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The Promise of Technology and HIV Prevention: What Have We Learned and What Is on the Horizon?

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Computer-based tools and systems, such as Web-based (Internet) programs, CD-ROM combined with touch-screen kiosks or similar methods, interactive voice response (IVR) technologies, also known as automated telephone disease management, personal data assistants (PDAs) or other hand-held devices, and cell-phone text messaging, have been proliferating globally for at least the last decade.

What is the relevance of this technology proliferation for the field of psychology and AIDS? Along with the widespread dissemination of technology have come numerous attempts to harness the power of the Internet, CD-ROM, and interactive voice technology (delivered via telephone) to effect positive change in health and health behaviors. In this article, we summarize current knowledge about the efficacy of these attempts and describe some areas that require more efforts to evaluate these attempts and others like them.

Current Knowledge About Interventions That Incorporate Technology

The Internet has great potential for public health as a vehicle for education, data collection, and intervention. Recent research on Internet-based, randomized controlled trials shows that interactive, individually tailored computerized interventions can lead to improved health outcomes in several major areas of care, including HIV/AIDS (Gustsafson et al., 1999). For example, HIV-positive patients given access to an interactive, Internet-based program with tailored information and social support reported less distress, greater cognitive function, and fewer and shorter inpatient hospital visits when compared with patients who did not have access to the program (Flately Brennan, 1998).

A number of innovations for HIV and STD prevention using Internet technology are emerging. Although they have yet to be rigorously evaluated, there is some evidence that they are feasible and easy to implement. These innovations are generally being implemented by health departments and AIDS service organizations (ASO) and include interventions such as online partner notification, access to STD testing online, chat-room outreach, self-administered risk assessments with tailored feedback, and use of banner advertising to share HIV and STD related information.

Internet-Based Partner Notification

The process of partner notification is typically conducted by a health department official (called a disease intervention specialist, or DIS) after a patient has been diagnosed with an STD such as syphilis. The DIS elicits names of sex partners and their contact information from the patient and then attempts to contact the partners and bring them to the clinic for testing and any necessary treatment. Many STD programs have begun to adapt traditional, face-

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Director's Letter

John Anderson, PhD

Over the past 10 years, I have witnessed a dramatic rise in the number of private practice clients who present with primary complaints associated with their use of the Internet for sex. Stories vary, but most of my clients with Internet-related problems report that they gradually, and often unwittingly, increased the amount of time they spent on the Internet looking for sex over the course of months or years. For many, time spent on the Internet slowly began to take over their lives, crowding out other activities. They have lost hours or days in semidissociative states while seeking sexual connections through cyberspace.

Over time, sex-seeking Internet use can evolve into a compulsive ritual that blots out uncomfortable feelings and leads to the avoidance of intimacy as emotional needs are increasingly serviced through relatively anonymous encounters. Compulsive use of the Internet for sex can also lead to unsafe sex practices when clients become immersed in a netherworld of "sexual hook-ups" that often seem unreal because they are so split off from normal life. Although this type of insidious pattern clearly does not develop in everyone who uses the Internet for sex, my anecdotal experiences in private practice certainly suggest that the problem is growing.

Until recently, there were no empirical studies to guide our understanding of the Internet, sex, and HIV/AIDS. Questions pertaining to who, what, when, where, and why were unanswered. Practitioners like me were left to our own devices as we struggled to come up with sensible case conceptualizations and effective interventions. Fortunately, the data-free state of affairs has begun to change, thanks to the leadership of researchers like those who have contributed to this issue of *Psychology & AIDS Exchange.*

Special acknowledgment and hearty thanks are due Dr. Jeffrey Parsons of the Hunter College Center for HIV/AIDS Educational Studies and Training, who conceptualized and coordinated the development of this special issue on the Internet, Sex, and HIV/AIDS. Jeff knew the issues, the researchers, and how best to put it all together. Not only that, but Jeff's characteristic sharp wit and hilarious sense of humor, combined with his down-to-earth practicality, made the entire process both fun and efficient. Thank you, Jeff, and thanks to all the authors who graciously contributed their time and effort to make this issue of the newsletter possible.

I hope that you enjoy reading this issue of *Psychology & AIDS Exchange*, and please send me your ideas for future theme-based editions.

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to-face, partner-notification strategies to the Internet. This process can be hampered in health departments where computer access is limited, employees are prohibited from using the Internet, or firewalls prevent access to some online venues. In these cases, health departments have developed innovative relationships with local community-based organizations (CBOs) to assist with online partner-notification efforts.

Online contact can be made through e-mail (frequently, an infected individual in the clinic can identify partners via their online handle or e-mail address; this is then used by the DIS or CBO partner to follow up with the contact). Once online contact is made with a partner, the DIS does not reveal to the contact that she or he has been exposed to a disease at all. Online contacts are told that health department staff have "important health information for you," and they are encouraged to call or visit a local facility. The actual disease is mentioned only on the phone or face-to-face, after the identity of the contact has been verified. Although there is some concern that the "important health information" message may be interpreted as junk e-mail and deleted by the recipient, this is considered an improvement over the alternative of reaching the wrong person with a message that describes syphilis or HIV transmission.

Online Testing

The San Francisco Department of Public Health (SFDPH) has been a leader in many of the innovations for Internet-based STD and HIV prevention and was among the first to offer access to laboratory tests (for syphilis) through the Web. Interested persons can log on to *stdtest.org* to obtain a physician-ordered (and signed) laboratory requisition ("lab slip") and a unique identification number. The lab slip, once printed by the user, can be taken to a number of local laboratories for specimen collection and analysis. When testing is complete, the results are provided to SFDPH, which takes responsibility for posting the results with the identification number on the Web site. While the site has generated interest—with thousands visiting—there were relatively few tests completed (140) in the first 6 months of operation. However, these tests identified six (4.3%) new syphilis infections (four infectious; two latent). Five of these infected patients were gay men. Of the gay men, one was HIV-positive, two were HIV-negative, and two were of unknown HIV serostatus. All infected patients received medical evaluation and treatment (McFarlane, Kachur, Klausner, & Roland, 2005)

A number of innovations for HIV and STD include interventions such as online partner notification, access to STD testing online, chat-room outreach, self-administered risk assessments with tailored feedback, and use of banner advertising to share HIV and STD related information.

Chat-Room Outreach

Chat-room outreach is perhaps the fastest-growing online intervention used by AIDS service organizations, other CBOs, and health departments. Staff frequently log on to chat rooms where sex solicitation is likely to occur (e.g., AOL chat rooms created by members with such names as "miamim4m," "sfm4m," etc.). Individual staff members often create a handle (or nickname) such as "letstalkaboutsex" or "askmeaboutSTD." Staff members create "profiles" (self-descriptions registered with the Internet service provider [ISP]) that explain the purpose of their visit to the chat rooms, the types of questions they can answer, and referral information for testing and treatment.

Sometimes, to establish credibility, a staff member may reveal his or her sexual orientation, race/ethnicity, or other pertinent characteristics. Most of the time, the outreach staff are fairly passive in the chat rooms, except when sending welcome messages to new arrivals. Occasionally, staff will post a brief line such as, "IM [instant message] me for sexual health info." This passivity prevents the chatters from becoming annoyed with the outreach staff, as has occurred in more active efforts. In addition, this passivity is more in line with the requirements of the ISPs who own the chat rooms.

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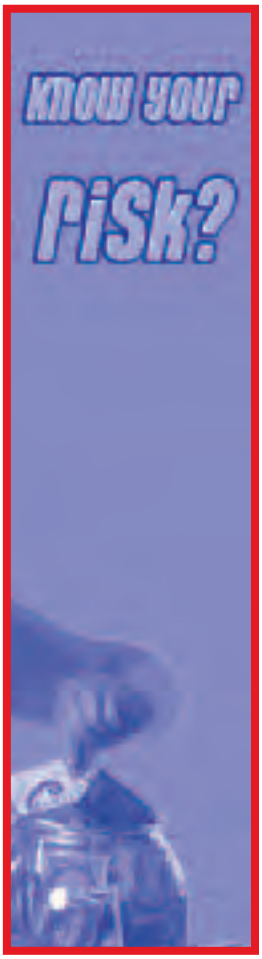
Self-Administered Risk Assessments and Tailored Feedback

Tailoring allows us to make messages relevant to a given demographic or behavioral risk characteristic by asking people to divulge information about themselves before being exposed to an STD prevention message. Preprogrammed algorithms can also be used to provide message content that is relevant to a specific risk behavior. For example, if a participant in an online education intervention completes a survey documenting 12 partners in 12 months, the message about risk could differ from that delivered to a participant who had 3 new partners in 12 months. Different role models, tailored to the user's race/ethnicity, age, and gender, can deliver messages to specific audiences, which facilitates message relevance. This approach has been tried for men who have sex with men (MSM), and although interpretation of the efficacy is strongly limited by methodological challenges to the evaluation, evidence suggests the approach may have efficacy for changing some HIV-related risk behavior (Bull, McFarlane, Lloyd, & Rietmeijer, 2004).



Banner Advertisements

Banner advertisements are analogous to billboards, in that they are generally rectangular advertisements, often approximately 1–2 inches high and 3–5 inches wide or larger, placed in high-"traffic" areas of the Internet. Clicking on a banner advertisement results in a transfer to the Web page of the advertiser's specification. One advantage of banner ads over traditional billboards is the ability to target advertising more effectively. For example, running a banner ad aimed at southern MSM in gay-oriented Web venues is potentially more efficient than placing a billboard along southern highways.

Banner advertisements can be used as stand-alone interventions—for example, as a brief appeal to viewers to test for STD. They can also be used to direct individuals to a particular Web site, where another intervention can be implemented (e.g., information sharing, online testing information, or self-administered risk assessments with tailored feedback). Some Internet researchers have used banner advertisements to encourage people to enroll in online studies related to HIV prevention (see examples of banners shown in this article). In San Francisco, SFDPH conducted an online banner-advertising campaign on *gay.com* and on AOL to promote their Web page. Nine separate advertisements were run, for a total of over 33 million impressions. The advertisements yielded 32,270 clicks to SFDPH Web sites that provide syphilis information (for a click-through rate of 0.1%). The cost per click-through ranged from $0.05 to $10, depending on the host site and ad placement.

Alternatives to the Internet

Ritterband and colleagues (2003) recently reviewed 12 Internet-based randomized intervention studies and offered strong evidence that Internet interventions are feasible and can be effective. Included in the review were interventions for weight loss, headaches, stress, and diabetes. Similarly, the use of CD-ROM has been shown to have an impact on health behaviors: A study of a highly interactive CD-ROM program for persons with type 2 diabetes demonstrated that the program contributed to increased levels of physical activity among users (King et al., 2006). Interactive voice response (IVR) uses computer-based telephone systems to call, receive calls, provide information, and collect data from users. A study of the technology used by the Department of Veterans Affairs to promote better self-management of diabetes demonstrated that individuals used the system and regularly reported their medical data by means of IVR technology (Piette, McPhee, Weinberger, Mah, & Kraemer, 1999).

New Innovations

We have seen relatively more evaluations of Internet-based methods for health promotion than other methods—at least within the field of HIV prevention. There are, however, other new innovations that are appealing and that should be considered for HIV prevention. For example, a recent study of the effect of cell-phone text-messaging on smoking behaviors among college students showed that it reduced smoking (Obermayer, Riley, Asif, & Jean-Mary, 2004). With the advent of streaming video, now available on cell phones and PDAs, it is possible to deliver brief prevention messages in an education-entertainment format.

