



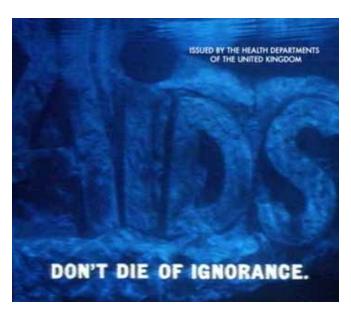
THE ROLE OF FEAR IN HIV PREVENTION

This Making it Count briefing sheet examines the research on sexual health promotion interventions that aim to elicit fear. It explores if, when and where such interventions could successfully meet the sexual health needs of gay and other homosexually active men.

HOW MIGHT FEAR WORK?

When we are faced with a threatening message or image our emotions may become aroused and we may become fearful. For several decades health promotion interventions have sought to arouse a fear of potentially harmful consequences as a means of dissuading us from engaging in particular behaviours. Images of car crashes and injured children have been used to encourage us not to drink alcohol and drive; messages about the risk of coronary heart disease on cigarette packets are used to encourage us not to smoke; and the potential for being hit by a car is shown visually to young people to dissuade them from playing near busy roads.

In the past, fear has also been used as part of HIV prevention activity in the UK as a means of encouraging people not to engage in sexual risk behaviours. The first national, mass-media campaign in response to the emergence of AIDS (HIV) in 1980s Britain used images of tombstones and icebergs to highlight the severe and



[Source: Health Education Authority, 1987]

potentially fatal threat it posed. The metaphor of the iceberg commonly used on the television and in printed media inferred that far more people may be infected, or become infected, with HIV than was already the case.

"A large number of health promotion campaigns are based on a simple strategy: get behind people with a big stick (lots of threat and fear) in the hope this will drive them in the desired direction." (Soames-Job 1988, page 163)¹

It was assumed that if people were made fearful of the consequences of HIV infection then they would be motivated to use condoms to protect themselves. The stark imagery and the message that 'AIDS Kills' posed a threat that led to the arousal of fear for some of those who engaged with the message. The potential remedy for the threat was straightforward: use a condom. Similar approaches were adopted in the United States, and in Australia (utilising images of the Grim Reaper). While fear based campaigns in the 1980s highlighted the fatal nature of HIV infection, fear arousing campaigns in later years focussed more on the realities of living with HIV connected with treatment side effects (for example, facial wasting, diarrhoea, lipodystrophy).

Campaigns aiming to arouse fear may be good at attracting attention², mainly because they use graphic imagery, simplistic language and statements that are designed to shock. These features make such interventions very memorable³ and can lead to improved knowledge of HIV precautionary behaviours⁴.

Recent years have seen a renewed interest in fear-based interventions as a means of encouraging behaviour change among homosexually active men. This interest is common across many health related behaviours (e.g. calling for more graphic imagery to illustrate the effects of smoking, alcohol

use, or drug use etc.). Research suggests that the general public often hold great faith in the power of fear to change behaviour^{5,6}. Recent calls from the media, and some parts of the gay community, for interventions to focus more on the potential negative consequences of sexual risk behaviour as a means of encouraging behaviour change warrants consideration.

WHO IS AFFECTED BY FEAR?

While several reviews of fear-based health promotion interventions have indicated that fear may be an effective means of motivating behaviour change^{7,8}, many of the studies that were reviewed were flawed in terms of their research methods, or were naive in their beliefs about how research findings translate to the real world. Often the researchers have not used clear definitions of fear-based interventions or used narrow or inappropriate samples (often undergraduate university students) to test out their theories. More importantly however, the research that has come out in favour of fear-based approaches has often been conducted in artificial, laboratory environments. We know from studies of advertising and marketing that in natural environments people selectively attend to advertisements that support their prevailing attitudes and behaviours9. People do not always wish to be challenged about the way they behave, and so if they feel threatened they may simply avoid the fear-arousing message.

