

Culturally Sensitive AIDS Educational Videos for African American Audiences: *Effects of Source, Message, Receiver, and Context*

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Abstract

The importance of using culturally sensitive educational materials in HIV-related interventions with racial and ethnic minority groups is widely recognized. However, little empirical research has been conducted to assess the relative effectiveness of different techniques for creating culturally sensitive AIDS educational videos. Two field experiments with three samples of African American adults (Ns = 174, 173, and 143) were conducted to assess how source characteristics (race of communicator), message characteristics (multicultural message versus

culturally specific message), and audience characteristics (racial distrust and AIDS-related distrust) influence proximate (perceptions of the message's credibility and attractiveness) and distal (AIDS-related attitudes, beliefs, and behavioral intentions) output variables for AIDS educational videos. In Study 1, an AIDS video with a culturally-specific message was rated as more credible, more attractive, and of higher quality than was a video with a multicultural message. The multicultural message was rated less favorably when delivered by a White announcer than when the announcer was Black. In Study 2, the same pattern was replicated with a second community sample and a campus-based sample. Study 2 also indicated that a multicultural message might be more effective if delivered in a culturally-specific context, viz., after audience members watch a culturally specific video. Minimal changes were observed in distal outcome variables. It is argued that influencing proximate output variables is necessary, though not sufficient, for effecting long-term change in AIDS-related attitudes, beliefs, and behaviors.

As the HIV epidemic in the United States nears the end of its second decade, African Americans continue to be disproportionately affected by AIDS. Compared to other racial and ethnic groups, non-Hispanic Blacks in all age and gender categories had dramatically higher rates of AIDS in 1996 (Centers

for Disease Control and Prevention [CDC], 1997, pp. 9-11). They accounted for more than one-third of AIDS deaths in the United States in 1994 and 1995. AIDS is particularly a problem for low-income, inner-city African Americans, who are also among those least likely to have access to new AIDS treatments that offer hope to many people living with HIV (e.g., Krieger, 1997; Stolberg, 1997). Consequently, AIDS prevention programs targeting African Americans represent an ongoing public health priority.

The purpose of the present study was to identify strategies for increasing the effectiveness of video as a tool for those programs. Health educators have used video and television extensively for disseminating information about HIV in the United States (Herek & Capitano, 1994; Mitchell, O'Brien, Semansky, & Iannotti, 1995) and other countries (Lyttleton, 1994; Schiavo, 1995). A 1991 national survey, for example, revealed that more than two-thirds of Black and White Americans alike obtained AIDS information from television shows and announcements (Herek & Capitano, 1994). As Kalichman (1996) noted, video technology has the advantages of being relatively inexpensive, nearly universal in its availability, and capable of delivering uniform and complete messages about HIV and AIDS.

The use of culturally sensitive materials is widely recognized as an important requirement for HIV-related interventions with racial and ethnic minority groups (e.g., Kalichman, 1996; Jemmott & Jones, 1993). However, little empirical research has been conducted to assess the effectiveness of various techniques for creating culturally sensitive AIDS educational videos. The principal conclusion that can be drawn from the few studies that have focused directly on AIDS videos for minority audiences is that videos with culturally similar content are superior to culturally dissimilar videos.

For example, Stevenson and Davis (1994) showed either of two commercially-available videos to urban African American adolescents as part of an AIDS education intervention. Teenagers who viewed a culturally similar video (i.e., one that featured Black actors in an urban environment confronting life dilemmas similar to those faced by the research participants) showed greater retention of AIDS information two weeks after the intervention than did teenagers who watched a culturally dissimilar video (which had a White, suburban, middle-class focus).

In another study, Kalichman, Kelly, Hunter, Murphy, and Tyler (1993) assessed self-reported risk reduction among African American inner-city women in Chicago 2 weeks after they watched a 20-minute

AIDS educational video. Three versions of the video were shown: a professionally produced video featuring Surgeon General C. Everett Koop and summarizing his report on AIDS for a general audience; a version of the same video that the researchers produced, with African American women presenting the same script; and a third version with the same African American women as communicators, and a different script and visuals intended to present AIDS information framed within a context of cultural pride, community concern, and family responsibility. The women who watched either video featuring Black female announcers were more likely at follow-up to request condoms and to report having talked with friends about AIDS. In addition, those who had viewed the culturally-contextualized video were more likely at follow-up to report having obtained HIV testing after watching the video.

