Relationships among Sexual-Esteem, Sexual Self Efficacy and Sexual Risk Cognitions of Men Who have Sex with Men (MSM) in Davao City

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Abstract

Research on AIDS knowledge does not produce changes in sexual behavior; knowledge may be necessary, but it is definitely not sufficient. Behavior change remains the only means for primary prevention of HIV disease. Psychology should take a leading role in efforts to curtail the epidemic, but has not contributed to HIV prevention at a level proportionate to the urgency of the crisis. This study investigates the sexual -esteem and self-efficacy of Filipino MSM and its relation to sexual risks cognitions. Descriptive techniques and bivariate correlation were used for analyses. Convenience sampling was adapted of eighty (80) participants for the survey from venues frequented by different clans of MSM in the community. Sexually active MSM whose age ranged 13-35 with a mean of 20 years old, were administered measures of sexual - esteem and self- efficacy and were asked about their sexual behaviors. Respondents feel good about the way they express their own sexual needs and desires, (mean=3.53) with the capability to take care of their own sexual needs and desires (mean=3.58). They showed their partners that they are somebody special so sex is more exciting without a condom (mean=4.02) Using regression analysis, only self efficacy had a direct influence on engaging in UAI. (R2 = 0.330; F =18.934; df = 2; p = 0.000) and self efficacy correlated positively to sexual risk cognitions. Among the men who practice unsafe sex an emphasis on the pleasures of unprotected penetrative sex appears to override their risk awareness and them knowledge of condom efficacy, implications for HIV prevention strategies given these findings are to develop multilevel counseling interventions to achieve a sense of self worth in the sexual domain. Translate one's belief to deal effectively with the sexual aspect of risks cognitions into HPSB of protected anal intercourse for Filipino MSM.

Key words: *sexual self-esteem, self efficacy, risk cognitions, unprotected anal intercourse (UAI), and health promoting sexual behavior (HPSB)*

Worldwide, it's estimated that sex between men accounts for between 5 and 10% of HIV infections. The situation varies between countries however, and in much of the developed world – including the USA, Canada, Australia, New Zealand and many parts of Western Europe – more people have become infected with HIV through male-male sex than through any other transmission route. Current epidemiological reports estimate that 40,000 citizens in the United States become infected with HIV each year. HIV infections increased 40% in 2002 and 60% in 2003 (PHSKC, 2005). One in seven gay men live with HIV, and only 25% of those are above 40 years old. Gay and bisexual men constitute 70% of the total cases of HIV infected persons.

After more than two decades of living in this pandemic, developing knowledge, implementing education, and establishing an industry of care and prevention, it is curious to many why HIV persists in the life of any citizen. This is especially true for the case of gay men. But whomever or whatever the case may be, it is clear that the efforts of knowledge, research, treatment, and prevention are not functioning in the direction it seems they should: we have not stopped the microscopic to the macro-system replication of HIV. Currently, the social side of the field presents with some trends, debates, and points of consensus. The term "risk" and all its permutations are caught between a traditional notion of unprotected anal sex, UAI, (and varying gradations from there) and a burgeoning body of literature attempting to expand it toward social and other philosophical grounds. Mediators and moderators of "risk" find great representation in research, though primarily focused at the individual psychiatric level, suggesting control, responsibility, and accountability by that individual. Interventions therein are lacking in numbers alone, but also in going beyond the individual, cognitive level as well; community directions are now starting to be suggested

Research on AIDS knowledge is based on the rationalistic assumption that once people know "the facts" about AIDS and HIV transmission, they will modify their behavior to eliminate the risk of becoming infected. For gay men, education about HIV/AIDS and availability of condoms are not showing to prevent risky sexual behaviors. It is generally

agreed now that knowledge per se does not produce changes in sexual behavior; knowledge may be necessary, but it is definitely not sufficient (Rogers's et al. 1999). A high level of awareness in the risk of HIV/AIDS had no correlation in the condom use among 40 Filipino MSM (Malonzo et al, 2011). Multiple factors including psychological attributes, health promoting behaviors (HPB) and biological factors influence an individual's ability to make required lifestyle changes. The concepts of self–esteem, self–efficacy and hope have consistently produced strong relationships with HPB (Klein-Hessling et al., 2005).

