



Section Introduction

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More than most diseases, AIDS exists within the world of intimate behavior. This is so because AIDS is frequently transmitted through the most intimate of human relationships, because HIV both infects and stigmatizes, and because AIDS often kills, not randomly, but along interpersonal lines of connection and commitment. AIDS forces us as scientists and practitioners to know people in ways we have never had to know them before. It is not enough for psychologists to take the liberal stance of “each to their own.” It is not enough to look the other way and say “that is not my concern.” Rather it is important that we educate ourselves about HIV and its transmission and prevention. We are teachers, researchers, practitioners, consultants, friends, parents, and lovers. In all of these roles, we can contribute to halting this disease.

But before our AIDS prevention efforts can be truly effective, it is important that we learn the science of communicating within intimate relationships. We must know the issues intimately associated with everyday-life realities. The articles in this section focus on these concerns in several populations who are often overlooked or misunderstood. These populations were not in the first wave of funded research, treatment, or prevention. They have emerged from the shadow of what we now know about the effects of AIDS on gay men, Whites, and adults.

The backdrop for understanding the behavioral choices that people make is understanding the context and life circumstances of their behavior. The Mays and Cochran article underscores the importance of knowing how Black and Latina women perceive the world before effective risk reduction activities can be developed. This article, like the others in this section, does not focus on the proximal facets of sexual behaviors and needle use but rather the distal factors—those that lead to the decisions individuals will make when they get into the bedroom or use intravenous drugs. Flora and Thoresen, in their call for comprehensive theories of behavior change, highlight the importance of knowing the *antecedents* of sexually related behaviors of adolescents. Knowing these antecedent and situational determinants will help us to develop interventions better tailored to these populations. Brooks-Gunn, Boyer, and Hein bring an important lifespan perspective to prevention efforts with children and adolescents and remind us to develop strategies consistent with their cognitive and social development. They, like Flora and Thoresen, propose several indigenous locales and techniques for education and prevention efforts with this population, such as school-based clinics, court-related facilities, community groups, skills training, and media

campaigns that best fit the life realities of these groups. Our lack of knowledge and, for many, our discomfort in talking or asking about the intimate choices of individuals hampers prevention. Some choices by HIV-affected individuals when viewed out of context may seem irrational—such as the person with hemophilia who does not discuss safer sex with a partner or the HIV-infected Black woman who has a second child after the first is born infected. By focusing our sights on both proximal and distal influences in decision making, we may achieve the understanding needed to educate and intervene appropriately.

Each article examines the realities and intimate choices of individuals and ways in which to educate. These articles bring to life decisions and circumstances that particular subpopulations must confront, as well as the status of our behavior change models and risk reduction efforts in relation to these decisions. When we psychologists confront AIDS in these groups, we are not just tackling a virus but also the total complexity of people's lives. We cannot just change IV drug-using behavior or people's sexual behaviors without profoundly changing their lives. The choices that people are being asked to make are not simple choices. They are choices with implications for both the individual and that individual's relationships with children, friends, sexual partners, and family.

We know that psychologists can influence people's behavior. Our history attests to our ability to accomplish such change. We also know that changing people's behavior is not easy. It requires great thought and planning. For instance, Mason, Olson, and Parish offer generative strategies that may have applications for heterosexuals in general. Flora and Thoresen write about creative ways of influencing a risk-taking population. We will never change adolescents into a non-risk-taking population because risk taking is a fundamental part of their developmental stage. Risk taking and decision making about risks are integral aspects of growing up. It is real and we cannot change it. We have to work with it. This same theme runs throughout the other articles—effective prevention efforts have to *work with* the issues of a population. This means tailoring interventions to the ethnic/cultural dynamics of women (Mays & Cochran), to issues that occur with adults with hemophilia who struggle to live independent, non-illness-focused lives (Mason, Olson, & Parish), or to the reasoning abilities of young adolescent substance abusers (Brooks-Gunn, Boyer, & Hein).