Chat-room outreach is perhaps the fastest-growing online intervention used by AIDS service organizations, other community-based organizations, and health departments.

Another approach to the use of technology is through the use of games for HIV prevention. Game development can require sophisticated—and expensive—programming that is likely to be beyond the scope of health department, ASO, and CBO budgets. An alternative would be the development of very brief, lower tech games that can focus on a single message (e.g., "know your status" or "ask your partner their status"). For example, a simple graphic of a board game might be used, in which the computer rolls the dice and a game piece moves

along a board. If it lands on a square naming a "safe" behavior, the player is rewarded with points. If it lands on a square naming a "risky" behavior, the player loses points. Although gaming technology is incredibly advanced, even the simplest incarnation of a game can be an effective teaching tool.

Beyond the Internet and Cell Phones

In an effort to keep rapid pace with an ever-changing technological environment, we may have forgotten some existing technologies that can still work to prevent HIV and that might be more appropriate for some audiences:

- Substantial evidence demonstrates the efficacy of a **peer-role-modeling** approach to preventing HIV (Centers for Disease Control [CDC], 1999).
- This publication recently devoted an entire article to discussion of the MARCH (Modeling and Reinforcement to Combat HIV/AIDS) project. MARCH is a CDC-funded endeavor that emphasizes the use of **education entertainment**—largely by using radio serial dramas—to promote awareness of HIV and positive attitudes and norms toward prevention measures (Galavotti, Pappas-DeLuca, & Lansky, 2001).
- **Television** is still a very powerful educational medium that provides interesting ways in which to have an effect on norms and attitudes regarding factors relevant to HIV prevention (e.g., stigma, gender roles, substance use). The MARCH program has shown promise for the use of **radio** as well.
- Evidence points to the efficacy of **social marketing** through messages on buses, billboards, bus shelters, and in bathroom stalls that use marketing techniques to "sell" prevention behaviors.

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Methodological Issues and Challenges in Internet-Related Surveillance and Intervention for HIV Prevention:
What Have We Learned and What Is on the Horizon?

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Scientists have devoted substantial time and money in the past decade to evaluating the efficacy of technology-based interventions. It has become apparent that there are substantial methodological challenges—related to sampling, technology access, testing intervention efficacy, and delivering interventions to the right people—in the evaluation of technology-based interventions.

Sampling

In implementing interventions on the Internet, we have yet to identify rigorous methods for determining a sampling frame. We can—and have—recruited very large samples to complete studies online (Bull, McFarlane, & Rietmeijer, 2001; Rhodes, DiClemente, Cecil, Hergenrather, & Lee, 2002), but determining who those samples represent is challenging. Researchers have shown that those enrolled in their online studies tend to be White and well educated (Bull et al., 2001), and although this is not exclusively the case, it does bring up concerns that online interventions may miss the opportunity to target those at highest risk, particularly when considering HIV-prevention interventions.

How can we determine the best places to intervene with online populations? Some of our interventions may be hampered by administrative protocols of Internet service providers (ISPs), such as America Online (AOL). AOL has policies in place that limit the sexual explicitness of language that can be used in banner advertising. However, more "acceptable" language could limit the appeal of an advertisement or the veracity of advertising to promote an online intervention. AOL also has strict limits on the use of chat rooms for anything other than informal conversations, so attempts to conduct outreach in AOL chat rooms can quickly be thwarted. If a chatter reports an outreach worker to AOL, the company will freeze the account on the grounds that their policies have been violated.

We can choose to intervene using ISPs that are welcoming, but this may not effectively reach an intended audience. For example, *gay.com* has historically been open, supportive, and even encouraging of HIV prevention efforts online. They have allowed more explicit banner advertisements, offered discounts to health departments, and agreed to post HIV prevention information on their site. *Manhunt.net* has offered extended collaborations, allowing health departments to conduct partner notification and outreach using their site. However, for those interventions targeting heterosexuals or youth, *gay.com* and *manhunt.net* may not be the best sites for intervention implementation. Our challenge is to find a balance and to identify sites that will reach our target audience while being open to public health efforts for HIV prevention. This can only be accomplished by public–private partnerships that encourage ISP and Web site owners to allow public health program planners to gain access to the relevant population.

Our experience is that this young adult, low-income, inner-city population is much more comfortable with cell phones and text messages than with the Internet, and our intention is to consider more appropriate technologies to reach this group.

Technology Access

Regardless of the oft-cited data implying that the "digital divide" is shrinking, we still face a paradox with the Internet: Those persons who are at elevated risk due to socioeconomic status have less access to, familiarity with, or ease of use of the Internet compared with other groups. To reach a population with limited access to the Internet or limited computer literacy, program planners should consider either making access more available to these groups or taking other approaches to reaching them. For example, in our own ongoing study examining the efficacy of a self-administered risk assessment with tailored feedback online, we are working with clinics throughout the Denver metropolitan area to recruit youth. Participants complete the Internet-based intervention using kiosks placed in waiting rooms. Despite the availability of kiosks and lists of other places where Internet access is available for free, this population does not tend to return to the Web site for follow-up assessment.

All in all, anecdotal reports from our participants suggest that although they will use the Internet and know where they can do so for free, they have not incorporated its use consistently

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enough in their daily lives to make an online intervention relevant. This is largely because they do not have a computer with Internet access at home or at work. Our experience is that this young adult, low-income, inner-city population is much more comfortable with cell phones and text messages than with the Internet, and our intention is to consider more appropriate technologies to reach this group.

Efficacy of Interventions

In the previous article, we described some current innovations online, including online partner notification, online testing, chat-room outreach, self-administered risk assessments with tailored feedback, and banner advertising. Although many of these efforts are indeed innovative, few if any have substantial data to support their efficacy. We need better systems—described in more detail below—to identify rapid evaluation procedures for these interventions. These methods will allow us to remain on the cutting edge of innovation for technology-based HIV prevention.

Real-time interactivity is a component unique to computer technologies—persons can plug in information about their behaviors, for example, and instantly receive tailored, personalized feedback.

For example, if community-based organizations and health departments spend a substantial amount of their limited resources on conducting chat-room-based outreach for HIV prevention and yet this doesn't result in more testing, reduced risk behavior, or some other measurable effect, it becomes an intervention that will be difficult to justify. These are similar to challenges in testing the efficacy of other technology-based interventions (e.g., CD-ROM). Although there is certainly an appeal to developing a stand-alone, easy-to-use intervention that can be packaged nicely on a disc, there are substantial development costs to creating a CD-ROM. Once created, researchers face issues similar to those faced online—will there be enough available computer equipment and mechanisms to disseminate HIV/STD-prevention CD-ROMs to effectively target those at highest risk?

We may be held back by limitations in the way we have conceived interventions incorporating technology. Many research articles on technology examine the efficacy of one single mode (e.g., CD-ROM or Internet) instead of considering the utility of multimodal approaches to the delivery of health messages. Our theories have not regularly capitalized on the social–ecological perspective. That is, we have not considered that it may be useful to view technology not as a stand-alone intervention to promote healthy sexual behavior but rather as a way to reinforce messages received in other forms. For example, we have recently seen articles that discuss the utility of combining partner notification with text messaging (Tomnay, Pitts, & Fairly, 2005); another example used e-mail effectively to reinforce weight-loss counseling (Tate, Wing, & Winette, 2001).

Finally, it is not clear that we are reaching the potential of new technologies to effect changes in risk behaviors. A recent review of Web sites devoted to providing information about diabetes prevention and management revealed that few sites took advantage of interactive capabilities, tailoring, or the opportunity to use social support online (Bull, Gaglio, McKay, & Glasgow, 2005). In fact, the majority of the sites were devoted to creating an online version of informational brochures. To the extent that technologies simply transfer other interventions to a new medium, we are not really tapping into new potential.

Real-time interactivity is a component unique to computer technologies—persons can plug in information about their behaviors, for example, and instantly receive tailored, personalized feedback. Thus, something demonstrated to change behaviors when used in print materials now has the added advantage of instant feedback (Kreuter & Strecher, 1995; Lipkus, Lyna, & Rimer, 1999). Real-time social support—24 hours a day, seven days a week—is a feature that has not been tested in evaluations of new technologies. Researchers have shown that men frequently solicit sex partners online (Bull et al., 2001; Bull, Lloyd, Rietmeijer, & McFarlane, 2004), and many anecdotal reports indicate that HIV prevention organizations are using chat rooms to deliver safer sex information. However, there is no scientific evidence that this approach (a) reaches those at risk, (b) changes their risk behavior, or (c) is more effective than face-to-face efforts to prevent HIV.

Are We Reaching Whom We Think We Are?

While some of the innovative interventions being tried online are indeed reaching whom they are intended to reach (e.g., chat-room outreach to men in M4M rooms online), it may be that some efforts reach individuals who are intentionally duplicitous online. A recent example from our own work (testing our self-administered risk assessment with tailored feedback among an online sample) illustrates this point. Persons interested not in the intervention but rather in the

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$35 incentive for study participation have identified all study-eligibility criteria, despite efforts to mask them. Most frequently we have identified persons much older than the targeted age range of 18–24 who have lied about their age in order to participate. Other participants have attempted to enroll multiple times, creating multiple e-mail addresses to thwart the system. Other research has shown that lying online is commonplace. Program planners may need to consider this a common hazard of online interventions and either decide to offer interventions regardless of who people say they are or institute strict protocols requiring disclosure of substantial personal information (e.g., credit card number, social security number) if the integrity and nonduplication of individuals in a program is a priority.

The Technology and Science Paradox: How to Produce Good Science and Not Get Left Behind in the Fast-Paced Information Age

One critical consideration in this discussion is the role of rigorous research in testing the efficacy of technology interventions. The pace of introduction of new technologies is rapid; scientific testing of efficacy traditionally has not been. We need to harness the potential of technology, not only to develop new and innovative interventions but to develop new and faster ways of evaluating them. We have within our power the capability of standardizing certain measures and sharing data so that we can avoid costly and frequently duplicative efforts for surveillance. We can simplify data collection by using PDAs and audio-computer-assisted survey instrumentation (CASI) and Internet-based data-collection more standard in field settings. We need to extend our scientific dialogue to include discussion of how much information about efficacy is enough and to focus our efforts on dissemination of effective interventions.

Ultimately, we have to avoid getting bogged down in a sophisticated and elegant research design that may show efficacy for an intervention—several years after its popularity has waned and the public is warming to a new innovation. If researchers could streamline their evaluations to be fast-paced assessments of "what works"—as has been accomplished for other interventions in the face of emerging epidemics—we would be better prepared to adopt and disseminate effective programs quickly. This is our best hope of staying perhaps further ahead of new infections and acquisitions than we are today.

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Cyber-Based Education and Referral for MSM (CyBER/M4M)

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Scott Rhodes and his research team. Left to right: Rochelle Muse, Scott Rhodes, Reggie McCall, and Jesse Duncan.

The Internet and Sexual Risk

Traditionally, HIV educational efforts targeting gay men and men who have sex with men (MSM) have focused on physical spaces where these men meet other men, including bars and discos, bathhouses, cruising areas, and social groups and clubs (Hospers, Harterink, Van Den Hoek, & Veenstra, 2002). With the rapid increase in the use of the Internet as a place to interact without risk of negative social consequence, the number of men who use HTML (hypertext markup language) chat rooms for both social and sexual networking continues to expand (Rhodes, 2004). Thus, new opportunities exist to reach at-risk individuals for prevention intervention using the Internet.