Evaluations of fear based campaigns have found that feararousing messages are effective in raising awareness and changing attitudes^{10,11} but few campaigns demonstrate the desired change in sustainable behaviour. For example, a study¹² exploring the impact of late 1980s tombstone / iceberg campaigns on attenders at a drug dependency unit (part of the target audience) and students (not part of the target audience) found that anxiety was raised among non-target individuals but not among the target. No discernable change in behaviour was observed in either group. Most people in the study did not think that the message was targeted at them, although they were unanimous in agreeing that it applied to others. This process of deflecting anxiety provoking messages away from oneself is described in more detail in the next section.

Those already bearing the costs of a desired (health-protective) behaviour have a vested interest in believing the consequences of not doing so to be truly dreadful — otherwise it may not have been worth all the effort they have been making. Research suggests that fear appeals are more favoured by individuals who are already engaging in the desired, health-protective, behaviour than they are for individuals not already doing so (that is, the target audience)¹³. One explanation for this might be that those already engaging in the desired behaviour are already bearing the costs associated with that behaviour. For example, those already using condoms may have had to incur the social cost of raising an embarrassing topic in sexual situations, the cost of reduced sexual sensation, or

perhaps a negative impact upon the demonstration of trust within romantic relationships. Given these costs, it makes sense that averting more dangerous consequences (those that evoke greater fear) will provide more benefit than averting less serious consequences. This suggests that there may be a role for fear to help reinforce existing safer sex behaviour, but that arousing fear is not necessarily an effective means of facilitating behaviour change among those who engage in sexual risk behaviours.

"Fear appeals appear to be effective when they depict a significant and relevant threat (to increase perceptions of severity and susceptibility) and when they outline effective responses that appear easy to accomplish."

(Witte & Allen 2000, page 604)¹⁴

Fear appeals may be more effective in older individuals as the age of the target audience influences the audience's perceived vulnerability to the threat¹⁵. Younger individuals may feel as though death and disease happen to other people but not themselves¹⁶. Older people, on the other hand tend to perceive a greater threat to their health and well-being in general and so may be more responsive to fear-based interventions. That said, recent research has indicated that some older homosexually active men may regard HIV as less significant in later life because their longevity is more likely to be influenced by other chronic illness¹⁷.

UNINTENDED CONSEQUENCES

When we are afraid we may engage in a number of different coping strategies including:

- Avoidance: ignoring the fear-arousing message and turning ones attention elsewhere (for example, by changing the television channel or turning the page in a magazine).
- Denial: believing that the harmful consequences portrayed by the fear-arousing stimuli are unlikely, or even impossible.
- Counter-arguing: individuals might reject the whole notion of the risk, perhaps believing it to be exaggerated by expert sources or expressed as a way of controlling populations (for example, "I've had unprotected sex loads of times and I've never caught HIV", or, "It's just some do-gooders trying to stop me doing something I enjoy").
- Othering: The process of othering involves individuals
 deflecting the message away from themselves asserting
 that, "This message is not meant for me". Individuals
 whose fear has been aroused may project the message
 onto others who they feel are more likely to face the
 harmful consequences given their personal characteristics
 or behaviour (for example, "This message is meant for

MAKING IT COUNT

Making it Count is the strategic planning framework that guides HIV prevention for MSM across the CHAPS partnership. One of the aims of *Making it Count IV* is that men are aware of the consequences of becoming infected with HIV. Some men may become fearful when told about these consequences. If such fear arises as a result of interventions then men have a number of behavioural choices (including abstaining from sex, avoiding anal intercourse or avoiding UAI) in order to reduce the chances they might become infected. However, if those consequences are not fear-inducing, the aim of the intervention should not be to make men fearful of HIV by any means necessary. To accomplish that may mean you have to mislead in order to make them fearful. This is neither an ethical or an effective means of facilitating behavioural choices that will reduce the likelihood of becoming infected with HIV.

older / younger / more promiscuous men"). A study in which participants viewed fear-arousing HIV prevention posters (about the reality of living with HIV and possible treatment side effects) found that individuals often sought to deflect the messages in the posters away from themselves: men over 30 tended to believe the target was younger men, while those who were aged under 30 felt that the target was scene-oriented, promiscuous gay men¹⁸. Similarly, research found that Scottish teenagers were aware the HIV campaigns they were shown were intended to frighten people, but while they may have felt they were good campaigns, they did not identify with them¹⁹. Shock approaches would, they felt, work for others, but not for themselves.