Decade since AIDS was first diagnosed; behavioral research has focused intensively on risk reduction change processes and, to a lesser extent, on mental health needs of persons with HIV conditions. Although research to date has yielded important findings for primary prevention efforts and has identified some psychological dimensions relevant to mental health interventions, there is a pressing need for much more systematic intervention outcome research in both the prevention/behavior change and emotional coping areas. Progress in these areas will be facilitated by better linkage of intervention approaches to behavioral theory; identification of intervention elements that produce HIV risk behavior change; evaluated field-testing of promising intervention models; continued focus on populations that remain at risk (such as gay men and iv drug users); and expansion of prevention efforts to urban, poor, and minority populations increasingly threatened as AIDS/HIV enters a "2nd wave." Although AIDS is still a relatively new problem, existing behavioral medicine conceptual models and intervention strategies can be adapted to meet the enormous challenges created by AIDS and HIV infection. (PsycINFO Database Record (c) 2011 APA)

Sexual self-concept is considered a multidimensional construct that refers to an individual's positive and negative perceptions and feelings about him- or herself as a sexual being. As with other dimensions of self-concept, the development and consolidation of one's sexual self-concept is considered an important developmental task of adolescence (Longmore, 1998). Despite its developmental significance, however, only a handful of published studies have focused on assessing adolescents' sexual self-concepts and

determining associations between adolescents' sexual self-concepts and sexual behaviors and experiences (Tolman, 2006).

Self–efficacy was determined to be a dominant predictor of positive health related behavior in a group of 345 fourth grade students (mean = 10.5 years) (Klein-Hessling et al., 2005). Stigma of being attracted to the same-sex has been suggested to negatively influence self-esteem and self-worth and bring about stress (Thornton et al., 1998). As a consequence, men who are not comfortable with their sexuality may engage in risky sexual behaviors because they either lack the self-esteem to protect themselves or want to avoid discussions of HIV and condoms with their sex partners for fear of being labeled "Gay."

Relatively little empirical work has been directed toward creating valid multidimensional measures of sexual self-concept in adolescence. Existing measures are either unidimensional (Breakwell & Millward, 1997; Winter, 1988) or focus solely on girls' sexual self-concept (O'Sullivan et al., 2006). Despite some limitations, the few studies that have used these measures have consistently found that sexual self-concept is significantly associated with sexual experiences and sexual behaviors.

Officially, the Philippines is a low-HIV-prevalence country, with less than 0.1 percent of the adult population estimated to be HIV-positive. As of November, 2011, the Department of Health (DOH) AIDS Registry in the Philippines reported 8,000 people, between 15-49 years old, living with HIV/AIDS (PLWHA) - www.plwha.org. UNAIDS estimates that 12,000 Filipinos were HIV-positive by the end of 2011.

In Davao City, there are 189 PLHIV, 173 males and 16 females, out of which, there are 166 still living, 154 males, 12 females and 23 deaths, 19 males, 4 females. The data shows that more male died than female, an indication of a rising pandemic among MSM.

With this present alarming data of HIV/AIDS in Davao City, the present study, examined a multidimensional measure of sexual self-concept previously validated on university samples of males and females to determine its usefulness in assessing sexual esteem and its associations with sexual self-efficacy and sexual risk cognitions among MSM.

