV and other STDs. According to a man who appreciated bathhouses because they allowed him to incorporate sex on a regular basis into his busy schedule of full-time employment and graduate studies, "After I leave there, I still feel like I've done something wrong. I don't view it as a good thing. . . . I wouldn't want anyone else to view me as being in a situation to where I have to go there to have sex." Another participant reported a similar negative attitude, but placed it in a broader context of gay male values:

I feel at odds because people view it only as a place that you go to have sex, and I've just gone there to do what most people view it as, and they don't view it kindly, on the whole. They see it more as a slutty or trampish place to be, because you go there to engage in multiple acts of sex. But some of those same people who cast those stones go to jack-off parties or to partners' fuck parties, or whatever type sex party it is. And so they cast a stone in one area, when they're not realizing it's on the same level, just in a different place.

One patron reported that he immediately left a bathhouse whenever he saw an acquaintance there to ensure he did not develop a reputation among his peers as a bathhouse patron.

Despite the recognition of regular condom use for anal sex between men, and the attitude that the sexual nature of bathhouses places them at higher risk for sex with HIV or other STD-infected men, no men in this study reported enjoying condom use. Men in this study had generally negative attitudes toward how condoms felt and the necessity of using them, but they reported positive attitudes about staying healthy and believed condoms reduced the risk of HIV infection. When we asked participants what they believed men like them thought about condoms, many responded with answers such as, "I think they wish they didn't have to use condoms. They would prefer not to. But it's necessary to stay alive." In this study, MSM's attitudes about using condoms were generally negative, but they also saw condoms as necessary. That is, MSM in this study believed condoms prevented STDs, protected health, and were responsible but were also awkward, spoiled the mood, and did not feel as good.

When men reported observing men being penetrated by partners who were not wearing condoms, they often attributed psychological problems or HIV infection to such individuals. Some insertive partners attributed a lower degree of infection risk (a belief) to unprotected insertive anal sex—and some men were implicitly willing to foster this particularly risky behavior in others:

You're here in the bathhouse, and I've seen you here before, and you let me and a half-dozen other men in here tonight fuck you. You're just sick. You're just out to get a disease, baby. You're depressed, you're fucked up, and you're really sad. And if you're going to let me stick my dick in there, all right, I'll stick my dick in there. I'm going to get my rocks off. I'll try not to come in you, but fuck it, I'm sorry. This disease has been around for like over 10 years and you're doing it—where've you

been? How many friends have you lost? Are you on some kind of death wish? And if they're positive and letting somebody do it, it's like you don't care about yourself.

To summarize for research question 2A, some men reported negative attitudes toward bathhouses due to their obvious sexual nature. Men who reported this circumspect attitude generally reported condom use purportedly because they equated the blatant sexual nature of bathhouses with an increased likelihood of meeting sexual partners with HIV or other STDs. Many men reported witnessing unprotected sexual encounters among men, and they thought that these men were infected with HIV.

Communication attitudes—verbal. Research question 2B asked: What are the attitudes about communication regarding sex and HIV prevention behaviors at bathhouses? One patron summarized the beliefs of communication in bathhouses in a pithy way: "You don't go to the bathhouse with your friend laughing, having a conversation about Bosnia." Beliefs about communication dictate not only that one should not discuss foreign affairs—indeed, any affairs—in bathhouses, but simply that one almost never should speak in bathhouse public areas. Staff members of one bathhouse customarily prefaced their public address system announcements with the greeting, "Excuse me, gentlemen," inspiring this manuscript's title. This preface reinforces the silence norm by apologizing for any intrusion (several participants viewed this announcement as reinforcing beliefs about silence).

Participants frequently remarked that bathhouses are not only a setting in which oral communication seldom occurs, but also a setting in which patrons enforce this communication rule. The patron who will not speak about Bosnia in bathhouses described how his attitudes were formed:

Participant: When I first started to go there, I would see somebody and say something like, "Hi, Bill! What's going on?" And, you know, people would kind of look at you like, "Shh, just don't talk in here."

Interviewer: Why? Why are you not supposed to talk?

Participant: I don't know. I never figured that part out.

Although this respondent could not cite a rationale for this attitude toward the absence of verbal communication, most participants, when asked, provided reasons related to their desires for taciturn efficiency in their sexual encounters within the bathhouse setting. One man said,

I think people usually go to bathhouses because they just want sex. You can do it and you can leave, with no questions asked. You don't have to make up an excuse. You don't have to wake up in bed with them the next morning and say you have to be somewhere.

Another participant stated, "It's time to touch, not talk." In this way verbal communication is viewed negatively and discouraged.

This latter theme of not having to make excuses or to feel compelled to establish and perpetuate an illusion of intimacy appears elsewhere. One man said that he appreciated the lack of conversation in bathhouses because he was reluctant to disclose any details about himself:

It takes out the whole lying factor out, and, in turn, you can be as anonymous as you want to be. You don't have to say where you came from. You don't have to say

anything. I think that makes it pretty safe for some people to go there because they can be anonymous.