These responses occur because being challenged about our prior beliefs or behaviours can be threatening, so we try to find a way of rationalising or defending our actions. As none of these coping strategies result in adoption of the desired behaviour, we might consider them 'maladaptive responses' (however, they may also be seen as responses that allow us to engage in a valued behaviour, so in that respect could be considered adaptive). [For more information on maladaptive responses see Blumberg (2000)²⁰ or Eppright et al. (2002)²¹]

If people engage in a given behaviour for a long period of time without harmful consequences then they begin to question whether the message is accurate or whether they are somehow immune to the risk of HIV infection⁴. It is, therefore, important not to always present target populations with 'worst case scenarios' that are in fact unlikely to arise for the majority of individuals.

If fear messages are to be successful at reducing risk, individuals need to feel personally susceptible to harm²². However, there is a need to ensure that interventions do not increase 'othering'. Interventions are required that make the target audience feel susceptible without highlighting sub-group and / or behavioural characteristics that put them at a higher risk. For example, in the case of HIV in the population of homosexually active men, these include (for example) having a higher number of sexual partners, or being sexually active in cities such as London, Manchester or Brighton. Highlighting this to homosexually active men may

lead some to assume that unprotected anal intercourse (UAI) with men outside of these groups is always safe. They may also stigmatise men who fall within these groups. A fearful emotional state activates a sense of wanting to be distant from a disease that has historically been bound up with the social taboos of sex, immorality and death, meaning that individuals fail to incorporate consideration of HIV into their sexual activity.

Stigmatising HIV makes it harder for diagnosed positive men to disclose their HIV status to potential sexual partners for fear of being rejected. As a result, some men with diagnosed HIV may resort to more implicit methods of HIV status disclosure (that may not always be understood by their sexual partners), or to engagement in sex in venues where they can maintain a belief that everyone having UAI must also be positive (such as saunas)²³. There is also evidence to

FACIAL WASTING



[Source: Stop AIDS Project, San Francisco, 2002]



[Source: Health Education Authority, 1987]

suggest that the fear of receiving a positive test result is a disincentive to seeking HIV testing²⁴. Campaigns that focus solely on the negative consequences of HIV infection may serve to disempower men with HIV by making them appear weak, helpless or diseased. Depictions of visible symptoms (either of an AIDS-defining illness or treatment side effects such as lipodystrophy) may reinforce commonly held perceptions that they can tell who has HIV by looking at them, and may also discourage newly diagnosed men from taking anti-HIV therapies for fear of potential side effects¹⁸.

Fear-arousing campaigns may be most persuasive with those segments of the target population who are (already) the best equipped, psychologically and socially, to act on and benefit from the persuasive message. Evidence suggests that an individual's self-efficacy (their belief they have the necessary knowledge, will, and ability to perform a given action) influences how likely maladaptive responses are to occur^{25,26}. Fear arousal in an individual with a low selfefficacy may mean he is even more likely to engage in avoidance or denial20. Individuals with high self-efficacy perhaps established by experience of the desired behaviour - may be more receptive to fear-arousing messages because they know that the required response is not beyond their ability²¹. For example, men who have a lot of experience using condoms and negotiating safer sex they feel comfortable with may be receptive to fear-arousing messages about the potential impact of HIV because they know they are able to manage that risk and protect themselves. On the other hand, men who are psychologically and socially less well-resourced and struggle to negotiate sex as safe as they want it to be, may feel even worse when confronted by fear-arousing messages. Feelings of anger and defensiveness may encourage maladaptive responses that make risk reduction even less likely²⁷.