These and other empirical studies of AIDS educational videos (Kalichman, 1996) support the general conclusion that AIDS videos are more effective when they include images and content that are consistent with the day-to-day experiences of their target audience. The studies do not reveal, however, which characteristics of videos are most important for cultural sensitivity. Is it necessary, for example, that all AIDS information be presented solely by an individual of the same race or ethnicity as viewers? If so, is it sufficient simply that the communicator be matched to the audience, or must the message content also be specifically tailored to that audience's racial or ethnic group?

Previous studies have not answered these questions because they compared videos that differed on many dimensions related to production style, technique, and quality. The two videos used by Stevenson and Davis (1994), for example, differed not only in the race of communicators and the content of the message, but also in the age groups and genders of their actors; the quality of performances by their actors; their use of dramatizations versus didactic presentations; their inclusion of authoritative experts; and their overall production styles and techniques (Herek & AIDS Psychosocial Research Group, 1991). Similarly, Kalichman et al. (1993) noted that their videos were sufficiently different from each other that it was not possible to determine precisely which aspects of the tapes produced the observed effects.

Professional video producers appear to have developed their own competing theories about making programs culturally sensitive. In our research group's review of more than 100 AIDS educational videos (Herek & AIDS Psychosocial Research

Group, 1991, 1993, 1994, 1995, 1996, 1997), we have observed two common approaches to cultural sensitivity. Many existing AIDS videos employ what could be called a *multicultural* approach: Targeted at multiracial audiences, they feature communicators from multiple ethnic and cultural groups and discuss the problems posed by AIDS for all of the different groups. Examples of such tapes include *AIDS: Changing the Rules* (1987), *People Like Us* (1994), and *Talkin' About AIDS* (1989). Other videos take a *culturally-specific* approach: Targeted at a single ethnic or racial group, they feature communicators exclusively from that group and discuss AIDS specifically as it affects that community. Examples include *AIDS Is About Secrets* (1988), *Are You With Me?* (1989), and *Vida* (1989).

Both multicultural and culturally-specific AIDS videos generally respect the sensibilities of viewers in their target audience. However, whether they are differentially effective in reaching particular audiences is not clear. Because multicultural videos have a larger potential audience than culturally-specific videos (the former can be used with several ethnic and racial groups rather than only one), they may be more economical to produce. Any monetary savings might be offset, however, if they are significantly less effective than culturally specific videos in reaching their target audience.

The question of how to increase the cultural sensitivity of AIDS videos can be approached as part of a larger question: What makes any AIDS educational video effective for a particular audience? Although responses to AIDS education may be affected by a myriad of factors, social psychological research on communication and persuasion provides a conceptual framework for analyzing persuasive communications in terms of multiple categories of *input* variables (McGuire, 1985). These include characteristics of the *source*, *message*, and *receiver* (e.g., Hovland, Janis, & Kelley, 1953; McGuire, 1985). Communicators have consistently been found to be more influential to the extent that they are judged to be credible (i.e., perceived to be trustworthy and competent) and attractive (i.e., perceived as physically attractive, likable, and similar to the audience member). Perceptions of the communicator, in turn, can be influenced by message characteristics (both the content of the message and the way it is presented), as well as audience characteristics such as perceived similarity to the communicator (McGuire, 1985; McGuire, McGuire, Child, & Fujioka, 1978).

This framework suggests that culturally sensitive AIDS interventions for African Americans should be

based on the recognition that Blacks' judgments about the credibility and attractiveness of a source may differ from those of other audiences depending on the race of the communicator (a source characteristic), the extent to which the message is directly relevant to the cultural identity and community experiences of audience members (message characteristics), and the extent to which individual audience members are highly distrustful of Whites in general or AIDS information from White-identified sources in particular (receiver characteristics).

Credibility and Cultural Sensitivity

This translation of the social psychological model into a framework for identifying factors relevant to a video's cultural sensitivity highlights the importance of credibility. In addition to the consistent finding that it is a key factor in successful persuasion (McGuire, 1985), credibility is a particularly crucial variable in AIDS education targeted at communities and populations disproportionately affected by the epidemic. Many U.S. residents doubt the veracity of official information about AIDS and HIV. In particular, many African Americans believe that AIDS represents government malevolence toward their community. In a 1990 *New York Times* survey, for example, almost one-third (29%) of Black New Yorkers agreed that the statement "the virus which causes AIDS was deliberately created in a laboratory in order to infect Black people" was true or might possibly be true (DeParle, 1990, p. A12). Only 13% of White respondents answered comparably.