Data suggest that gay men and MSM who use the Internet are different from men who meet one another in traditional physical spaces (Hospers et al., 2002; Koch & Schockman, 1998; Rhodes, Bowie, & Hergenrather, 2003; Rhodes, DiClemente, Cecil, Hergenrather, & Yee, 2002; Ross, Tikkanen, & Mansson, 2000). Online MSM are more likely to report bisexual behaviors, unprotected anal intercourse (Rhodes et al., 2002), and a history of sexually transmitted diseases (Rhodes et al., 2002). Additionally, online MSM may not follow aggregate trends of Internet access and use as defined by a concept known as the "digital divide" (Hospers et al., 2002; Koch & Schockman, 1998; Rhodes et al., 2002, 2003). The digital divide suggests that in the United States, younger, more educated, higher income White men have greater access to the Internet (U.S. Government Working Group on Electronic Commerce, 2000). This assumption is changing as the number of individuals online increases, and studies of gay and bisexual populations suggest that Web users from these populations include a higher proportion of less educated, lower income, unemployed, and disabled individuals (Koch & Schockman, 1998; Rhodes et al., 2003; Ross et al., 2000).

Because of the increased use of chat rooms by gay men and MSM for social and sexual networking and the evidence that men online are at increased risk for HIV exposure and transmission through their risk behaviors, health departments, community-based organizations (CBOs), and AIDS service organizations (ASOs) in North America and Europe have begun to experiment with providing HIV/AIDS education via MSM-oriented chat rooms (Rhodes, Hergenrather, Wilkin, Alegria-Ortega, & Montano, 2006). However, the efficacy of these intervention approaches is largely unknown (McFarlane, Ross, & Elford, 2004; Rhodes, 2004; Rietmeijer, Bull, McFarlane, Patnaik, & Douglas, 2003).

In this article, we describe our own experiences with the development and implementation of an HIV prevention intervention known as *Cyber-Based Education and Referral for MSM (CyBER/M4M)* that is currently being implemented within geographically oriented chat rooms in central North Carolina.

How Do Chat Rooms Function?

A chat room is a channel of synchronous dialogue between computer users who are connected through a network of computers. On their computers, chatters can type messages that are transferred almost instantaneously by the server to the other chatters within the chat room. Thus, users are able to talk to each other "in real time." This speed differentiates chat-room dialogue from asynchronous computer-mediated communication methods such as electronic-mailing lists and newsgroups (Leaning, 1998; Rhodes et al., 2003).

There are public rooms in which written dialogue is seen by all chatters who are logged on in the room. Depending on the host (e.g., AOL, gay.com, yahoo), up to 100 chatters may be in a chat room at one time. Chatters also may communicate to one another using instant messages (IM), in which only the designated chatter receives the message. This is often used for private detailed and ongoing discussions between chatters.

CyBER M4M: A Chat-Room–Based Intervention

Because more in-depth research is needed to understand the potential for harnessing the Internet to prevent HIV exposure and transmission, we are currently pilot-testing a chat-room-based HIV/AIDS intervention known as Cyber-Based Education and Referral for MSM (CyBER/M4M). This study was designed and is being implemented and evaluated by a community–university partnership that includes representatives from a local ASO, Wake Forest University School of Medicine, and the University of North Carolina Center for AIDS Research. Since the mid-1980s, the host ASO has been the area's leading provider of comprehensive case management, support services, prevention education, and direct financial assistance to individuals living with HIV/AIDS and their families in a statistical metropolitan area in the southeastern United States with nearly 1.5 million residents.

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CyBER/M4M educators are trained to serve as online health advisors, popular opinion leaders (Kelly et al., 1992), and community advocates. They enter geographically oriented chat rooms to increase awareness and knowledge of HIV/AIDS; provide online education and support; facilitate access to local resources; encourage HIV counseling and testing; assist chatters in making informed decisions about their sexual health; provide healthy social and sexual options; recommend harm reduction techniques; apply peer-counseling and prevention-management strategies; and strengthen the safer sex norms within the online community.

CyBER/M4M educators work within the established norms of the online community and strive to be viewed as insiders and not as "sex police." The CyBER/M4M educators are openly self-identified gay men and particularly knowledgeable about local gay and MSM communities, including non-self-identifying MSM who may have girlfriends or female spouses.

Upon entering the chat room, CyBER/M4M educators announce their purpose and availability to answer questions and provide referrals about HIV and AIDS in a general message in the public chat room, using triggers such as "In the room to answer questions about HIV and AIDS"; "I can answer questions about HIV and AIDS"; "Want to get tested for HIV? I can help"; "I am here as a resource for HIV/AIDS support"; "Want to talk about sex?"; and "Need condoms? I can tell you where to get them." The CyBER/M4M educators do not privately IM other chatters; rather, a CyBER/M4M educator only engages in a private one-on-one chat if the chat-

Sample Chat From CyBER/M4M

(Note: SexDaRiteWay is the CyBER/M4M educator)

sportsguy85 (8:16:46 p.m.): sup how are you doin

sportsguy85 (8:16:53 p.m.): this is sportsguy85 we talked before

SexDaRiteWay (8:17:52 p.m.): Hey

sportsguy85 (8:18:11 p.m.): how r u

SexDaRiteWay (8:18:18 p.m.): I'm doing good

sportsguy85 (8:18:35 p.m.): thats good

sportsguy85 (8:18:42 p.m.): got some questions for you

SexDaRiteWay (8:18:54 p.m.): OK

sportsguy85 (8:19:08 p.m.): you said you were an educator of stds and hiv

SexDaRiteWay (8:19:44 p.m.): I try

sportsguy85 (8:20:46 p.m.): i was talking with some friends the other night and someone said that they had a substance on the end of their private part it was kinda yellow and thick

sportsguy85 (8:20:54 p.m.): what could that be

SexDaRiteWay (8:22:50 p.m.): Hello?

SexDaRiteWay (8:23:06 p.m.): Hey sorry my computer is acting strange tonight

SexDaRiteWay (8:23:08 p.m.): Still with me?

sportsguy85 (8:23:29 p.m.): yeah

sportsguy85 (8:23:30 p.m.): im here

sportsguy85 (8:23:35 p.m.): did you get my messages

SexDaRiteWay (8:23:50 p.m.): thick yellow substance from his penis?

sportsguy85 (8:23:54 p.m.): yeah and it hurts when he pees

SexDaRiteWay (8:25:01 p.m.): I'm not a doctor and can't give a definite diagnosis, but the symptoms sound like gonorrhea

SexDaRiteWay (8:25:12 p.m.): I recommend he go get checked out

sportsguy85 (8:25:45 p.m.): thats what i told him but i wasnt sure

sportsguy85 (8:25:51 p.m.): is it curable or what

SexDaRiteWay (8:26:01 p.m.): Yes it's curable but he should be careful. He should do what the doctor or nurse tells him. He won't be able to have sex for awhile

sportsguy85 (8:26:16 p.m.): i'm not too knowledgeable about it but how do you get it

SexDaRiteWay (8:26:57 p.m.): And he should always use condoms during vaginal, anal, or oral sex

SexDaRiteWay (8:27:15 p.m.): Likely to have been unprotected

sportsguy85 (8:27:29 p.m.): so someone who could have given him oral gave it to him

sportsguy85 (8:27:31 p.m.): ?

SexDaRiteWay (8:27:52 p.m.): It's possible. Does he have a dr. or someplace to go?

SexDaRiteWay (8:28:12 p.m.): You there?

sportsguy85 (8:26:16 p.m.): here

sportsguy85 (8:26:21 p.m.): sorry man what did you say?

SexDaRiteWay (8:26:54 p.m.): No problem. Do you think your friend has somewhere to go get tested and treated?

sportsguy85 (8:27:19 p.m.): where can he go around here?

ter initiates the dialogue. This policy was established to respect the priorities of the chatters in the chat room. Some chatters are angered by being singled out, distracted from their social and/or sexual networking, or assumed to be appropriate targets for risk reduction.

As opinion leaders, CyBER/M4M educators assert safer sex norms and reframe risky norms. As one CyBER/M4M educator shared during a debriefing:

> *I have to help establish safer sex norms. Some men need to know, they need to hear, that it is ok to take care of themselves. That it is ok to risk rejection for saying they want their partner to use a condom. I help them and tell them what I'd do if a man I met online said I should use a condom with him. It helps. People always think the worst but the worst doesn't happen that often. I help them find a level of self-respect . . . no, they respect themselves, I just remind them and help them practice what they'll say.*

As community activists, CyBER/M4M educators take information and perspectives back to the research team about the intervention and about what is going on the community. For example, CyBER/M4M educators report on what they hear about community counseling and testing sites from chatters. They may advocate for changes in the counseling and testing protocol or suggest ways in which a site can become friendlier to gay men and MSM in order to increase client trust. This has been especially important, as chatters tend to report higher rates of sex with both men and women (Rhodes et al., 2002). The CyBER/M4M educators offer insight about potential barriers to risk reduction and about how to move beyond individual-level changes to more community and environmental changes.

With the rapid increase in the use of the Internet as a place to interact without risk of negative social consequence, the number of men who use HTML chat rooms for both social and sexual networking continues to expand. Thus, new opportunities exist to reach at-risk individuals for prevention intervention using the Internet.

Brief Description of CyBER/M4M Research Procedures

A cohort of chat-room intervention participants (i.e., chatters) was recruited for the study and asked to complete a Web-based assessment that evaluates knowledge, attitudes, and behavior. Chat-room dialogue will be collected and analyzed over time to identify and understand strengths and weaknesses of this Internet-based intervention approach.

CyBER/M4M educators completed 16 hours of training by professional trainers experienced in HIV/AIDS context, theories of behavior change, communication, and research methods. Demographic data from each chatter are abstracted from user "bio lines" and "profiles." Although the creation of a bio line is not necessary in order to participate in the chat room, most chatters have one. The bio line may describe a chatter's personal characteristics (e.g., "46 y[ear] o[ld], wh[ite], athletic man") or his purpose in the chat room (e.g., "Here to chat—no hook-ups"). In addition to bio lines, many chatters also create profiles that are responses to standard closed and open-ended questions. The standard questions are created by the host of the chat room. These profiles include such characteristics as gender; geographic location; relationship status; sexual orientation; HIV status; what the chatter is seeking online (action/sex, conversation, friendship, love/relationship, roommate, or travel companion); ethnicity; and level of "outness" about one's sexual orientation. All bio lines and profiles of chatters who are online during the data collection periods are printed for data entry.

Lessons Learned

A variety of lessons have been learned during the development and implementation of CyBER/M4M:

- During debriefing sessions to assess intervention progress, CyBER/M4M educators have identified the need to implement the intervention 24 hours a day because different types of chatters are online at different times, and many chatters tend to have regular times that they are online. Thus, CyBER/M4M has benefited from reaching out at all hours, not just evening hours when the rooms tend to be most active. This is particularly important because CyBER/M4M educators have found that chats that occur later at night (e.g., after 11 p.m.) tend to be geared more toward sexual networking, while chats at other times seem to have longer periods of discussion before moving toward discussions of sex.
- It also may be that in terms of their risky behaviors, chatters who engage with the CyBER/M4M educators to discuss HIV and sexually transmitted diseases may be different from those who do not. CyBER/M4M educators contend that chatters who chat with them are less at risk. Data to compare chatters who do and do not engage with an educator are being collected in a supplementary study.
- CyBER/M4M educators seem to benefit from changing their profiles over time. Although chat-room profiles are often sexually explicit, the profiles of CyBER/M4M educators accurately represent their role. Although titillating (but "G-rated") photographs were used in creating CyBER/M4M educators' profiles, it was important that the photographs changed over time in order to continue to spark interest from chatters. The CyBER/M4M educators have been particularly adept at maintaining a positive reputation within the chat room. They are careful not be seen as harassing chatters or disturbing the priorities of chatters in the chat room; however, this has been challenging.