Efficiency and confidentiality also contribute to the rationale for the belief that silence is appropriate behavior. A participant who leaves the bathhouse when he spies someone he knows (for fear that his friends will ascertain his bathhouse attendance) responded to the following question:

Interviewer: Do you think most men who go can count on the men they see there that they know to keep the code of silence?

Participant: I think so. I've kept silent about the things and men that I've seen there. You just say nothing about being there or seeing anyone you know.

Interviewer: So you think most men are likely to keep quiet and not say, "Hey, guess who I saw last night at the bathhouse?"

Participant: Well, I think so, due to fear that they will be revealed as well.

The contradiction in this attitude is also worth noting. If this participant truly believes that silence extends outside the bathhouse, then any other patron who saw him there would not reveal his attendance. He is clearly not confident that this would be the case. As this quote demonstrates, silence and anonymity are important components of these communication attitudes. Such attitudes can be expressed nonverbally as well, as we describe next.

Communication attitudes—nonverbal. The clear negative attitudes toward any verbal communication in this setting do not prohibit use of nonverbal cues. Consistent with the desire for silence, confidentiality, and efficiency, cruising behaviors—indicating one's desire to have sex with another (Henriksson & Mansson, 1995)—are extremely basic:

Usually they're erect, they're showing you their erection through their towel or sticking it out. Or, they're masturbating or something. That's always a good clue. Oftentimes, they'll approach you and they'll come up to you and touch you.

Indicating desire in bathhouses is not always so candid. In trafficked public areas, men rely on other nonverbal behaviors:

Participant: Let's say I'm at the bathhouse up against the wall in the hallway and all of a sudden a guy comes in. He'll look at you and walk past you, and stop within eye distance of you.

Interviewer: How do you know if someone in the steam room is interested in you?

Participant: Same way—eye contact. Or, a lot of men can be aggressive. They'll come up to you, sit next to you, reach over and grab you, or fondle you, or try something like that.

When asked expressly how one might indicate a desire to use condoms in such a situation, a man replied, "I don't know how you could do it. There's no way to carry them when you're only wearing a towel. Besides, you really can't say anything unless it's something like, 'Yeah, man, fuck it, yeah.'" Other men report very explicit communication that is nonverbal: "You don't have to say anything, just hand him a condom, or help him put it on, if that turns you on." In this sense, there is less negotiation of the issue verbally, rather than simply expressing desire to use condoms (broaching the topic). Briefly stated, the attitudes about silence in bathhouse public areas facilitate anonymous sexual

encounters and constrain the ability to verbally suggest or to negotiate condom use.

Condom Use, Communication, and Social Norms

Condom use norms. Research question 3A asked: What are MSM's perceived norms regarding sex and HIV prevention behaviors at bathhouses? The quotations presented earlier demonstrate a norm (in addition to attitudes) among participants that condom use is supposed to be practiced for anal sex. In addition to the idea that men who patronize a sexually oriented business are more likely to have sexually transmitted diseases, participants voiced the idea that condom use also reflects the anonymity of most bathhouse sexual encounters. For example, "Condom use comes from not knowing the person. You know, they can have all sorts of diseases that I might pick up." This is consistent with beliefs that we see people we know as less likely to be risky or have STDs (cf. Metts & Fitzpatrick, 1992).

Consistent with the earlier-voiced preference for unprotected anal intercourse, "It's something most top [insertive] men try to get away with." Some men appear to "get away with" unprotected anal sex in bathhouse public areas. In these stories, situational factors interfere with conforming to the perceived norm of always using condoms for anal penetration. One patron described such an episode that occurred in the maze, a dark room similar to a boxwood garden maze or the circuitous puzzle in newspapers:

He was gorgeous, a real man. Tall, really broad shoulders, and a big chest. Big muscles everywhere and a really big cock. I just have to have him, you know? I thought about using condoms, I did, but I didn't want to talk about it because it might break the moment, or he might go away. I just had to have him, so I backed onto him and he really filled me up. It felt so good. I even thought that we should have used a condom while he was [having sex with] me. I knew what the risks were, but I didn't care.

Another participant told a similar story:

In the maze, one man tried to back onto my dick, and I wasn't wearing a condom. The two places I've seen unsafe sex go on is in the maze, where it's the darkest, and in the steam room, in the back section of the steam room where it's kind of secluded.

Men who reported engaging in unprotected sex talked generally about risks but not specifically about the transmission of HIV or other STDs.

In summary for research question 3A, participants acknowledged a perceived norm for condom use for all anal intercourse (although not oral sex); however, this norm can be overwhelmed by the norm of silence in bathhouse public areas. The norm of silence can preclude telling a partner about desire for the insertive partner to wear a condom. Men who reported being penetrated by partners not wearing condoms stated a desire to use condoms but also felt constrained by the silence norm that precludes conversation.