AIDS prevention: Impotent paradigms

Aggleton et al. (1994: 341) claim that "Behavioral science has already identified the main determinants of risk behavior and has contributed substantially to the design of programs that reduce personal risk, thereby limiting the spread of the virus." This claim is suspect. Gold (1994), with respect to gay men, has made a persuasive case for the conclusion that AIDS education is currently ineffective in reducing the alarming rates of unsafe sexual practices among gay men, whose earlier impressive rates of change have not been sustained. We share the doubts expressed by Hahn (1991: 1) when he wrote, "It is not clear that we have the theoretical knowledge about how to modify behavior to reduce the likelihood of HIV/AIDS transmission".

According to social cognitive theory (Bandura,2001),self-efficacy, or an individual's beliefs about his/her ability to perform a particular behavior in a given situation, mediates the relation between an individual's knowledge and skills related to performing a behavior and his or her actual performance of the behavior. Only a few studies have examined sexual self-concept and sexual self-efficacy in adolescence, and findings are inconsistent. Taken as a group, the primary focus of available studies has been on sexual risk taking, the majority examining condom use among sexually active females in university samples. Only one study used an African American sample, only one measured resistive self-efficacy, and none examined sexual situation self-efficacy. We sought to extend previous research by assessing specific sexual self-efficacy factors and specific sexual self-concept factors (sexual self-esteem in a sample of MSM.

Few studies have examined sexual situation self-efficacy, and risk cognitions that have received less empirical attention in condom self-efficacy. Resistive self-efficacy is particularly important as it is relevant to the sexual interactions to those who have partners. A positive sexual self-esteem and high sexual self-efficacy to refuse unwanted or unsafe sexual situations and interactions may contribute to sexual health (as well as risk reduction) throughout adolescence and young adulthood. Therefore, these constructs are worthy of additional research attention.

At this period of time perhaps more than any other, one of the key developmental tasks is acquiring or maintaining a positive sense of self as a sexual being while learning when, where, and how to initiate, resist, and manage sexual interactions with a partner. We chose to focus on sexual esteem, self-efficacy and risk cognitions assuming that the MSM's confidence in his ability to manage potentially risky sexual situations and to refuse unwanted sex is important to his psychological well-being and to his sexual health. We assume that differing social pressures and gendered expectations related to sexual behavior create differing individual and interpersonal challenges to managing and resisting sexual risk among MSM. However, they should be empowered to resist unwanted sexual situations and to manage potentially risky sexual situations.

The primary purpose of the present study was to examine the associations between sexual esteem and sexual self-efficacy to sexual risk cognitions among MSM.

It specifically aimed to answer the following questions;

1. What is the level of sexual-esteem of the respondents?
2. What is the level of sexual self efficacy of the respondents?
3. What is the level of sexual risk cognition of the respondents?
4. Is there a significant relationship between
   4.1 sexual-esteem and sexual risk cognition
   4.2 self efficacy and sexual risk cognition
5. Do sexual-esteem and self efficacy significantly influence the sexual risk cognition of the respondents?

Method

The community-based sample used in this study is composed of 80 all single gay and bisexual men recruited in 2011 from throughout the Davao region. To lessen the biases inherent in recruitment strategies of studies of gay men that draw only on bar patrons or organization members, key persons (enumerators) were instructed to recruit for diversity among different communities in Davao City and included socio demographic variables in terms of age, civil status, educational attainment, monthly income and family acceptance of their true identity.

While health issues provided a primary impetus for this research, the study was a broad, general investigation into Filipino gay life, and the investigation was not narrowly focused on HIV/AIDS but related to acquiring it through risk-taking behavior. The research plan was approved by the Brokenshire Ethics Committee.

Our subjects ranged in age from 13 to 35 years, with (mean age =20.42, st. dev. = 3.16). The marital status of these men is 100% single. While 90 % are accepted by their family of their true identity as exclusively homosexual and 10 % as predominantly bisexual.

The sample is also more inclusive of the diversity in this population than would be samples drawn more traditionally from bars and organizations. But as always in the case for research on hidden populations, it is impossible to demonstrate absolute representativeness since random sampling of such populations cannot be done (Davies et al. 1993).