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CyBER/M4M educators may have missed potential educational opportunities to ensure that chatters did not complain about the intervention.

- Although CyBER/M4M educators are very familiar with chat rooms and strive to interact within community norms, the effect of being trained to serve as an official CyBER/M4M educator may be that one can no longer truly be an "insider." CyBER/M4M educators generally have different objectives than other chatters. This is a challenge often identified in approaches that train community members to reach their peers; after community members are trained, they may no longer reflect their community.

CyBER/M4M educators work within the established norms of the online community and strive to be viewed as insiders and not as "sex police." The CyBER/M4M educators are openly self-identified gay men and particularly knowledgeable about local gay and MSM communities, including non-self-identifying MSM who may have girlfriends or female spouses.

- CyBER/M4M has fluctuated between having the educators work out of their homes and out of the office of the host ASO. Given the late hours in which the intervention has been implemented, it made sense to have the educators work from home. However, at various intervals, the educators have come into the office for intervention delivery, and this process of working together as a team seems to offer the social support that has been identified as key to natural helper and peer leader approaches. Thus, although an advantage to online interventions is that these types of interventions can be implemented from any location, there may be an advantage to having educators and interventionists work out of a CBO, ASO, or health department office.

Conclusions

Communication via Internet chat rooms may offer a potential mechanism to deliver tailored interventions to communities that may not be available in traditional intervention approaches. The HIV/AIDS epidemic has evolved over the years, and HIV/AIDS prevention efforts must evolve as well. The goal of CyBER/M4M is to find prevention models that enhance the effectiveness of public health efforts to prevent HIV infection transmission. Further research is clearly needed. This study provides initial guidance and insight into the development, implementation, and evaluation on a chat-room-based HIV/AIDS prevention intervention.

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Using Internet Chat Rooms to Recruit Hispanic MSM Into HIV-Related Research Studies:
Lessons Learned

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While the perception of the Internet as a place of risk has been established, less focus has been placed on the use of the Internet as a positive force in prevention research. Because of its large volume of users from diverse backgrounds, the Internet is a powerful recruitment tool for HIV prevention research. Although use of the Internet as a vehicle for HIV research is increasing, its viability as a tool to recruit at-risk populations to participate in community-based HIV studies is still being tested. In this article we describe procedures developed and used in our National Institute on Drug Abuse (NIDA) funded study on the effectiveness and cost of Internet versus face-to-face strategies for recruiting men—in particular, Hispanic men who have sex with men (HMSM) who use drugs and have risky sex—to participate in research studies, referred to as Party&Play.

When we first planned our research study, we intended to post attractive banners on targeted Internet Web sites to advertise the study. The banners would then link through to our study Web site, which would then provide more information about the project. Our initial focus groups and qualitative interviews conducted for the purpose of prepiloting the recruitment plan led us to a complete project overhaul; most men agreed that they routinely ignored banner advertisements and that directly approaching men within the chat rooms would be a better way to establish a connection that could lead to a successful recruiting event.

The pilot participants also explained that given the environmental features of Internet chat rooms, gaining the attention of chatters would be challenging; they stressed that the initial approach of the chatter must be "quick," "witty," and "engaging." They cautioned that "what you say" and "how you say it" matters. They also stressed the importance of having some type of picture associated with the profile; many even stated they had a "no pic, no click" rule for engaging chatters. Interestingly, there was less agreement about the relative importance of profiles in engaging chatters; many men expressed skepticism regarding the veracity of much information included in profiles.

The Behavioral Health team at work.

After consulting with our community partners and our institutional review board (IRB), we constructed a model engagement dialogue, drafted three fictitious profiles of Hispanic men modeled after profiles posted on Internet sites, generated a list of 10 screen names (e.g., *dragon, dancingqueen, lionkingtop, wapo, r-a-w*), and selected six public domain pictures to use as profile images (three were color abstract images and three were non-sexually-explicit images of men). The pilot revealed that chatters could indeed be successfully engaged in conversation, that the abstract images were more appealing than the images of men, and that screen names were relatively unimportant. The pilot also revealed the necessity of having a separate study Web site that would increase the credibility and legitimacy of our study. After the formative groups, interviews, and initial pilot testing, we finalized our Internet recruitment procedures and began the IRB approval process.

We encountered a number of challenges in the process of gaining the approval of the IRB. The IRB process proved to be a long one, in which many concerns over recruitment on the Internet in general were raised, and at one point a university provost requested a temporary hold of IRB approval pending his personal review. The provost had asked us to maintain logs of a subset of chats in which we were engaged, but we had reservations regarding the legality of doing so. However, university attorneys determined that logging chat transcripts was legal, and we thus modified our own procedures to record a systematic subset of chats.

The IRB expressed particular concern over the potential use of images of men (i.e., the public domain images of men) who were not members of our staff; therefore, we elected to use nonidentifi-

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able pictures of our own staff to remove any trace of deception. The IRB was also concerned that our recruitment staff might click on a potential participant's profiles and learn about him—including, potentially, his identity—in this indirect manner. A strict guideline of "no profile viewing" was added to our recruitment procedures to circumvent this issue. In addition, the IRB was interested in the member agreements of the chat rooms we would be using to ensure we were not violating any guidelines set forth by the chat rooms themselves. The IRB also requested that we not reveal our university affiliation when we engaged in the dialogues.

The following procedures represent the end product of a true collaboration between our study team and the IRB to construct a mutually agreeable set of recruitment procedures. For the formal recruitment phase of our study, we adapted time and space sampling procedures (Stueve, O'Donnell, Duran, San Doval, & Blome, 2001; Valleroy et al., 2000) for use in Internet chat rooms. Internet venues were randomly selected from the universe of potential venues that cater to HMSM. For each venue, we specified "peak" and "off-peak" periods and randomly selected sampling events (days and blocks of time when recruitment occurred) from these periods. Following the monthly schedule of sampling events, two experienced male researchers entered the preselected chat room, using an approved screen name, profile, and image (see Figures 1 and 2 for examples). Using systematic sampling methods, staff approached every fifth screen name on the line list and initiated the engagement dialogue. The IRB-approved recruitment script consisted of five parts:

- Introduction (e.g, "Hi" or "What's up?")
- Preliminary screen (e.g., "Are you Hispanic?" "Do you live in Miami?")
- Consent to proceed (e.g., "We are doing a study, would you like to learn more?)
- Study description ("This is a study about gay Hispanic men . . .")
- Procedures for enrollment (e.g., "We have two sites where you can participate: South Beach and South Miami")

All interested and preliminarily eligible individuals were referred to the project Web site (see Figure 3) and invited to visit either of our community sites for full screening and enrollment. For every chatter engaged in dialogue, staff recorded the chatter's screen name, time of interaction, chat room, screen name used by researcher who initiated the approach (investigator or chatter), whether the chatter visited the project Web site while chatting, and any general comments (e.g., "not Hispanic" etc.).

Participants then presented at one of our two community field offices, located in South Beach and south central Miami. Our community sites were open from 12:00 noon to 10:00 p.m. Wednesdays through Sundays. Chatters who presented at the community sites were screened for eligibility and, if eligible, were invited to participate after a full explanation of the study procedures. For an individual to be enrolled into Party&Play, we used six inclusion criteria: (a) self-identifies as Hispanic or Latino; (b) has had sex with a man in the last 5 years; (c) is 18 years of age or older; (d) resides in South Florida; (e) has been directly approached by our staff on the Internet or face-to-face; and (f) came to one of our two community assessment sites to complete an audio computer-assisted self-interview. To verify that participants had been directly approached by our staff, we asked each potential participant to provide the screen name that had been used during the initial chat in which he was approached.

Using these procedures, we successfully recruited 294 men from Internet chat rooms during 4 months of active recruiting; total recruitment time was 443 staff hours. We found that individuals recruited online were more likely to be bisexual and more likely to be HIV seropositive, implying that the Internet offers additional access to these hidden subpopulations within the MSM community.

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Figure 1. *Sample abstract art profile image.*

Figure 2. *Sample project staff profile image.*

Figure 3. *Home page of the project.*

The Internet and Sexual Compulsivity Among Gay and Bisexual Men:

Instant, Effective, and Often Problematic

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Sexual Compulsivity (SC) is characterized by sexual fantasies and behaviors that increase in frequency and intensity so as to interfere with personal, interpersonal, or vocational pursuits (Black, 1998). The prevalence of SC in the United States is estimated to be 3-6% (Carnes, 1991; Coleman, 1992a, 1992b), with significantly higher incidences among men (Dodge, Reece, Cole, & Sandfort, 2004; Gullette & Lyons, 2005). It has also been suggested that rates of SC are significantly higher specifically among gay and bisexual men (Cooper, Delmonico, & Burg, 2000).

Researchers investigating SC among gay and bisexual men have consistently identified a link between SC and risky sexual behavior (Benotsch, Kalichman, & Kelly, 1999; Kalichman & Rompa, 1995, 2001). Likewise, many researchers have identified links between the Internet and sexual risk behaviors (Chiasson et al., 2006; Liau, Millett, & Marks, 2006), but some findings have been mixed. Little is known about the intersection between SC and the Internet among men who have sex with men (MSM).

Between 2002 and 2003, the research team at the Center for HIV Educational Studies and Training (CHEST), as part of the program entitled Project SPIN (see Figure 1), interviewed 180 gay and bisexual men (19-63 years of age) with symptoms of SC about how the Internet intersected their lives and behaviors. Several themes associated with Internet use and SC were identified, and we describe those themes in the following sections. The quotes used in the following sections illustrate themes that have emerged among multiple participants.

Connecting the Internet to SC

In the opening of our interviews, men were asked about periods in their lives when they have had difficulty controlling sexual impulses and behaviors. In some cases, this onset was immediately connected to the Internet:

> *Well like the Internet, I think for a lot of people [it] has changed the ability to find sex. And I think I spend a lot of time on the Internet and there are more opportunities to have sex. I don't jump at every opportunity, and I try to be responsible; but that was one of the main reasons. (Participant 6229)*

> *Well, I think this [my SC] probably started back in 1999. It's when I first got a computer and very slowly but surely discovered the Internet. I found I was spending a lot of time on that. And after a while, it doesn't even feel like, I'm not even thinking about the process, the thought process. . . . It's just automatic, and I'll just get up, or I'll turn on the computer and start looking. . . . And I think in the beginning, I didn't really think of it as a problem. But it was just something new and different, and some sort of experimentation, a different way of doing things. But I think as time went on, it grew a little bit more gradually, and then with the . . . [loss of my job], there was more time, I found that it was definitely really becoming a bigger problem. (Participant 6249)*

Both of the men who are quoted above describe the novelty of the Internet as a medium through which to find sex partners. For the first individual, it has become the primary modality to meet sex partners, and for both men, it had become the outlet through which problems associated with their SC emerged and were facilitated.

In addition to connecting the Internet to the onset of their SC, a few men identified how the Internet endangered physical health (a component of SC):

> *I was handling the two things in my life very poorly. I started using the Internet a lot. I became much less discriminant [sic] about who and where I'd have sex with. (Participant 6191)*

> *I would spend way too much time thinking about sex, or on the Internet, or hooking up with someone than what I should be doing. And I end up jeopardizing my health because I'm not getting proper rest or things like that. (Participant 6329)*

This first participant indicated he was less discriminating about the partners he met online. The second identified a physical health risk associated with his Internet use, but not a sexual one. Admittedly, these negative consequences discussed could have been attributed more to SC than to the medium which was used to enact it (i.e., the Internet). Nevertheless, the Internet was the conduit.