Communication and social norms. Men in bathhouses consider it appropriate to keep conversation in public areas to a minimum. This standard facilitates

confidentiality and expediency in sexual gratification. In private rooms, however, respondents typically reported talking about the type of sex they want to have and negotiating safer sex activities. For example, the man who said that most top men attempt not to wear condoms also said, "I've heard all the excuses. I had one guy tell me that he couldn't come if he had one on. I'm like, 'That's very sad, you know, but too bad.'" Men in this study describe common excuses for not using condoms and attempts not to comply with condom use attempts, but more communication in private areas and a strong prohibition against talking in public areas of bathhouses. A more encouraging example is provided by another participant:

Participant: Well, the last time. The man I had sex with put it on me.

Interviewer: How did you feel about that?

Participant: The first thing that he asked was if we could have anal sex.

Interviewer: This was in his cubicle at the baths?

Participant: Yes, in his room, right. I was asked to come in. The first thing I asked him was, "Do you have a condom?" He said, "Yes," so I didn't hesitate then.

Interviewer: Did you like him putting a condom on you better than doing it yourself?

Participant: I think there was more of a comfort level there for both of us.

Interviewer: Why?

Participant: I don't know. I liked the idea of him putting it on.

In summary for research questions 3A and 3B, the norms mentioned by participants were exclusively for sexual partners. For condoms, there was a norm to use them but men recognized special instances where unprotected sex might occur. The emphasis on silence or no verbal communication, especially in public areas, was strong. It is important to recognize the strength of these norms, and some potential power or role dynamics. For example, receptive MSM in particular may have more difficulty initiating discussion about condom use.

Discussion

The purpose of this study was to provide a detailed description of the attitudes, norms, communication patterns, and condom use intentions and practices of MSM who attend bathhouses. We elucidated information about when MSM patronize bathhouses and illustrated how communication attitudes and norms facilitate or preclude safer sex behaviors. Through this examination, we found that attitudes toward bathhouses lead some men to engage in safer sex behaviors, including condom use for anal sex. We also found these men maintained a clearly identifiable norm (and intention) to use condoms for anal intercourse. Any physical site, including a bathhouse, can influence communication and behavior; however, settings are a composite of the physical site, people's perceptions, and their reactions to others' behaviors. Some MSM believe that being the insertive partner protects them from STD infection. This inaccurate belief is in contradiction to participants' beliefs that sexual partners met in bathhouses were more likely to be infected with HIV or other STDs than partners met elsewhere. Acts of unprotected anal sex also were attributed to fear of breaking the communication norm for silence in bathhouse public areas. In the context of MSM's condom use intentions in bathhouses, norms regarding

silence were more strongly associated with condom use than were attitudes toward condom use.

Implications and Applications

Implications for Health Campaign Designers

Condom use for anal sex was practiced by some (45%) MSM in this sample with most (87%) intending to use condoms. Although many participants reported not always using condoms, these occasions were expressed as aberrations to normative expectations of both self and others. Clearly prior interventions and community-based efforts have been at least partially effective in establishing condoms as a standard HIV preventive measure. It should be noted, however, that condom use is a norm only for anal sex; men did not report condom use or other preventive measures for fellatio or anilingus. Health campaigners may want to assess whether their target audiences hold separate norms regarding condom and other latex barrier uses for different sexual behaviors and tailor their programs accordingly.

Some men reported conscious adherence to condom use in bathhouses because the expressly sexual nature of the setting led these men to believe that their bathhouse sex partners were more likely to be infected with HIV and other STDs than men met in other venues. The praxis of assessing one's risk for HIV infection based on partner type or appearance has been analyzed (e.g., Brouwer, 2000; Metts & Fitzpatrick, 1992). Based on their review of research on ability to select safer partners, Metts and Fitzpatrick (1992) concluded that sexual scripts are often devised in order to support the hypothesis that the partner is not at risk, again highlighting the absence of direct verbal communication strategies. Our findings with this sample of MSM are consistent with the "know your partner" misbelief—people frequently believe that familiar sexual partners are less likely to have STDs than anonymous partners. Campaigns specifically addressing this perception have clearly been ineffective and should be rethought expressly to address issues such as, "Just because you know him doesn't change his HIV status."

MSM reported that the norms for silence in bathhouse public areas facilitate efficient and confidential sexual encounters. Men who appreciated these qualities sought sex without even the illusion of intimacy to protect their identities from their sex partners and to avoid developing reputations as bathhouse patrons. This same communicative norm, however, at times precludes adherence to the MSM intention of condom use for anal sex because to negotiate a specific sexual act and whether to use condoms is to violate the immediate subjective norm that requires silence in sexual encounters that occur in common areas of bathhouses. It is worth noting that examples in these data included communication or discussion about condom use, yet current health messages often encourage people to talk about each other's sexual and drug use past. There were no examples in these data of verbal communication on these topics, only isolated instances of discussion of condom use. Thus, the silence norm extends far beyond condom use to many sexual topics (except sexual likes and dislikes) in this study.