Measures

Interview procedures

The interview instrument used in this study was standard questionnaire from Multidimensional Sexuality Questionnaire (MSSCQ; Snell, 1995) and Sexual Risk Cognitions Questionnaire (SRCQ). In the case of sexual risk-taking behaviors, sexual self-efficacy necessitates not only a belief in one's ability to control one's own behavior, but also a belief that one can control key aspects of a sexual situation or interaction.

Key persons traveled with their volunteers to different locations in Davao City for interviews. Each subject worked at his own pace through the questionnaire. Subjects recruited by key persons had absolute anonymity since only the key persons knew the identity of their own recruits. Some names and addresses of individual volunteers were known to the study but their responses were anonymous

Standard demographic questions prompted participants to indicate their age, civil status, educational attainment, monthly income and acceptance in the family. Demographic and descriptive information was collected to characterize and describe the respondents.

Data analysis

Analyses included correlations and multiple regression analyses with multiple predictor variables and multiple outcome variables. Correlations were used to identify the direction of associations. Measures of central tendency were determined for all interval and ordinal data using mean and standard deviation for interval data and median and range for ordinal data.

To test the first and second hypotheses regarding associations between sexual esteem and sexual self-efficacy to sexual risk cognitions, bivariate correlations were examined. To test the third hypothesis, stepwise regression analysis were performed using sexual esteem and self-efficacy as the two outcomes.

Finally, to test for the moderating effects of age, educational attainment, monthly income and acceptance in the family of their true identity, bivariate correlations were also used.

The level of significance for hypotheses testing was set at 0.05. Pearson's product Moment correlation was used to assess relationships among the behavioral attributes of self–esteem, self–efficacy, and sexual risk cognitions.

Data were analyzed using SPSS 17. Data management and analyses require statistical support and knowledge of the programs used for computerized analyses.

Data were secured in a locked cabinet in the investigator's locked office. Computerized datasets were stored with password protection during data analyses. Participants identifying information remained confidential during recruitment, data collection, data management, analysis, and will remain confidential after the study ends.

The link between participants' identifying information and the data was destroyed after data analysis

Results and Discussion

Using the convenience sampling methods, data were collected between November and December 2011 where the enumerators interviewed 80 gay persons and completed the questionnaire.

Moderating and control variables

Table 1 (appendix) presents the demographic and social characteristics of the participants resided in homes in different barangays in Davao City and displays frequencies and percentages of the sample for the age, educational attainment, income, civil status and acceptance of their family to their true identity.

Standard demographic questions prompted participants to indicate their age, educational attainment, monthly income and acceptance of their true identity to their family. They are all single in their civil status and with a mean age (20) years old that indicate that they are in the young adulthood range. Majority is below poverty level with an average monthly income of Php9, 500 and most of them are in the college level.

Most of the 80 men in the final sample were younger than 35 years in age (n=80) and identified as gay and bisexual. The ages of the participants ranged from 13 to 35 years (mean = 20.42 ± 3.16). Theoretically, younger age is suggested to contribute to UAI because youth's cognitive abilities for regulating behavior and understanding risks are still under development during adolescence (Overton, Steidl, Rosenstein, & Horowitz, 1992). Typically, research among MSM in general has supported that young MSM are particularly vulnerable to infection because they practice more unsafe sex than older men (Centers for Disease Control and Prevention, 2001)

Even though poverty is rampant in the city, these respondents ranked their subjective social status a bit lower minimum income of Php1, 000 with a mean of Php 9, 573. Economic inequities are major contributors to poor health outcomes (Raphael, 2000). Such inequities are also suggested to influence the HIV epidemic (Fournier & Carmichael, 1998; Gillies, Tolley, & Wolstenholme, 1996; Holtgrave & Crosby, 2003; Mosley, 2004; Murrain & Barker, 1997). Epidemiological studies tend to use income, education, and employment as proxy socioeconomic 32 indicators (Krieger et al., 1993). These variables (i.e., lower income, inadequate education, and unemployment) have been shown to be linked to engaging in UAI among MSM (Myers et al., 2003 ;).