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Loss of Time Conceptualized as a Problem

Many participants described their problems in terms of the amount of time devoted to online activities. Others more broadly described how they felt a distorted (or lost) sense of time while online.

Explicit mention of time lost

> *It's not necessarily the act [using the Internet to meet sex partners] that bothers me, it's the time wasted. It's like wasting 4 hours for like a 20-minute [sexual] encounter with someone. It's like, "Alright that was a big waste of my afternoon," when I could have been writing or reading or doing something for my job. (Participant 6007)*

> *I go to very different sites like M4M4Sex.com or Gaydar.com and I started to meet a lot of guys and have a lot of sex. A lot of group sex, a lot of parties. . . . Well, it takes a lot of my time. (Participant 6176)*

When describing how his SC interfered with his life, another participant indicated:

> *I spend more and more time at it [online], and basically because it's a problem—you know it's not like, a lot of people in twelve-step programs, and I imagine people you have seen [among men you are interviewing], you know have a sexual compulsivity problem where they feel they're endangering their life or something, their health and stuff like that, and that's not an issue for me. I just feel like I'm wasting a lot of time [online]. (Participant 6345)*

Implicit mention of time lost

Not all men specifically used the word *time* to describe a problem resulting from Internet use but rather discussed how their Internet use inhibited them from participating in other activities:

> *Well I think if I have my computer on all day even if I am not at home, and then when I get home I immediately log on the computer. Because I could be at the gym, I could be at a friend's house, I could be writing or doing other things. (Participant 6229)*

> *I could be doing a lot more stuff right now. I could be looking for more jobs right now than I am. [Instead] I've been cruising the [Inter]net for sex. (Participant 6248)*

> *I'd be doing this [online] when I know I have to get to class or something like that . . . and I would show up at class late because I was looking at porn on the Internet or chatting with somebody on the Internet, knowing that I had to go to class. (Participant 6354)*

Although these participants did not specifically cite the amount of time involved in online activity as being a problem, they juxtaposed their Internet use in reference to other, perceivably more important, activities.

Figure 1. *Sample of Project SPIN participant recruitment card.*

Distorted sense of time

Some men described the Internet in terms of an "addiction"—they couldn't pull themselves away from their computer once online. One participant indicated he often overcooked his dinner, while another indicated having neglected walking his dog. Although cognizant of important activities needing attention, these individuals were aware of a sense of time lost or distorted once in the virtual world of the Internet:

> *I find myself going to that [my e-mail] first now, and before I know it, I've been on there for two hours or so. (Participant 6035)*

> *There are times when I've been like, "It's 10:00, I've got to get offline! One more instant message." "It's midnight!" "Oh my God, it's 2:30 in the morning!" (Participant 6109)*

Strategies to Reduce Internet Use

In an effort to prevent some of the negative consequences associated with their Internet use, some men identified rules they created for themselves. The most common initiatives taken to reduce negative consequences involved limiting the amount of time spent online:

> *I would say I am not going to spend more than 2 hours. If I sat down at the computer at 10 a.m., I'd say, "By hook or by crook, I will be through with this adventure or off the computer by noon." (Participant 6090)*

Another method of limiting Internet use included making multiple user accounts, with different accounts for different purposes. With this tactic, men divided their Internet use into sexual and nonsexual virtual spaces:

> *I had my "real" screen name for them [my friends/family] and the alternate [screen name] that I would use [for sex]. So I just try to stick to my "real" one and then I'll talk to my friends and stuff like that. (Participant 6052)*

I have two accounts. I made a rule to not go on the account that I specifically use for meeting people [for sex]. (Participant 6126)

One individual asked his partner to assist in limiting Internet use by changing passwords to Web sites and e-mail accounts believed to be at the root of the problem:

I asked my boyfriend to change the password on one AOL account that I was using a lot, and I put my own password, which was kind of silly because I know the password. But I put it on two sites, one site that was particularly problematic for me, so that every time the page loaded, I would have to type in a password. So it sort of became kind of a pain in the neck. (Participant 6230)

Many men recognized that some of these rules may not be entirely effective in preventing problems associated with their Internet use or that these rules might be difficult to adhere to:

I would say, "I'd go on the Internet twice this week," when it winds up being 5 to 10 times. (Participant 6007)

I would say to myself, "Okay, I'm only going to be online for 10 or 15 minutes." I would look at the little clock and then totally violate the rule. (Participant 6230)

For men who felt unable to abide by their rules, the Internet was implicitly framed in terms of an addiction. In addition to this framing, some men described negative feelings similar to a sense of withdrawal when they lost or reduced their Internet use. The following two men both described feelings of loss, longing, and even stress when, not by their own choice, their computer use was restricted:

I guess I have some kind of like Internet addiction. . . . One time my computer was being repaired. I was just, it felt weird. . . . First I, I couldn't check e-mails or whatever. I, it's like losing a cell phone or like losing an appointment planner book or whatever. I just felt naked. . . . I didn't know what to do with my time. . . . I always had to do something else to kind of get my mind away. (Participant 6162)

Right now my computer is in the shop for repair and when they told me I wouldn't have it for 10 days that was a little, I sort of felt like I was coming home to a black hole, not being able to come home and get on that computer right away or turn it on when I wake up in the morning . . . a little bit like my candy's been taken away and, there's not much I can do about it. So that's stressful in that sense. But in terms of like when I don't participate in these behaviors or try not to, and in all honesty I feel better. I don't feel . . . worse. It's just a matter of getting to that point where I'll actually do it and put it down or whatever. (Participant 6064)

In addition to describing negative feelings as a result of not having access to his computer, Participant 6064 indicated that a point exists when these negative feelings subside. Specifically, a sense of personal locus of control was tied to these feelings of conquering his problems related to Internet use.

Comparing/Contrasting the Internet to Other Venues

Many men discussed the Internet by comparing and contrasting it to other venues for meeting sex partners (i.e., gay bars/clubs, bathhouses, via public cruising). Some men described positive aspects of using the Internet over other venues, while some men explicitly preferred other venues to the Internet.

Advantages of the Internet as a venue

Some men identified the Internet as an alternative to other social spaces to meet friends and find sex partners, such as gay bars, clubs, bathhouses, or the gym. These men indicated positive aspects of using the Internet, such as ease of finding partners, personal safety, and avoidance of undesirable social/physical settings:

Usually the Internet was the easiest way to do it [meet sex partners]. I never really liked [gay] clubs. I hate cigarette smoke. I hate that whole cliquish attitude. But on the Internet, it's like, "It's as easy as pressing the 'enter' button." (Participant 6062)

I'd say it's [my compulsive sexual behavior] probably better now than it was 5 years ago . . . because the advent of the Internet, not needing to resort to the public restroom as I did when I was a teenager or a cruise area like I did when I was in my early twenties, or in an adult book store like I did in my late twenties. . . . Now it's primarily on the Internet, yeah. (Participant 6385)

For one individual, the Internet was used as a tool to reduce both his SC behaviors and the number of sex partners:

Yeah, because I would only have sex with one person. If I went online, whereas opposed to the bathhouse, I'd try to get off at least three times. (Participant 6122)

These men illustrated how the Internet has become a resource for meeting partners. They specifically contrasted the Internet to other venues, citing the benefits of the Internet. In addition to mentioning the increased ease of finding sex, the latter two men (Participants 6385 and 6122) implicitly identified ways in which the Internet was a medium to increase safety, either by reducing the number of sexual partners (which has been linked to risk for HIV) or avoiding physical hazards more common to public cruising (e.g., assault, robbery).

Another participant echoed this theme:

Either I stop off like in a park, you know, and have an anonymous encounter. Or, cruise online for an anonymous encounter. . . . If I'm on the Internet, time is spent fantasizing, and not acting on it. Sometimes I feel that, like that's enough. That's enough to satisfy it [my sexual drive]. (Participant 6095)

Implicit in his argument is how cybersex on the Internet has become a medium to channel some of his sexual behaviors, including SC behaviors.

When probed about the anonymous nature of meeting partners from the Internet, one participant indicated how the

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Internet was not anonymous, as he was able to obtain more detailed information from partners (i.e., "interviewing") than was typically gained from more discrete methods of communication in other venues, such as public cruising:

> *I don't consider it [meeting partners via the Internet] to be anonymous because I think that you establish some sort of communication with them, and you sort of talk to them before you meet. . . . You're interviewing each other—your likes, your dislikes—you switch a picture, and then you meet, you talk a little bit. I'm always cautious. I always ask about someone's sexual history and they ask me. Anonymous to me seems, you know you'll be on a train and then you'll see somebody cruising you, and then they follow you, and they take you to a corner or something, and then they'll have sex with you. So I haven't done that. (Participant 6249)*

The disadvantages of the Internet as a venue

A few men did report more negative consequences of the Internet when compared with other venues for meeting sex partners:

> *I go to bath[house]s or I just go online. But I really don't like online, because I had very awful experiences with people online. If you go to a bath . . . you may see the person, and you can look [at his] behavior, and you feel comfortable with the way he speaks and the way he moves. . . . Many people online, they have very—I'm not saying that I don't have them, but they have really bad, about 80%, emotional issues. Like establishing healthy relationships with people. Even just to have sex. So, the experience that I have with it [the Internet] . . . shuts me down. (Participant 6092)*

> *I don't pick people up from the [Inter]net because I think that, "I've tried this before," and usually they lie with their picture . . . or send a picture of what they looked like 30 years ago. (Participant 6133)*

Although these types of discussions were in the minority, these men illustrated how there is an ambiguous and impersonal nature to the Internet, and this increases the ease with which potential partners can misrepresent themselves. This included falsifying information such as physical attributes, psychosocial well-being, and age.

Closing Remarks

Most research on MSM and the Internet has focused on sexual risk behavior(s). Research highlighting the positive aspects and harm reduction potential(s) of the Internet is largely absent. While referencing the Internet to other venues for sex partners, men often implicitly identified the harm reduction benefits of the Internet such as (a) having fewer partners via the Internet, (b) interviewing potential partners prior to sex, (c) no longer having to use venues that might be more physically dangerous (e.g., public cruising), and (d) avoiding social environments that were thought to be undesirable (e.g., cliquish bars).

By and large, men did not connect the Internet to sexual risk behavior. Some connections could be drawn by happenstance (i.e., "I'm less discriminant [sic] about who and where I have sex"); however, men did not indicate that the Internet was leading them into unsafe sexual behavior. In many circumstances, negative consequences associated with Internet use were explicitly related to the loss of time that could have been devoted to other activities. Negative physical health consequences were discussed (i.e., lack of sleep); however, these consequences (as with the loss of time) could be a result of the behaviors associated with SC (Black, 1998; Kafka & Prentky, 1994; Muench & Parsons, 2004) and not necessarily the medium through which they are enacted. Other venues such as bathhouses or public cruising could have resulted in similar negative consequences related to the loss of time.

Those who identified negative consequences resulting from their Internet use discussed tactics to reduce or gain control of this problem. Most often, this included simply reducing the amount of time online, while others took further steps, such as dividing their Internet use between sexual and nonsexual virtual spaces. Admittedly, men identified how these tactics may have been ineffective in resolving their problems. This is not to say these tactics overall were ineffective, as this could largely have been related specifically to the men we interviewed.