This silence norm appears to be self-enforced to a degree. Participants men-

tioned being admonished if they engaged in phatic communication; no one expressly stated being reproached for requesting condom use during a sexual encounter in a public area. There was evidence some men feared breaking the mood by raising the topic of safer sex, an example of potential conflicts between primary and secondary goals (Dillard, Segrin, & Hardin, 1989; Edgar, 1992). Participants did state a fear of chastisement or termination of a sexual encounter if they attempted to negotiate condom use in a public area. Whether any men would endure actual reprisals for directly requesting condoms in bathhouse public spaces remains unclear. A campaign (perhaps poster) could show support for others asking for condom use. Such a poster could be placed on walls in public areas or cubicles, such as is done with health promotion posters in bars.

The final health campaign implication relates to the applicability of these findings to other risk behaviors. In any context where a health behavior is negotiated by a couple, there is a possibility that silence norms may inhibit expression of goals. For example, a couple with a child may both smoke, but one partner might be reticent to ask the other to smoke outside. This example is much less sensitive than the sexual topic but may still be difficult to request. Other risk taking types of behaviors are influenced by norms, much like the norms for silence here (and arousal) interfered with some condom use. For example, cigarette smoking and marijuana use are both influenced by partner and peer norms.

Implications for Health Care Workers and Counselors

The norms of silence findings are important for people working with those who could be at risk for contracting STDs (for example nurses, social workers, therapists, or HIV test counselors). Specifically, people should be encouraged to negotiate, perhaps through efficacy building strategies. The implications for couples are important, and might also be addressed. For example, the difficulty experienced by the receptive partner in raising the topic of condom use is similar to reports of gender differences in heterosexual relationships where women are more inhibited about raising safer sex topics (Lear, 1995; Metts & Spitzberg, 1996). Some of the same strategies used to encourage assertiveness among heterosexual women may also be applied to receptive gay men to extend the findings. This study found that sexually receptive MSM share an affinity with women in that both MSM and women have less power to negotiate condom use in their sexual relationships. Health educators who conduct interventions with MSM may want to share condom negotiation techniques that have worked well for women (except, of course, for the proverbial "I don't want to get pregnant"). Also relevant for relational findings, the type of relationship (casual versus primary partner) affects both the communication and behavior (Lear, 1995). For gay and heterosexual relationships, there is a tendency to increase condom use if the relationship is casual (and perhaps decrease condom use once a relationship develops). This would lead one to expect even higher condom use in bathhouses (or for example for people picked up in bars) than the half of MSM who reported always using condoms in this study. The difference between expectations of condom use and actual condom use again points to problems with issues such as susceptibility.

Our research has demonstrated the continued value of TRA in exploring

communication factors for HIV prevention and its mutual relevance and utility to research regarding sexual communication. Two additional practical and immediate applications also emerge from our findings.

First, health educators should seek to establish and encourage the norm of directly communicating, verbally and nonverbally, about condom use. Many insertive men specifically pursued anal intercourse without condoms (similar to reports of heterosexual men who are reluctant to use condoms); some receptive men did not request condom use because to do so would violate an established tacit policy of avoiding conversation. Vázquez-Pacheco (2001), a leading HIV and AIDS educator, interviewed MSM and found that many of them—HIV positive and negative—did not discuss serostatus or condom use with their sexual partners. Specifically, he found that there is “no chitchat at the baths.” He concluded,

Broaching the subject [of HIV transmission] means we have to take some kind of responsibility. . . . Strange that twenty years into the epidemic we as gay men can't seem to negotiate this with each other. It's sort of like being one of two people stranded in a life raft and not cooperating with the other person in the boat (p. 25).

This is clearly not a knowledge issue, though much education focuses here. Health education efforts should work toward providing patrons with the motivation to negotiate condom use in bathhouse public spaces with their sexual partners in ways that maintain the confidentiality of bathhouse encounters. It is also possible to focus on nonverbal strategies if verbal negotiation is too awkward. For example, Adelman (1992) included nonverbal strategies in providing recommendations for reframing the dominant sexual metaphor from negotiation to play. Brouwer (2000) also extended nonverbal focus on disclosure and discovery of HIV infection through trick exams and intuitions, though he points out the drawbacks of relying solely on nonverbal cues in sexual settings. This emphasis on verbal and nonverbal initiation of condom use is critical to stem the HIV epidemic.

Second, educational efforts must foster a greater sense of responsibility in sexually active individuals. Despite common references to “the gay community,” many scholars and activists argue that there is little evidence of communal identity and practice among gay men (Harney, 1999; Lehr, 1993; Sedgwick, 1991; Vaid, 1995); Lehr (1993) argues that it is more appropriate to understand the existing relationship as a coalition, a necessary precursor to community. In discussing the creation of community, Kaplan (1994) states, “It seems to me that unless we can establish communion in these cases, we will not have communion at all. It is easy to talk with people we love; the trick is to be able to talk with people we do not love” (p. 42). No one likes to talk about HIV and AIDS, particularly before sex in a setting dedicated to sex between men who subscribe to the belief that it is inappropriate to converse in that space.