Also, about 88.8% of their parents accepted their true identity as gay and 10% did not disclosed their true identity so they just checked no as their answers. Differences in sexual risk behaviors have been noted between men whose self-identify as bisexual and gay. Findings shows that among MSM whose self-identify is accepted in their families tend to engage in more risk behaviors than those who have no disclosure.

The mean score for sexual-esteem was 3.26 (SD = .85). Table 2 shows items loading on the sexual esteem scale that included, “I feel good about the way I express my own sexual needs and desires “which have a moderately characteristic of the respondents. They rated each item on a Likert-type scale, with responses ranging from "not at all characteristic of me" (1) to "very characteristic of me" (5). Sexual esteem was not associated with educational attainment, income, acceptance of sexual identity. Sexual esteem was associated with age; Men who were younger had lower self-esteem scores than those who were older.

The second factor (self efficacy) was composed of five items (Table 3). This factor assessed confidence in saying “I have the capability to take care of my own sexual needs and desires “The mean score for this sample was 3.43 (SD = .861).

Predictors

Four subscales (22 items) of the Multidimensional Sexual Self-Concept Questionnaire (MSSCQ: Snell, 1998) were selected to assess positive and negative dimensions of sexual self-concept. Respondents rated each item on a 5-point Likert scale ranging from "not at all characteristic of me" to "very characteristic of me. There are two items with highest mean (3.66 and 4.02)" I want to show him that he's somebody special and Sex is more exciting without a condom" respectively, which is moderately characteristic of the respondents. The grand mean and standard deviations were 3.07 (0.97) as presented in Table 4.

The intercorrelations among all study variables are displayed in Table 5 (appendix). Supporting the first hypothesis and consistent with previous research findings, bivariate associations indicated that age is significantly associated with lower sexual esteem, with positive correlations that the older the respondents the higher is their sexual esteem., but no significant association with educational attainment, monthly income and acceptance of their true identity Levels of self efficacy has no significant relationship with age. Sexual self efficacy is not significantly associated with all the socio demographic variables.

Table 6 shows results of regression analyses conducted to examine the hypothesis that perceived self efficacy is related to a greater likelihood of engaging in UAI. The moderate characteristic of having the skills, the capability to cope with and to handle his own sexual needs and wants leads to influence that he has the moderate characteristic to enjoy sex more without a condom because he wants to show his partner that he is somebody special. These statements are answered with the highest mean in sexual esteem, self efficacy and sexual risk cognitions respectively.

However, higher levels of sexual esteem are not a predictor of sexual risk cognitions although there is a significant association of the two variables. In this model, it indicates that having a sense of pride, positive feelings and proud of the way he deals with and handle his own sexual desires and needs do not influence to practice safe sex.

One possible explanation for the dearth of studies on sexual self-concept is the more

general criticism that constructs such as global sexual esteem are not useful predictors of important outcomes and thus have been highly over-rated as targets of intervention (Baumeister, 2003). On the other hand, Swann, (2007) recently argued that self-view constructs (such as self-efficacy and sexual esteem) are problematic as predictors because global, rather than specific, measures are most often used to predict specific outcomes. A similar critique of self-efficacy research has led researchers to attend carefully to using specific measures of self-efficacy that relate directly to the behavior of interest (Pajares, 1996). Unfortunately, many past research studies have failed to observe this specificity-matching principle. When this principle is observed, however, self-efficacy (Bandura, 2001) predicts important psychosocial outcomes among MSM. Less attention has been given to the relation between the two constructs.

In the present study, we assessed two specific dimensions of sexual esteem and sexual self-efficacy, two constructs that have received more theoretical than empirical attention in the adolescent literature, but less among MSM, despite their importance to healthy development as well as risk reduction. In contrast to previous findings with university students (Rosenthal et al., 1991), our findings revealed that younger MSM reported lower levels of sexual esteem than did with older young adolescent MSM.