The benefits of the Internet as a tool to improve the lives of sexually marginalized individuals have not been widely explored. Clinicians working with sexually active MSM should consider exploring both the benefits and risks of Internet use as a resource for finding sex. Further, they should consider exploring ways in which to encourage men to engage in strategies that might reduce physical and/or sexual risk if they use the Internet to find sex partners

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MEETING THE **HIV PREVENTION** NEEDS OF YOUNG MEN WHO HAVE SEX WITH MEN

Hank Tomlinson, PhD
Director, APA Healthy Lesbian, Gay and Bisexual Students Project

Young men who have sex with men (YMSM) are the largest group of young people infected with HIV. Although only 6% of males report ever having had a same-sex sexual encounter—defined as oral or anal sex—during their lifetime (Mosher, Chandra, & Jones, 2005), YMSM account for 76% of all HIV infections reported among young men between the ages of 13 and 24 from 2001 to 2005 in the 33 states that had name-based HIV infection reporting. HIV infections among YMSM during that 5-year period make up 48% of all cases reported among 13- to 24-year-olds (Centers for Disease Control and Prevention [CDC], 2007).

Put in different terms, the proportion of YMSM who are infected with HIV is astonishingly high. Data collected in the 1990s as part of the Young Men's Survey suggested that 7% of YMSM between the ages of 15 and 22 in seven major cities were HIV-positive (CDC, 2001). Data collected more recently indicate that the epidemic's disproportionate impact on YMSM continues to worsen. Among 18- to 24-year-old YMSM participating in the first wave of the National HIV Behavioral Surveillance System in 2004 and 2005, 14% were HIV-positive (CDC, 2005). In the 33 states with name-based reporting for HIV, the numbers of infections among YMSM between the ages of 13 and 24 increased at an average rate of 10% per year between 1999 and 2003, or a total of 48% over the 5-year period (Rangel, Gavin, Reed, Fowler, & Lee, 2006). The magnitude of that increase is reminiscent of the early years of the epidemic and has created alarm among public health and prevention professionals.

Addressing the HIV prevention needs of YMSM presents a number of challenges—determining how and in what settings YMSM can be identified, deciding who bears responsibility for HIV education and prevention (parents, schools, peers, or community members), considering how participation in prevention programs can be encouraged in light of stigma and competing cultural norms, working sensitively in political systems or environments that my be hostile to programs perceived as supporting gay youth, and acquiring the resources necessary for sustained efforts.

The American Psychological Association (APA) works to reduce HIV infection among YMSM through its Healthy Lesbian, Gay and Bisexual Students Project (HLGBSP). Housed in the Public Interest Directorate's Office of Lesbian, Gay, Bisexual, and Transgender Concerns, the HLGBSP was begun in 1998 and has been continuously funded since 1999 by the CDC's Division of Adolescent and School Health (CDC–DASH).

Hank Tomlinson, PhD

In May 2005, the HLGBSP entered into a new 5-year, $1.6 million cooperative agreement with DASH. The award funds the project's efforts to build the capacity of the nation's schools and youth-serving organizations to improve health and mental health outcomes for lesbian, gay, and bisexual youth. The HLGBSP takes the position that HIV prevention efforts that focus too narrowly on behavioral risks without consideration of the broader context in which those risks develop are likely to achieve limited success. As such, the project works on multiple levels—by strengthening individual HIV prevention interventions and by improving the broader psychosocial environment for lesbian, gay, bisexual, and questioning (LGBQ) youth.

The HLGBSP works to build the capacity of youth-serving organizations across the country to provide HIV-prevention professional development to education agencies.

The HLGBSP focuses its work in three main areas:

- First, the HLGBSP works to build the capacity of youth-serving organizations across the country to provide HIV-prevention professional development to education agencies. The target population for this professional development is school-based counselors, nurses, psychologists, and social workers, and its purpose is to increase their capacity to prevent HIV among lesbian, gay, and bisexual adolescents, as well as among other young people who desire or engage in same-sex sexual behavior. The HLGBSP has sought long-term partnerships with education agencies in areas of high prevalence (e.g., San Diego Unified School District, District of Columbia Public Schools, and the North Carolina Department of Public Instruction) and is cultivating collaborations among those agencies and local HIV and LGBT community organizations.

  The project has committed to providing long-term support for those collaborations to improve their HIV-prevention professional development for health and mental health

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providers. To date, the HLGBSP has sponsored APA's CDC-cleared workshop, Preventing Health Risks and Promoting Healthy Outcomes Among LGBQ Youth: A Training Workshop for School Counselors, Nurses, Psychologists, and Social Workers (Sawyer, Porter, Lehman, Anderson, & Anderson, 2006) 40 times, reaching an audience of 1,100 school professionals. Education agencies and their collaborating partners will host annual workshops led by members of the project's national training cadre and will also receive ongoing support to develop their own cadre of local trainers.

In the 33 states with name-based reporting for HIV, the numbers of infections among YMSM between the ages of 13 and 24 increased at an average rate of 10% per year between 1999 and 2003, or a total of 48% over the 5-year period. . . . The magnitude of that increase is reminiscent of the early years of the epidemic and has created alarm among public health and prevention professionals.

- Second, the HLGBSP aims to strengthen the capacity of youth-serving organizations to prevent HIV among LGBQ youth by establishing linkages with HIV-prevention experts. In partnership with APA's Office on AIDS, project staff members identify and work with a pool of Behavioral and Social Scientist Volunteers (BSSVs) to provide technical assistance to youth-serving organizations seeking to develop or enhance their HIV-prevention programs for LGBQ youth. The HLGBSP solicits requests for capacity-building assistance from LGBQ-focused and mainstream community-based and nonprofit youth-serving organizations. APA facilitates, supports, monitors, and evaluates the technical assistance linkages between youth-serving organizations and technical assistance experts.
- Finally, the HLGBSP is in the process of developing and disseminating resources that increase the capacity of youth-serving organizations to prevent HIV among young men who have sex with men (YMSM). These resources are being developed through a substantive needs-assessment process that is based on a deliberative review of the scientific literature, key informant interviews, and a survey of organizations that serve—or aspire to serve—lesbian, gay, and bisexual youth, particularly African American and Latino youth.

The coordination of efforts between APA's Offices on AIDS and Lesbian, Gay, Bisexual, and Transgender Concerns has produced a program with a rare combination of offerings. We can think of no other program that is funded by CDC to work at the national level with both schools and community-based organizations to reduce HIV infections among YMSM. With infection rates among YMSM expected to continue to increase, the application of psychological science and knowledge in service of HIV prevention remains desperately needed.

For more information about the project, please visit the HLGBSP Web site at *http://apa.org/pi/hlgbsp/* or contact Dr. Hank Tomlinson at htomlinson@apa.org.

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A Close-Up View of Health Policy Process and Content

Susan E. Walch, PhD
William A. Bailey Health and Behavior Congressional Fellow


Susan E. Walch, PhD

For the 2006–2007 academic year, I have been serving as APA's William A. Bailey Health and Behavior Congressional Fellow. In memoriam to William Bailey, a ground-breaking psychologist–advocate for HIV/AIDS who was instrumental in the original enactment of the Ryan White CARE Act, this fellowship offers psychologists a chance to spend a year working on public policy relevant to health and behavior, with an emphasis on HIV/AIDS.

The Bailey Fellowship offers a one-year, hands-on, feet-first plunge into health policy. It is a unique opportunity for early career psychologists or professionals in transition who want to integrate psychological science and public policy as a career. It is also an incredible learning opportunity for mid-career and seasoned psychologists to expand their knowledge of public policy and the fascinating social processes that drive it. It will test you and challenge many assumptions. In spite of some frustration resulting from bureaucratic delays and holdups, you will gain a new respect for the process. However, if you are looking to avoid change or growth, this fellowship is not for you!

The Bailey Fellowship offers a one-year, hands-on, feet-first plunge into health policy. It is a unique opportunity for early career psychologists or professionals in transition who want to integrate psychological science and public policy as a career. It is also an incredible learning opportunity for mid-career and seasoned psychologists. . . . It will test you and challenge many assumptions.

As an academic psychologist who has been involved in HIV/AIDS prevention, care, research, and technical assistance to community-based organizations, I found myself drawn to this opportunity for several years before I actually applied. Finding it impossible to divorce my professional activities from the public policy context that influenced them so strongly, I had a desire to learn more about how such policies were developed and implemented. The fellowship opportunity floated in the back of my consciousness for several years while I worked hard to serve my local and regional community, develop my scholarly endeavors, and acquire tenure at my university. When I was approved for my first sabbatical leave for a full academic year, I found my chance to broaden my understanding of health policy by applying for the fellowship.

The fellowship is a year-long placement in Washington, DC, in a congressional office. Fellows have the opportunity to work as legislative staffers in either the U.S. Senate or the U.S. House of Representatives in either a congressional committee office or the personal office of a member of Congress. These appointments are mutually determined between fellows and the congressional offices they approach. I have spent my fellowship placement in the office of Representative Jan Schakowsky (D-IL-9), a progressive Democrat and member of the Health Subcommittee of the House Energy and Commerce Committee, one of the few House committees with jurisdiction over health policy. I selected a House member's office because I wanted to be exposed to a broader public policy portfolio than that which might be offered in a committee office or a Senate member's office.

In my fellowship placement, I have had the ability to focus on health policy while getting some exposure to other policy areas (such as education, human rights, science and technology, and even agriculture policy). I have worked extensively on the Microbicide Development Act, the reauthorization of the State Children's Health Insurance Program (SCHIP), and Medicaid. In addition, I have handled a variety of mental health, health insurance, drug safety, and Medicare issues. Although the Ryan White CARE Act reauthorization was virtually finished by the time I started my fellowship, I have been involved in the beginnings of the reauthorization of the President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fight Against HIV/AIDS, Tuberculosis, and Malaria.

In my capacity as a fellow, I engage in most of the professional responsibilities of a legislative staffer. I track health policy legislation by attending staff meetings and briefings and reviewing legislation, policy briefs, and other sources. I filter information for Rep. Schakowsky and help to keep her apprised of policy issues in my area. I provide her with memos and briefs and other materials to assist her in her role during congressional hearings, floor statements, and speeches. I attend congressional hearings and mark-ups. I communicate with experts in the field and constituents from the district I serve. I meet with individual activists and lobbyists from large and small organizations. I participate in and closely observe the political process as it relates to health policy (and other important policy areas, like the war in Iraq).