Participant comments like those presented earlier, including the statement that condomless sex is “something most top men try to get away with” in a setting in which “you can do it and leave with no questions asked,” demonstrate the lack of regard and, therefore, the lack of community identification some MSM have for other MSM. This is not unique to MSM, as similar dynamics occur in other couples and sexual situations. One possibility for fostering community and condom use would be to build upon the post-Stonewall, pre-AIDS notion of

promiscuous sex as an act of gay liberation. This notion would also apply to MSM with HIV who could perceive disclosure and condom use as acts of political action and responsibility to their community (see also Elwood, 1999c). These messages could be related to campaigns that focus on the relationship, such as "do it for us" or "show you care" (Edgar, 1992). Some bathhouses have taken further steps to encourage this safer sex reinforcement, utilizing *lifeguards*, men who enforce safer sex rules in public spaces. This change in HIV prevention, obviously, cannot occur overnight. It can, however, encourage condom use and a sense of kinship by changing egocentric thought related to the slogan, "Be here for the cure," to the motive that people should "be here" to inform and protect one another.

Implications for Theory

These data provide added evidence for the utility of TRA in understanding health behavior and for expansion of research on sexual communication. Specifically, most MSM reported intentions to use condoms but their bathhouse behavior was not always consistent with intentions. Previous research indicates that the attitudinal component of intentions is generally a better predictor of intentions (Hale et al., 2002); however, subjective norms were critical in the present study. This finding may be related to the sexual topic. Our data also demonstrate how important it is with TRA to continue to examine subjective norms in addition to attitudes. Particularly, the motivation to comply with partner norms (combined with sexual desire) at times overrode MSM's own positive attitudes toward condom use. In addition to being superceded by compliance with partner norms and sexual desire, positive attitudes toward condom use were overridden by communication norms: "We were going at it hot and heavy. I wanted to use a condom, but there just wasn't one handy. There was just no stopping and saying, 'Sorry, but I gotta go get a condom.'" These and similar quotations support Janz and Becker's (1984) conclusion that perceived barriers are crucial in preventive health decision making (see also Dillard et al., 1989; Edgar, 1992). Availability of condoms is a necessary but not sufficient condition for condom use (cf. Kashima et al., 1992). To accomplish this goal, condoms must be available in all areas of bathhouses, much like installation of condoms in vending machines and restrooms in some college dorms, gas stations, and bar restrooms. Condom holders or baskets could be placed on walls, even outside steam rooms and in cubicles.

Future Research

These findings reinforce Fishbein's (1995) admonishment that our safer sex curriculum instructions must be absolutely specific by population and behavior. In this case, the perceived norm and intention for these MSM is condom use for anal sex. However, the desire for relatively silent, expedient sex in bathhouses precludes enacting the norm for condom use in this particular setting. Moreover, related negative attitudes toward bathhouses expressed by some participants prohibits these men from allowing their peers to know about their patronage—and precludes them from receiving peer support that could facilitate a subjective norm for condom negotiation and usage in all sexual settings, including bath-

houses. Consequently, future research efforts and interventions with this or similar populations should explore the possibility of strengthening the condom use norm by fostering a norm to negotiate condom use, even in settings in which talk generally is unaccepted. HIV prevention interventions may integrate suggestions regarding condom use negotiation (verbal and nonverbal), as evaluations for such interventions frequently concentrate solely on beliefs or behavior change.

It is likely this silence norm exists in other contexts, for example in relationships with power imbalances, among women, or even among sexually experienced people who are not socially adroit. Further research on the inability openly to discuss sexual issues generally, beyond condom use, is important for many different relationships and settings. Extending the finding of silence norms to other contexts can provide the added value of generalizing to other populations and settings beyond MSM in bathhouses. There is much work to be done in this area, exploring similarities and differences between populations and relationships as well as the applicability to other risk behaviors and settings.

Endnotes

1. The advent of protease inhibitors and HAART around 1996 led the authors to anticipate pertinent differences in 2000–01, and the study was extended with additional data collection. The descriptions provided by men at both time periods were remarkably similar; therefore, they are combined in descriptions of results. In addition, examination of differences by site was not conclusive. The only trends toward differences by site were not directly related to the research questions. Specifically, there was site variation in the language used to describe certain sexual practices (for example, slang for barebacking and for top/bottom men).