Additionally, MSM in this study reported higher sexual self-efficacy. Consistent with other findings (Mitchell et al., 2005; Rosenthal et al., 1991), adolescent MSM in this study reported lower sex refusal to safer sex practice that leads to UAI. The current study also revealed higher sexual self-efficacy among young adolescent MSM, a sexual self-efficacy factor previously neglected in the literature. In regression models, the main effects for sex again indicated that being an MSM was associated with higher sexual esteem and sexual self-efficacy to sexual risk cognitions. Past research, perhaps again reflecting gender socialization, has focused primarily on self-efficacy in females (e.g., Seal et al., 1997), to the relative neglect of the importance of self-efficacy among MSM and the shared responsibility for sexual decision making.

Together, these findings suggest that young adolescent MSM has confidence in their ability to manage sexual interactions with a willing partner even if they have the knowledge acquired that sex without condom has a higher risk of acquiring HIV/AIDS. According to social cognitive theory (Bandura, 1986), self-efficacy, or an individual's beliefs about his/her ability to perform a particular behavior in a given situation, mediates the relation between an individual's knowledge and skills related to performing a behavior and his or her actual performance of the behavior.

Perhaps these results are indicative of MSM sexual scripts that portray male sexual desire or arousal as something that cannot (or should not) be resisted, particularly if one has access to a willing partner. Exercising self efficacy in sexual interactions with a willing partner may pose a dilemma for adolescent MSM in which healthy sexual decisions may be sacrificed in the service of having the capability to take care of their own sexual needs and desires.

In sum, only a few studies have examined sexual esteem and sexual self-efficacy among MSM, and findings are inconsistent. Taken as a group, the primary focus of available studies has been on sexual risk taking, the majority examining condom use among sexually active MSM. A longitudinal study of young MSM from New York City has shown self-esteem to be significantly associated with UAI (Rotheram-Borus,1995) and conforms to the findings of our study.

Our findings may reflect the developmental stage of early experimentation with sexual activities and romantic/ sexual partners and the uncertainty and lack of confidence that may arise in young adolescent MSM who are expected to portray a sense of self pride from the way they handle their sexual needs and desires and because they are still young it contribute to UAI because youth's cognitive abilities for regulating behavior and understanding risks is still under development during adolescence Therefore, sexual health programs should actively reinforce valuing of ones self as a sexual health strategy.

Research on diverse adolescent MSM populations that examine positive aspects of sexuality and sexual development, including the development of positive sexual self-concept and sexual self-efficacy, are needed as a counterpoint to the longstanding tradition of problematizing and pathologizing MSM sexuality (O'Sullivan, 2005). Certainly a fuller understanding of how socio demographic factors (age, educational attainment, income and true identity) shape the development of adolescent sexual esteem and adolescent sexual self-efficacy will allow us to identify factors and processes that facilitate and deter the development of unhealthy sexuality.

Overall, the regression models predicting self-efficacy revealed similar patterns. Higher levels of sexual esteem were associated with age. These results suggest that feeling positively about oneself as a sexual being may facilitate the development of adaptive sexual self-efficacy. Most likely, these associations are directly proportional and an increase in one's age may result in an increase in the other. Young MSM are particularly vulnerable to infection because they practice more unsafe sex than older men

Contrary to some previous findings (Buzwell & Rosenthal, 1996), the MSM in our sample who reported below poverty income has no significant associations with their sexual esteem and self efficacy, but self efficacy significantly influence to be linked to engaging in UAI among MSM..