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The American Psychological Association

Invites Applications for the 2008–2009

William A. Bailey Health and Behavior Congressional Fellowship

PROGRAM: *The American Psychological Association (APA) and the American Psychological Foundation (APF) established the William A. Bailey Congressional Fellowship in 1995 in tribute to Bill Bailey's tireless advocacy on behalf of psychological research, training, and services related to AIDS. Fellows spend one year working as a special legislative assistant on the staff of a member of Congress or congressional committee. Activities may involve conducting legislative or oversight work, assisting in congressional hearings and debates, and preparing briefs and writing speeches. Fellows also attend an 8-day orientation program on congressional and executive branch operations, which includes guidance in the congressional placement process and a year-long seminar series on science and public policy issues. These aspects of the program are administered by the American Association for the Advancement of Science for the APA Fellows and those sponsored by over two dozen other professional societies.*

PURPOSE: *To provide psychologists with interests in health and behavior issues, including HIV/AIDS, health disparities, and lesbian, gay, bisexual, and transgender health issues, with an invaluable public policy learning experience, to contribute to the more effective use of psychological knowledge in government, and to broaden awareness about the value of psychology-government interaction among psychologists and within the federal government.*

CRITERIA: *A prospective Fellow must demonstrate competence in scientific and/or professional psychology related to health and behavior issues, such as HIV/AIDS. Fellows must also demonstrate sensitivity toward policy issues and have a strong interest in applying psychological knowledge to the solution of societal problems. Fellows must be able to work quickly and communicate effectively on a wide variety of topics, and be able to work cooperatively with individuals having diverse viewpoints. An applicant must be a psychologist, a member of APA, and have a doctorate in psychology or related field, with a minimum of 2 years of experience postdoctorate preferred. An applicant also must be a U.S. citizen.*

AWARD: *APA will sponsor one Fellow for a one-year appointment beginning September 1, 2008. The Fellowship stipend ranges from $60,000 to $75,000, depending upon years of experience postdoctorate. Up to $3,500 is allocated for relocation to the Washington, DC, area and for travel expenses during the year. An additional monthly stipend of $350 is provided for health insurance and/or other Fellowship-related expenses. Final selection of the Fellow will be made in early spring 2008.*

APPLICATION: *Interested psychologists should submit the following materials by January 4, 2008: (1) a completed APA Congressional Fellowship Application coversheet, available on the APA Fellowship Web site at www.apa.org/ppo/fellows/coversheet.pdf; (2) a detailed vita providing information about educational background, professional employment and activities, professional publications and presentations, public policy and legislative experience, and committee and advisory group appointments; (3) a statement of approximately 1,000 words addressing the applicant's interests in the Fellowship, career goals, contributions the applicant believes he or she can make as a psychologist to the legislative process, and what the applicant wants to learn from the experience; and (4) three letters of reference specifically addressing the applicant's ability to work on Capitol Hill as a special legislative assistant.*

Application materials should be sent to Congressional Fellowship Program, American Psychological Association, Public Interest Directorate, Government Relations Office, 750 First Street, NE, Washington, DC 20002-4242. For additional information about the application process, please contact the APA Government Relations Office at 202.336.5935 or mhaskell-hoehl@apa.org or visit the APA Public Policy Web site at www.apa.org/ppo/fellows.

William A. (Bill) Bailey championed HIV/AIDS and lesbian, gay, and bisexual policy issues for the APA as a staffer in the Public Policy Office. Among his many accomplishments, Bailey oversaw the development of a major report on behavioral and social sciences and the HIV/AIDS epidemic for the National Commission on AIDS; participated in the planning of an APA training program for psychologists who serve HIV-infected clients; facilitated the development of the AIDS community prevention programs supported by the Centers for Disease Control and Prevention; forged collaboration between several government agencies to support the HIV/AIDS mental health services demonstration program; and successfully advocated for National Institute of Mental Health funding for research on anti-gay violence. An openly gay man who died from AIDS at the young age of 34, his legacy is one of great personal and professional strength.

FEATURED PROGRAMS ON HIV/AIDS AT THE 2007 APA CONVENTION

Symposium

Cutting Edge International Approaches to HIV/AIDS

Sponsored by Division 38

August 18, 2007
8:00–9:50 a.m.
Moscone Center, Room 2011

Cochairs

Janet St. Lawrence, PhD, Mississippi State University

John Anderson, PhD, American Psychological Association End-of-Life Training Project

Participants

Jeffrey D. Fisher, PhD, University of Connecticut

Li Li, PhD, UCLA Semel Institute—Center for Community Health

Jeffrey A. Kelly, PhD, Medical College of Wisconsin

Stephen L. Schensul, PhD, University of Connecticut School of Medicine

Discussant

Willo Pequegnat, PhD, National Institute of Mental Health

International HIV/AIDS research presents an opportunity to test the efficacy of behavior change prevention programs in new settings using both behavioral and biological outcomes and to assess the contribution of culture to our assumptions about human behavior.

This symposium presents four models of collaborative international research that have been successful. The goals of this symposium are to (a) review and evaluate four AIDS prevention research studies conducted in China, Eastern Europe, India, and South Africa; (b) identify the steps in the collaborative process that span setting, culture, and research focus (male sexuality, social networks, stigma and discrimination, adherence to medical regimens); (c) identify innovative methodological solutions to the design, data collection and sampling, and analytical and ethical problems in international research; (d) suggest promising future prevention research directions for psychologists; and (e) address the role of international research in improving the U.S. public health system.

There will be four presentations from senior prevention scientists. The first presenter will discuss results of a culturally-based intervention model to reduce sexual risk behavior in married men in urban India. The second presenter will describe the conceptualization, conduct, and outcomes of a randomized trial of a social-network-level HIV prevention conducted in high-risk populations in Russia and other Eastern European countries. The third presenter will discuss findings from a study in China of HIV-related stigma and discrimination in the health-care setting and its impact on the well-being of HIV-infected patients. The fourth presenter will review findings from a modification of the Options Project in South Africa, which is focused on enhancing medical adherence. The discussant has extensive experience in adapting models of behavior change interventions to international settings and will address the contributions of each presentation to achieving the goals of the symposium.

Continuing Education Workshop (4 hours)

Ethical Issues and HIV Mental Health Services

Sponsored by the APA Continuing Education Committee

August 20, 2007
8:00–11:50 a.m.
Hilton San Francisco Hotel, Room 21

Leaders

Maureen E. Lyon, PhD, Children's National Medical Center

John Anderson, PhD, American Psychological Association Office on AIDS

This intermediate, experiential, skill-building workshop is designed to teach mental health service practitioners how to use a systematic decision-making process model for dealing with ethical challenges posed by clients with HIV/AIDS. The model used in this workshop is based on key ethical and legal concepts that apply to all practice situations. The model requires clinicians to analyze cases from a variety of perspectives while carefully documenting each step of analysis. The model serves to reduce impulsive judgments that frequently occur when therapists feel pressured to act quickly because they fear the possibility of HIV transmission or lawsuits. It also helps to sharpen thinking and clarify both diagnostic and treatment issues because it requires clinicians to perform separate, sequenced analyses. The workshop covers the model in detail, emphasizing what is to be done at each step, why each step is important, and the ways in which each step is based on key concepts from practice, ethics, and research literatures.

Behavioral and Social Science Volunteer Program Update

Duane Wilkerson, MPH, MDiv, BSSV Program Director

The APA Office on AIDS Behavioral and Social Science Volunteer (BSSV) Program, funded by the Centers for Disease Control and Prevention (CDC), provides technical assistance for HIV prevention to community-based organizations (CBOs), HIV Prevention Community Planning Groups (CPGs), and health departments (HDs). Funding comes from the Division of HIV/AIDS Prevention (DHAP), a division within the National Center for HIV, STD, and TB Prevention (NCHSTP). CDC loves acronyms!

Since 1996, the BSSV Program has been funded by CDC through a subcontract with other agencies (i.e., the Academy for Educational Development, ASPEN Corporation, and ORC/Macro). As of October 2006, the program is funded through a direct contract with CDC—no subcontracts, yeah! This is an important and exciting difference, as it saves additional operating expenses that can be used for providing technical assistance. The elimination of subcontracts also provides the flexibility of allowing program staff to work more closely with the capacity-building branch of DHAP.

Technical assistance is accomplished by linking local, behavioral, and social scientist volunteers (BSSVs) with a requesting agency. Currently, the BSSV network includes over 250 volunteer scientists representing a wide range of disciplines (e.g., psychology, sociology, public health, anthropology, social work, etc.). Examples of common types of technical assistance provided by BSSVs include development of pre–post evaluation questionnaires, development of needs assessment questionnaires, and adaptation of evidence-based interventions to ethnically and culturally diverse target populations.

One of the newer areas of technical assistance for the BSSV Program involves supporting CDC's national effort to disseminate and train local community agencies in adapting and implementing particular evidence-based HIV prevention interventions associated with the Diffusion of Effective Behavioral Interventions (DEBI) Program (I told you CDC loves acronyms!). CDC currently has packaged 13 DEBI interventions, and more are being produced all the time. CBOs are invited to attend trainings on the DEBI interventions at various locations throughout the country, where they receive packaged implementation curricula free of charge.

The primary role of BSSVs in the DEBI Program is that of "coach" for four specific DEBI interventions: Healthy Relationships, SISTA!, Community Promise, and VOICES/VOCES (see www.effectiveinterventions.org for details). As a coach, a BSSV is available to a local CBO when the CBO is considering whether a particular DEBI intervention is appropriate for the agency and the local target populations it serves. After CBO staff decide to work with a particular DEBI and are trained by CDC to deliver it, a BSSV works with them as they adapt it and implement it in their community. In the past 4 years, over 125 BSSVs have completed a Trainer of Coaches course for at least one of the four DEBIs.

Beginning in fall 2006, the BSSV Program began to offer DEBI coaching courses through a distance learning approach using Web-based software that allows for real-time interaction. This program, called Web-Ex, integrates phone conferencing with a Web-based presentation using a shared desktop. Fourteen BSSVs completed a Healthy Relationships training consisting of four, 2-hour sessions, and 11 BSSVs completed a VOICES/VOCES training consisting of three, 2-hour sessions. The curriculum packets, which consisted of the Intervention Manual, TA [Technical Assistance] Guide, and various other tools and documents depending on the DEBI, were shipped to the participants. For example, included in the VOICES/VOCES packet is a penile model, a bag of different condoms (including the female condom), and a large condom poster. BSSVs were required to thoroughly review all the curriculum materials ahead of time and turn in homework assignments, due before each session of the training. BSSVs reported in their evaluations that this format worked remarkably well.The majority of BSSVs agreed that they felt capable of providing coaching on the intervention.

The BSSV Program has seen an increase in requests for technical assistance fom CPGs. The most frequent request is for help in developing a tool and a process for prioritizing at-risk populations. Recently, one of our BSSVs developed a 6-hour training that leads CPGs through the process of identifying and weighting critical factors needed to evaluate HIV risk. This training was originally conducted for the CPGs in Washington, DC.

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David DeVito,
HOPE Program Training Director

HOPE
HIV OFFICE FOR PSYCHOLOGY EDUCATION

David P. DeVito, Training Director

Christopher Rowe Salazar, Former
HOPE Program Training Director

Changes in HOPE Administration—and Not Missing a Beat

In May 2007, Christopher Rowe Salazar resigned as the training director of the HIV Office for Psychology Education (HOPE) Program to pursue other opportunities. We are grateful for Christopher's more than 8 years of dedication to the HOPE Program. Under his direction, HOPE hosted three National Training Conferences (NTCs), expanded its training modules, and welcomed more than 100 new trainers. We wish him well!

After Christopher's departure, I assumed the role of HOPE Program training director. Previously, I had served as the HOPE Program administrative coordinator from April 2002 until August 2006 while I worked on my master's degree in public administration, which I obtained from George Washington University in May 2006.

To help keep things rolling, the Office on AIDS' own Gwendolyn (Tina) Wolridge has stepped in to help interview our trainers about their upcoming training activities and make sure that the HOPE database is up-to-date. Many of our HOPE trainers may already know Tina from our most recent NTC, where she acted as a site coordinator, or as the first voice you hear when you call the main number of the APA Office on AIDS (202-336-6042). The HOPE Program is really glad to have her on board.

After the National Training Conference, Smooth Sailing at HOPE

In January 2006, the HOPE Program hosted its fifth NTC, in Memphis, TN. HOPE welcomed 49 new trainers, who joined 41 veteran trainers at the 3-day event. Veteran trainers have called it the best training yet, and new trainers reported that it was the best training event they had ever experienced!

New and updated training modules were distributed to new trainers at the NTC. These modules can easily be downloaded via our Web site: www.apa.org/pi/aids/hopemanual.html. New trainers participated in intensive study of the modules and peer teach-back exercises.