2. Sample questions from the interview guide are available from the first author.

References

- Adelman, M. B. (1992). Healthy passions: Safer sex as play. In T. Edgar, M. A. Fitzpatrick, & V. S. Freimuth (Eds.), *AIDS: A communication perspective* (pp. 69–89). Hillsdale, NJ: Lawrence Erlbaum.
- Afi, W. A. (1999). Harming the ones we love: Relational attachment and perceived consequences as predictors of safe sex behavior. *Journal of Sex Research, 36*, 198–206.
- Ajzen, I., & Fishbein, M. (1973). Attitudinal and normative variables as predictors of specific behaviors. *Journal of Personality and Social Psychology, 27*, 41–57.
- Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behavior*. Englewood Cliffs, NJ: Prentice-Hall.
- Bird, S. T., Harvey, S. M., Beckman, L. J., & Johnson, C. H. (2001). Getting your partner to use condoms: Interviews with men and women at risk for HIV. *Journal of Sex Research, 38*, 233–240.
- Boyd, B., & Wandersman, A. (1991). Predicting undergraduate condom use with the Fishbein and Ajzen and the Triandis attitude-behavior models: Implications for public health interventions. *Journal of Applied Social Psychology, 21*, 1810–1830.
- Brouwer, D. C. (2000). Nonverbal vernacular tactics of HIV discovery among gay men. In S. Petronio (Ed.), *Balancing the secrets of private disclosures* (pp. 97–108). Mahwah, NJ: Lawrence Erlbaum.
- Buysse, A., & Ickes, W. (1999). Communication patterns in laboratory discussions of safer sex between dating and nondating partners. *Journal of Sex Research, 36*, 121–134.
- Catania, J. A., Coates, T. J., Golden, E., Dolcini, M. M., Peterson, J., Kegeles, S., et al. (1994). Correlates of condom use among black, Hispanic, and white heterosexuals in San Francisco: The AMEN longitudinal survey. *AIDS Education and Prevention, 6*, 12–26.
- Centers for Disease Control and Prevention. (2001a, January 31). *HIV/AIDS among U.S. women: Minority and young women at continuing risk*. Fact sheet. Atlanta: Author.

- Centers for Disease Control and Prevention. (2001b, January 31). *Need for sustained HIV prevention among men who have sex with men*. Fact sheet. Atlanta: Author.
- Centers for Disease Control and Prevention. (2001c, September). *HIV/AIDS among African Americans*. Fact sheet. Atlanta: Author.
- Chan, D. K., & Fishbein, M. (1993). Determinants of college women's intentions to tell their partners to use condoms. *Journal of Applied Social Psychology, 23*, 1455-1470.
- Cline, R. W., Johnson, S. J., & Freeman, K. E. (1992). Talk among sexual partners about AIDS: Interpersonal communication for risk reduction or risk enhancement. *Health Communication, 4*, 39-56.
- Dillard, J. P., Segrin, C., & Hardin, J. M. (1989). Primary and secondary goals in the production of interpersonal influence messages. *Communication Monographs, 56*, 19-38.
- Edgar, T. (1992). A compliance-based approach to the study of condom use. In T. Edgar, M. A. Fitzpatrick, & V. S. Freimuth (Eds.), *AIDS: A communication perspective* (pp. 47-67). Hillsdale, NJ: Lawrence Erlbaum.
- Elwood, W. N. (1996). Trends among substance abusers in Houston: A report from special studies and the streets. In J. C. Maxwell (Ed.), *Current trends in substance use: Texas 1996* (pp. 113-116). Austin: Texas Commission on Alcohol and Substance Abuse.
- Elwood, W. N. (1999a). The politics of silence: Communicative rules and HIV prevention issues in gay male bathhouses. In W. N. Elwood (Ed.), *Power in the blood: A handbook on AIDS, politics, and communication* (pp. 121-132). Mahwah, NJ: Lawrence Erlbaum.
- Elwood, W. N. (1999b). Burden of sin: Transmitting messages and viruses in a stigmatized plague. In W. N. Elwood (Ed.), *Power in the blood: A handbook on AIDS, politics, and communication* (pp. 3-8). Mahwah, NJ: Lawrence Erlbaum.
- Elwood, W. N. (1999c). Victories to win: Communicating HIV/AIDS prevention and tolerance. In W. N. Elwood (Ed.), *Power in the blood: A handbook on AIDS, politics, and communication* (pp. 415-421). Mahwah, NJ: Lawrence Erlbaum.
- Elwood, W. N., & Williams, M. L. (1998). Sex, drugs, and situation: Attitudes, drug use, and sexual risk behavior among men who frequent bathhouses. *Journal of Psychology and Human Sexuality, 10*, 23-44.
- Farley, J. U., Lehmann, D. R., & Ryan, M. J. (1981). Generalizing from 'imperfect' replication. *Journal of Business, 54*, 597-610.
- Faulkner, S. L., & Mansfield, P. K. (2002). Reconciling messages: The process of sexual talk for Latinas. *Qualitative Health Research, 12*, 310-328.
- Fishbein, M. (1995). Developing effective behavior change interventions: Some lessons learned from behavioral research. In T. E. Backer, S. L. David, & G. Soucy (Eds.), *Reviewing the behavioral science knowledge base on technology transfer: NIDA Research Monograph 155* (pp. 246-261). Rockville, MD: National Institute on Drug Abuse.
- Fishbein, M., & Ajzen, I. (1975). *Belief, attitude, intention, and behavior change: Final report, theorists' workshop*. Bethesda, MD: National Institute on Mental Health.
- Fishbein, M., Middlestadt, S. E., & Hitchcock, P. J. (1994). Using information to change sexually transmitted disease-related behaviors: An analysis based on the theory of reasoned action. In R. J. DiClemente & J. L. Peterson (Eds.), *Preventing AIDS: Theories and methods of behavioral interventions* (pp. 61-78). New York: Plenum.
- Fisher, W. A. (1984). Predicting contraceptive behavior among university men: The role of emotions and behavioral intentions. *Journal of Applied Social Psychology, 14*, 104-123.
- Fisher, W. A., Fisher, J. D., & Rye, B. J. (1995). Understanding and promoting AIDS-preventive behavior: Insights from the theory of reasoned action. *Health Psychology, 14*, 255-264.
- Godin, G., & Kok, G. (1996). The theory of planned behavior: A review of its application to health-related behaviors. *American Journal of Health Promotion, 11*, 87-98.
- Goode, E. (2001, August 19). With fears fading, more gays spurn old preventive message. *The New York Times*, pp. 1, 30.
- Goodroad, B. K., Kirksey, K. M., & Butensky, E. (2000). Bareback sex and gay men: An HIV prevention failure. *Journal of the Association of Nurses in AIDS Care, 11*, 29-36.
- Greene, K., Derlega, V., Yep, G., & Petronio, S. (2003). *Privacy and disclosure of HIV in interpersonal relationships: A sourcebook for researchers and practitioners*. Mahwah, NJ: Lawrence Erlbaum.
- Greene, K., Hale, J. L., & Rubin, D. L. (1997). A test of the theory of reasoned action in the context of condom use and AIDS. *Communication Reports, 10*, 21-33.
- Hale, J. L., Householder, B. J., & Greene, K. (2002). Theory of reasoned action. In J. P. Dillard & M.