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Perhaps "failing" to resist using condom in sexual intercourse takes a toll on MSMs' confidence in their self pride to handle their own sexual tendencies and behaviors to resist unsafe sex in the future. In this study, however, we do not know to what extent MSM may have engaged in unsafe sex practice. This factor would be important to assess in future research. To the extent that these results continue to be replicated in longitudinal designs, then early intervention (prior to valuing oneself to increase sexual self-esteem and sexual self-efficacy could positively impact overall sexual health. On the other hand, MSM who have negative feelings or anxieties about themselves as sexual beings because of past sexual experiences may benefit from targeted interventions, such as multi level counseling to really transform their capability to take care of their own sexual needs and desires into

health promoting behaviors (HPB) and influence an individual's ability to make required lifestyle changes Certainly, more research in this area is needed to explicate the relative impact of sexual experiences, sexual esteem, sexual self-efficacy and sexual risk cognitions on sexual health and well-being.

While the correlational nature of this study precludes determining a causal relation between sexual self-esteem and sexual self-efficacy, our findings support the notion that sexual self-esteem is a significant mediator of sexual risk-taking knowledge. While social cognitive theory assumes that self-efficacy mediates the relation between knowledge and performance, our findings indicate that an adolescent's positive feelings about himself as a sexual being mediates the relation between sexual risk knowledge and sexual self-efficacy. This finding again supports the notion that interventions to promote positive sexual self-esteem may make a meaningful and significant contribution to the goals of providing comprehensive and effective sex education to MSM.

The measure of sexual esteem that was used in this study provided an assessment of positive and negative aspects theorized to affect positive sexual identity. Surprisingly, only one of the two factors (sexual self-efficacy) was associated with sexual risk cognitions in the regression models. Future research might fruitfully employ other measures of sexual self-concept. Given the salience of low sexual esteem for young MSM, in the present study, measures that assess multiple dimensions of MSM sexual self-concept are crucial.

Conclusion

We believe that to understand sexual behavior it is crucial to examine the role of cognition. Our results suggest that while the basic cognitive structure in the domain of eros is similar for those who engage in high risk behaviors and those who do not, variations in specific details provide insights into sexual thinking that we ignore at our peril. Our findings may be grounds for optimism because they suggest that attending to specifics - rather trying to completely overhaul the cognitive structure of those engaging in high-risk

behaviors - may suffice. Most prevention efforts involve an attempt to reduce risky sex through cognitive modification, e.g., by improving knowledge, by changing risk perceptions, and by altering attitudes. Thus, it is generally assumed that cognitive factors are important. But our failure to take into consideration the sexual cognition of the people we want to reach reduces our ability to address the issues in a manner that is convincing and meaningful to them.

The kind of research presented here is aimed at fine-tuning educational messages to make them compatible with the sexual understandings of high-risk individuals. It is aimed at focusing more precisely on the points on which these men differ from low risk takers.

The current study adds to the empirical literature by examining the relation between sexual esteem and sexual self-efficacy. Our findings suggest MSMs' positive views of themselves as sexual beings may enhance their ability to translate their knowledge of sexual risk into self-confident action on behalf of their sexual health and well-being. Future studies might examine more complex models that include behavioral indices of unwanted and unsafe sexual behaviors as well as situations or interactions that were successfully resisted or safely and satisfactorily negotiated. These kinds of studies might fruitfully take a dyadic approach and seek to understand sexual interaction and sexual decision making in the relational context in which they most often occur. Current research on MSM sexuality continues to focus on the individual rather than on the sexual dyad, despite evidence that relational factors have a significant impact on MSM sexual behaviors While the measures of self-efficacy in the current study included items that placed sexual decision making in the context of interaction with a sexual partner, much more research is needed that includes the relational context of sexual decision making and its subsequent impact on safer sex practices.

Creative strategies should be employed to encourage full participation of the sampling frame particularly the partner MSM. Research design should consider the role families play in the acceptance of the true identity of the MSM. Research findings should be used to guide health care policy to develop change in the individual behavior and execute strategies to motivate continued healthy behavior.

We cannot be certain that the shift in research paradigm that we are advocating will prove successful. What is certain is that new directions in prevention research are needed. Our experience leads us to believe that this one is worth pursuing**.**

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