NOT SUFFICIENT

There is some limited evidence to suggest that fear-based HIV media campaigns may increase levels of HIV testing^{28,29}, however it is uncertain to what extent those seeking testing in response to such campaigns are those at most risk of infection, and whether regular testing behaviour is maintained over time. It is widely believed that there was a reduction in sexual risk behaviour after the last wave of fear-based mass media interventions in the 1980s, but it is difficult to infer whether this was because the iceberg and tombstone advertisements made people fearful of HIV or simply that they provided people with information about HIV and how to avoid it - something that had previously been lacking. The 1980s campaigns were very well-resourced, and involved distribution of a leaflet through the door of every home in the UK as well as prime time TV advertisements. No HIV prevention intervention since has been this well funded.

After several reviews of what makes a good HIV prevention intervention^{30-32,} none have identified the use of fear as an essential component.

HIV prevention is a process and not an advert or an event. People cannot be held in a permanent state of fear and after a while they will simply 'switch off' from scary imagery or information as part of a self-protective mechanism³⁴. Fear appeals may be effective at triggering desired behaviour change in the short-term but, with repetition, their influence will diminish³⁵. Repetition can lead to habituation and annoyance, to the point that the message is tuned out. Research has demonstrated that smokers become immune to warnings about smoking on cigarette packets over time and become adept at screening them out36. From a social marketing perspective, long-term use of fear messages may negatively impact on how the source is viewed by the target population as it becomes irretrievably linked with the negative and the threatening³⁷. The aim of interventions should be to promote positive outcomes of engaging in a given behaviour, more than on the potentially harmful consequences of not doing so.

"Inducing fear is not an effective way to promote previous HIV relevant learning or condom use either immediately following the intervention or later on. However, HIV counselling and testing can provide an outlet for previous HIV-related anxiety and, subsequently, gains in both knowledge and behaviour change immediately and longitudinally."

(Earl & Albarracin 2007, page 496)³³

Ultimately, fear will only be a driver of change if the target is not already fearful. While this may not always be the case for homosexually active men, when asked in the 2006 *Gay Men's Sex Survey* (GMSS) if they agreed or disagreed with the

statement 'HIV is still a very serious medical condition', 97.8% either agreed or strongly agreed³⁸. In GMSS 2008, when negative or untested men were asked how they would respond if a potential sexual partner disclosed having HIV, over 50% indicated that they would not wish to engage in sex of any kind³⁹. Although there have been a few dissenting voices from abroad⁴⁰, most research conducted in the UK has concluded there is little or no association between optimism about HIV, given the success of antiretroviral therapy, and high risk sexual behaviour ^{41,42}. There is little evidence to suggest that men need to be made more afraid of HIV and it is doubtful whether the 2760 homosexually active men who were diagnosed with HIV in 2009 acquired it because they were not sufficiently fearful of becoming infected.

It will remain a constant challenge for those promoting sexual health and well-being to attract the attention of their target audience among the many other advertisements that compete for their attention. The temptation is to produce shocking or explicit imagery, which may stand a better chance of being noticed or being remembered. However, it is

FIVE KEY POINTS

- Fear arousing imagery can be good at attracting attention and is often memorable.
- Fear-based campaigns are more persuasive for individuals who are already engaging in the desired, health-protective, behaviour.
- Arousing fear in individuals can have many unintended consequences, such as denial or othering.
- Most homosexually active men are already fearful of HIV.
- Arousing fear is not an effective means of facilitating sexual behaviour change.

doubtful whether it will actually be successful at influencing behavioural choices. Most gay men and other men who have sex with men are already motivated to avoid HIV, but some still lack the knowledge or the power to do so.

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