- Pfau (Eds.), *The persuasion handbook: Developments in theory and practice* (pp. 259–286). Thousand Oaks, CA: Sage.
- Harney, D. M. (1999). Lesbians on the frontline: Battling AIDS, gays, and the myth of community. In W. N. Elwood (Ed.), *Power in the blood: A handbook on AIDS, politics, and communication* (pp. 167–179). Mahwah, NJ: Lawrence Erlbaum.
- Henriksson, B., & Mansson, S. A. (1995). Sexual negotiations: An ethnographical study of men who have sex with men. In B. Henriksson (Ed.), *Risk factor love: Homosexuality, sexual interaction, and HIV prevention* (pp. 147–174). Göteborg, Sweden: University of Göteborg.
- Janz, N. K., & Becker, M. H. (1984). The health belief model: A decade later. *Health Education Quarterly*, 11, 1–47.
- Jemmott, L. S., & Jemmott, J. B. (1991). Applying the theory of reasoned action to AIDS risk behavior: Condom use among black women. *Nursing Research*, 40, 228–234.
- Kaplan, A. (1994). *The life of dialogue*. Cresskill, NJ: Hampton.
- Kashima, Y., Gallois, C., & McCamish, M. (1992). Predicting the use of condoms: Past behavior, norms, and the sexual partner. In T. Edgar, M. A. Fitzpatrick, & V. S. Freimuth (Eds.), *AIDS: A communication perspective* (pp. 21–45). Hillsdale, NJ: Lawrence Erlbaum.
- Kasprzyk, D., Montano, D. E., & Fishbein, M. (1998). Application of an integrated behavioral model to predict condom use: A prospective study among high HIV risk groups. *Journal of Applied Social Psychology*, 28, 1557–1583.
- Kelly, J. A., Murphy, D. A., Sikkema, K. J., McAuliffe, T. L., Hoffman, R. A., Solomon, L. J., et al. (1997). Randomized, controlled, community-level HIV-prevention intervention for sexual-risk behavior among homosexual men in US cities. *The Lancet*, 350, 1500–1505.
- Kelly, J. A., St. Lawrence, J. S., Diaz, Y. E., Stevenson, L. Y., Hauth, A. C., Brasfield, T. L., et al. (1991). HIV risk behavior reduction following intervention with key opinion leaders of population: An experimental analysis. *American Journal of Public Health*, 81, 168–171.
- Lear, D. (1995). Sexual communication in the age of AIDS: The construction of risk and trust among young adults. *Social Science and Medicine*, 41, 1311–1323.
- Lehr, V. (1993). The difficulty of leaving "home": Gay and lesbian organizing to confront AIDS. In R. Fisher & J. Kling (Eds.), *Mobilizing the community: Local politics in the era of the global city* (pp. 246–269). Newbury Park, CA: Sage.
- Lemp, G. F., Hirozawa, A. M., Givertz, D., Nieri, G. N., Anderson, L., Lindegren, M. L., et al. (1994). Seroprevalence of HIV and risk behaviors among young homosexual and bisexual men: The San Francisco/Berkeley young men's survey. *Journal of the American Medical Association*, 272, 449–454.
- Magnusson, D. (1981). Wanted: A psychology of situations. In D. Magnusson (Ed.), *Toward a psychology of situations: An interactional perspective* (pp. 9–35). Hillsdale, NJ: Lawrence Erlbaum.
- McCoy, C. B., & Inciardi, J. A. (1995). *Sex, drugs, and the continuing spread of AIDS*. Los Angeles: Roxbury.
- Metts, S., & Fitzpatrick, M. A. (1992). Thinking about safer sex: The risky business of "know your partner" advice. In T. Edgar, M. A. Fitzpatrick, & V. S. Freimuth (Eds.), *AIDS: A communication perspective* (pp. 1–20). Hillsdale, NJ: Lawrence Erlbaum.
- Metts, S., & Spitzberg, B. (1996). Sexual communication in interpersonal contexts: A script-based approach. *Communication Yearbook* 19, 49–91.
- Meyer, I. H., & Dean, L. (1995). Patterns of sexual behavior among young New York City gay men. *AIDS Education and Prevention*, 7 (Suppl.), 13–23.
- Miller, R. L. (1995). Assisting gay men to maintain safer sex: An evaluation of an AIDS service organization's safer sex maintenance program. *AIDS Education and Prevention*, 7 (Suppl.), 48–63.
- Morris, M., Zavisca, J., & Dean, L. (1995). Social and sexual networks: Their role in the spread of HIV/AIDS among young gay men. *AIDS Education and Prevention*, 7 (Suppl.), 24–35.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods*. Newbury Park, CA: Sage.
- Pleck, J. H., Sonenstein, F. L., & Ku, L. C. (1990). Contraceptive attitudes and intention to use condoms in sexually experienced and inexperienced adolescent males. *Journal of Family Issues*, 11, 294–312.
- Quina, K., Harlow, L. L., Morokoff, P. J., Burkholder, G., & Deiter, P. J. (2000). Sexual communication in relationships: When words speak louder than actions. *Sex Roles*, 42, 523–549.
- Report calls for prevention, tracking of U.S. AIDS cases. (2000, November). *The Nation's Health*, p. 7.
- Rickman, R. L., Lodico, M., DiClemente, R. J., Morris, R., Baker, C., & Huscroft, S. (1994). Sexual communication is associated with condom use by sexually active incarcerated adolescents. *Journal of Adolescent Health*, 15, 383–388.