Veteran HOPE trainers participated in workshops such as HIV and Loss; Gay Men, Club Drugs, and Motivational Interviewing; and African American Men Who Have Sex With Men and Women. Plenary sessions included HIV Neuropsychology Assessment and Treatment Update; Current & Pipeline Treatment Updates: HIV Treatments and Adherence; and HIV & Women. In addition, HOPE trainers participated in clinical case consultations and training networking sessions.

Can a HOPE Trainer Help You?

Originally funded in October 1991 by a 3-year contract with the Center for Mental Health Services (CMHS), the HOPE Program created and pilot tested seven, 7-hour continuing education curricula on effective mental health service delivery for persons infected with, and affected by, HIV disease. Since then, the HOPE Program, using its train-the-trainer model, has trained more than 450 volunteer trainers, nearly 220 of whom are still active. To date, HOPE Program trainers have provided HIV/AIDS–related mental health training programs to more than 26,000 psychologists and other mental health professionals around the country.

Are you interested in having a HOPE trainer provide training to your staff or students? HOPE training workshops are designed to be highly interactive, and they include didactic presentations, facilitated discussions, and skills-building exercises. To locate a HOPE trainer in your area, please contact us at the telephone number and e-mail at the end of this article.

Learn More About HIV Treatment and Adherence While Receiving CEUs

We encourage you to check out our interactive, online APA Continuing Education (CE) course, "HIV Treatment and Adherence: What Psychologists Need to Know About HIV/AIDS Treatment and Helping Clients Deal With Medication Decision Making and Treatment Adherence." It is available 24 hours a day to any and all with Internet access. This course contains reading materials, short multimedia clips, and a test. The goal of this CE offering is to provide psychologists and other mental health professionals with the necessary knowledge base to better address HIV treatment complexities, HIV treatment decisions, and medication adherence issues that HIV-seropositive and AIDS-diagnosed clients commonly face. Successful completion will provide you with 4 CE credits. A CE certificate may be downloaded and printed immediately upon completion. You may view and

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Subsequently, it has been used by other BSSVs in Alaska and Puerto Rico.

As the face of HIV/AIDS changes over the years, the BSSV Program has changed to meet the needs of those conducting HIV prevention planning and programming. One of the implications of this change has been the need to restructure the staffing for the program. The most difficult change was the need to close the associate director's position in September 2006. Unfortunately, this meant we had to say goodbye to Dr. Robin Kelley, who has been with the BSSV Program since 1999. Dr. Kelley was an outstanding ambassador for APA and the BSSV Program. She was loved and respected by all. She was a strong and positive influence with CDC and our technical assistance and capacity-building colleagues across the United States.

Finally, I want to introduce to you our new graduate intern for this contract year, Sarah Neiderer, who will be with us until at least December 31, 2007. Sarah is an MPH student who is in her second year at George Washington University. Her duties include doing data analysis on the linkage evaluations and coordinating the evaluation procedures that are done after the completion of a linkage (e.g., a technical assistance task done by a BSSV). Sarah follows our first graduate intern, Meg Lafontaine, who recently completed her MPH work and was hired by CDC as a fellow in their Global AIDS Program.

The BSSV Program is always looking for new volunteers, particularly in geographical areas of the country where there are none or only a few. If you want to learn more about the BSSV Program—and what it means to be a volunteer—please contact me at 877.754.1404 (toll free) or send me an e-mail at *dwilkerson10@comcast.net.*

Close-Up, continued from page 21

Involvement in the process of health policy has offered expertise that is quite distinct from the content of health policy (and is hugely valuable in understanding the political context of our professional endeavors). I have been able to observe first hand and participate actively in the process. I have witnessed the great numbers of people, from different backgrounds and sectors, who come together in a variety of ways to make things happen. I have seen how individual citizens, community-based and non-governmental organizations, professional associations, faith-based organizations, and lobbying groups exert an influence on elected officials. And I have seen the power of votes to make an elected official consider various positions of their constituencies. I have seen how elected officials influence each other. I have also seen the behind-the-scenes politics that keep the wheels of this machine turning (or lock them up, in many cases). The very same process that has produced the very compassionate policies of the Ryan White CARE and PEPFAR has also produced the anti-prostitution pledge and the immigration and travel ban. This contextual and nuanced understanding of both the content and process of health policy will stay with me for the duration of my career. I also like to think I have developed some leadership, negotiation, and consensus-building skills along the way.

As a tenured faculty member who loves to work on research that inspires me, teach receptive young minds (and not-so-young minds), and work on the front lines of my community to improve health and well-being, I had no intention of changing careers when I began this fellowship. The fellowship certainly offers such a springboard opportunity. For me, however, I will return to my academic life with a greater ability to step out of the ivory tower. I am certain to be a better advocate for HIV/AIDS and other health issues, and I plan to pass this wisdom on to a few generations of students as well. I am honored to live in a nation with a participatory government, and I plan to make full use of the right and the responsibility to participate.

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participate in the course online at http://webclients.captus.com/apa/catalog.htm/.

HOPE Training Activities

The true focus of what HOPE does is training. Each of our CMHS contracts has stipulated that HOPE must provide training for a minimum of 1,000 mental health professionals per contract year. That's never been a problem; we consistently more than meet our goals. There's simply no stopping our dedicated HOPE trainers. To date, during our current contract, which began September 19, 2004, HOPE trainers have provided 776 hours of training in the form of 187 workshops that have reached a total of 4,401 mental health practitioner participants. That is nearly double our required minimum!

If you would like additional information about any aspect of the HOPE Program, please feel free to contact David DeVito at *ddevito@apa.org/* 202.216.7603. We look forward to hearing from you!

Sexual Compulsivity, continued from page 18

Gullette, D. L., & Lyons, M. A. (2005). Sexual sensation seeking, compulsivity and HIV risk behaviors in college students. *Journal of Community Health Nursing, 22*, 47-60.

Kafka, M. P., & Prentky, R. (1994). Preliminary observations of the DSM-III-R Axis I comorbidity in men with paraphilias and paraphilia-related disorders. *Journal of Clinical Psychiatry, 55*, 481-487.

Kalichman, S. C., & Rompa, D. (1995). Sexual sensation seeking and sexual compulsivity scales: Reliability, validity, and predicting HIV risk behavior. *Journal of Personality Assessment, 65*, 586–601.

Kalichman, S. C., & Rompa, D. (2001). The Sexual Compulsivity Scale: Further development and use with HIV-positive persons. *Journal of Personality Assessment, 76*, 379-395.

Liau, A., Millett, G., & Marks, G. (2006). Meta-analytic examination of online sex-seeking and sex risk behavior among men who have sex with men. *Sexually Transmitted Diseases, 33*, 576-584.

Muench, F., & Parsons, J. T. (2004). Sexual compulsivity and HIV: Identification and treatment. Focus: *A Guide to AIDS Research and Counseling, 19*, 1-3.

Visit us on the Web at:

www.apa.org/pi/aids

Ad Hoc Committee on Psychology and AIDS

Call for Nominations

The American Psychological Association (APA) Ad Hoc Committee on Psychology and AIDS (COPA) is seeking nominations for two new members whose term will begin on January 1, 2008, and end on December 31, 2010. The mission of COPA, an ad hoc committee that reports to the Board for the Advancement of Psychology in the Public Interest (BAPPI), is to guide the development and implementation of APA's organizational responses to the HIV/AIDS epidemic.

COPA members are required to attend two face-to-face meetings per year in Washington, DC, with expenses reimbursed by APA, and to participate in monthly conference calls. Between meetings, members are expected to devote a substantial portion of time to COPA projects, provide consultation to APA Office on AIDS staff, and participate in advocacy activities as needed. Each of the face-to-face meetings begins on a Friday morning at 8:30 a.m. and ends on Sunday morning at noon. On average, in addition to the time associated with the one-hour monthly conference calls and the two face-to-face meetings each year, members spend approximately 2–4 four hours/month on COPA business.

A candidate should have demonstrated expertise in dealing with HIV/AIDS issues as a researcher, practitioner, educator, and/or policy advocate. COPA seeks to involve a diverse group of psychologists, including persons of color and individuals who are living with HIV. COPA is particularly interested in candidates with expertise in the following areas: (a) HIV prevention and care for ethnic minority women and adolescent girls; (b) mentoring students and early career psychologists with interest in HIV/AIDS-related research pertaining to ethnic minority communities; and (c) public policy pertaining to HIV/AIDS prevention and care.

Nomination materials should include a summary of the nominee's qualifications, a letter from the nominee indicating a willingness to serve on COPA, and a curriculum vita. Self-nominations are encouraged. Materials should be sent by mail to:

Robert Beverly
Office on AIDS, American Psychological Association
750 First Street, NE
Washington, DC 20002-4242

All materials must by received by September 14, 2007.

Please contact Robert Beverly by phone (202.336.6051) or e-mail (rbeverly@apa.org) if you have questions or need additional information.

Office on AIDS

The American Psychological Association's Office on AIDS provides information, training, and technical assistance on a wide range of HIV/AIDS-related topics associated with coping, mental health services, prevention, technology transfer, community collaboration, public policy, and ethics.

BSSV Program

The BSSV Program is a national HIV-prevention technical assistance program directed by the American Psychological Association, Office on AIDS. The BSSV Program is funded by the Centers for Disease Control and Prevention (CDC). BSSV has established a national network of behavioral and social science volunteers to assist with HIV prevention efforts in their communities. This national network of psychologists, sociologists, anthropologists, and public health experts is organized to offer free and ongoing technical assistance to community-based organizations (CBOs), health departments, and HIV-prevention community planning groups (CPGs) that want state-of-the-science prevention for their communities. Highlights of activities of the BSSV program can be found on page 24 of this issue of the *Exchange*.

HOPE Program

The HIV Office for Psychology Education (HOPE) Program, funded by the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA), uses a train-the-trainer model to educate mental health providers about working with people living with or affected by HIV/AIDS. The program develops and pilot tests HIV/AIDS training curricula and then recruits and trains trainers to use curricula to educate mental health providers across the country. A comprehensive, Internet-based training program has been developed to expand the HOPE Program's training capability. A report of recent HOPE program activities can be found on page 25.

The APA Ad Hoc Committee on Psychology and AIDS

The Office on AIDS provides administrative support and staff support for the seven-members of the APA Ad Hoc Committee on Psychology and AIDS (COPA), which reports directly to the APA Board of Directors. In August 1990, the APA Board of Directors and Council of Representatives (COR) approved funding for COPA for three years. COPA was charged with the following responsibilities: provide policy direction and oversight for current APA activities related to AIDS; advise APA staff and establish liaisons with governance groups regarding AIDS issues; and formulate new APA initiatives to meet the continually changing challenges posed by the epidemic.

Providing Guidance on HIV/AIDS Advocacy Issues

The APA Office on AIDS collaborates with the APA Public Policy Office in advocating for the development and implementation of national policies that support behavioral and social science HIV/AIDS research and science-based mental health service delivery and education. Briefing sheets and background information related to emerging HIV/AIDS policy issues are developed and distributed to APA members, members of Congress, and federal agency officials.

Requests for Information

Office on AIDS staff respond to inquiries from APA members, other behavioral and social science researchers and practitioners, community-based organizations, federal agencies, and state and local departments of health. Staff routinely provide information, training, technical assistance, and referrals in the areas of HIV/AIDS-related research, mental health services, ethics, education, and policy. To request information, please e-mail us at officeonAIDS@apa.org, or by calling 202.336.6052.

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