- Sadownick, D. (1996). *Sex between men: An intimate history of the sex lives of gay men postwar to present*. New York: Harper San Francisco.
- Sarver, V. T., Jr. (1983). Ajzen and Fishbein's "Theory of Reasoned Action": A critical assessment. *Journal for the Theory of Social Behavior*, 13, 155-163.
- Sedgwick, E. K. (1991). *Epistemology of the closet*. Berkeley: University of California Press.
- Sheeran, P., & Taylor, S. (1999). Predicting the intentions to use condoms: A meta-analysis and comparison of the theories of reasoned action and planned behavior. *Journal of Applied Psychology*, 29, 1624-1675.
- Shilts, R. (1987). *And the band played on: Politics, people, and the AIDS epidemic*. New York: Penguin.
- Signorile, M. (1997). *Life outside: The Signorile report on gay men: Sex, drugs, muscles, and the passages of life*. New York: Harper Collins.
- Stall, R. (1994). How to lose the fight against AIDS among gay men: Declare victory and leave the field. *British Medical Journal*, 309, 685-686.
- Vaid, U. (1995). *Virtual equality: The mainstreaming of gay and lesbian liberation*. New York: Anchor.
- Valdiserri, R. O., Lyter, D. W., Leviton, L. C., Callahan, C. M., Kingsley, L. A., & Rinaldo, C. R. (1989). AIDS prevention in homosexual and bisexual men: Results of a randomized trial evaluating two risk reduction interventions. *AIDS*, 3, 21-26.
- van der Velde, F. W., van der Pligt, J., & Hookyaas, C. (1992). Risk perception and behavior: Pessimism, realism, and optimism about AIDS-related health behavior. *Psychology and Health*, 6, 23-28.
- Vázquez-Pacheco, R. (2001, June). A code of silence: Gay men, dating, and disclosure. *Body Positive*, pp. 22-26.
- Watters, J. K., & Biernacki, P. (1989). Targeted sampling: Options for the study of hidden and elusive populations. *Social Problems*, 36, 416-430.
- Weinberg, M. S., & Williams, C. J. (1975). Gay baths and the social organization of impersonal sex. *Social Problems*, 23, 124-136.
- Williams, M. L., Elwood, W. N., Weatherby, N. L., Bowen, A. M., Zhao, X., Saunders, L. A., et al. (1996). An assessment of the risks of syphilis and HIV infection among a sample of not-in-treatment drug users in Houston, Texas. *AIDS Care*, 8, 671-682.
- Zimmerman, R. S., & Vernberg, D. (1994). Models of preventive health behavior: Comparison, critique, and meta-analysis. In G. L. Albrecht (Ed.), *Advances in medical sociology: A reconsideration of health behavior change models* (pp. 45-67). Greenwich, CT: JAI.

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