A similar pattern was observed in a national telephone survey (Herek & Capitanio, 1994), which found that AIDS-related distrust was higher among African Americans than Whites. Roughly one in four Blacks – 27%, compared to 14% of Whites – expressed distrust of scientists and doctors who say that AIDS is not spread by casual contact. One in five Blacks (20%) believed that the government is using AIDS to kill off minority groups, compared to 4% of Whites. And nearly one-half of the Blacks (43%) and one-third of the Whites (37%) believed that information about AIDS is being held back from the public. Only 35% of Black Americans (compared to 55% of Whites) did *not* give a distrustful response to at least one of the three items. Herek and Capitanio (1994) also found that distrust had implications for AIDS-related attitudes and beliefs. African Americans who expressed distrust were more likely than others to overestimate the risks of casual contact and to support quarantine and public labeling of people with AIDS.

The reasons for African Americans' skepticism and distrust about AIDS undoubtedly are complex (for general discussions, see Stevenson, 1994; Turner, 1993). Perhaps it is inevitable that a minority group with substantially less political power than the dominant majority will respond with suspicion when disproportionately affected by a feared disease (Dalton, 1989; Rosenberg, 1987). In the United States, collective memories of slavery and segregation in the African American community further contribute to a climate of distrust for White-identified institutions and authorities (Dalton, 1989; Stevenson, 1994; Turner, 1993). Suspicions also are fueled by common knowledge about past medical abuses of Blacks, such as the Tuskegee Syphilis Study (Herek & Glunt, 1993; Thomas & Quinn, 1991; Stevenson, 1994; Turner, 1993). Consequently, fear of genocide has affected public health campaigns in Black communities (Farrell, Dawkins, & Oliver, 1983; Turner & Darity, 1973). Distrust about AIDS is further fostered by widely publicized claims that AIDS is not caused by HIV or is spread through casual social contact (e.g., Adams, 1989; Duesberg, 1996).

Disbelief and lack of trust clearly have important implications for AIDS education. Put simply, AIDS educational programs will be less effective to the extent that they are not believed by their target audience. People are unlikely to change their sexual behavior, for example, if they do not believe that AIDS can result from unprotected sexual intercourse. Nor are they likely to be willing to interact with people with AIDS (PWAs) if they doubt the truthfulness of medical experts who say that HIV is not transmitted through casual social contact. Creating credible information materials, therefore, is an especially important component of AIDS interventions targeting African Americans.

Proximate and Distal Outputs

Most studies of AIDS educational videos have focused on assessing changes in audience members' beliefs and attitudes about AIDS and, in some cases, AIDS-relevant behaviors such as requesting condoms, talking to friends about AIDS, or seeking HIV-testing. Whereas some studies have demonstrated post-video changes in one or more of these domains, the overall effects have been modest (Kalichman, 1996). In their study of African American adolescents, for example, Stevenson and Davis (1994) observed no differences between viewing groups in level of distress experienced during the intervention, attitudes toward AIDS prevention practices, scores on a forced-choice measure of perceived AIDS risk, and belief in

cultural myths about AIDS (e.g., that AIDS represents a genocidal government conspiracy). Similarly, Kalichman et al. (1993) found no differences among viewing groups for a large number of measures of AIDS-related knowledge, attitudes, and behavior.

Social psychological research on communication and persuasion, however, suggests that expecting a brief video to produce changes in attitudes or behavior may be unrealistic. As McGuire (1985) noted, responses to a communication – which he called *outputs* – range along a continuum from the proximate (e.g., simply noticing the persuasive communication and attending to it) through the more distal (making decisions on the basis of the message, acting in accord with those decisions, consolidating that action into one's ongoing behavior pattern). Each type of output can be influenced by the various input variables (e.g., characteristics of the communicator or message). McGuire (1985) warned about the dangers of expecting that manipulation of an input variable that affects an output variable early in the continuum – such as attention or comprehension of the message – will also affect a distal output variable, such as behavior change. He referred to this as the “great-expectation fallacy” (McGuire, 1985, p. 260).

To be sure, the ultimate goal of all AIDS interventions – including educational videos – is to influence distal variables, such as risk-related behavior. Expecting change in complex habits related to sexual behavior or drug use after a brief exposure to an intervention, however, may be an example of the great-expectation fallacy. Moreover, focusing primarily on distal output variables in empirical research on AIDS videos runs the risk of failing to detect important differences among interventions in their effects on proximate output variables. Such differences may seem modest, but may well be the basis for creating behavioral change through repeated exposure to a variety of communications in an ongoing and comprehensive AIDS intervention.

The Present Studies

For the studies presented in this paper, we began with the assumption that AIDS videos for African Americans should be culturally sensitive (Kalichman, 1996). To address the question of how cultural sensitivity can best be achieved, we manipulated key characteristics of the source (race of communicator) and content (multicultural message versus culturally-specific message). For this purpose, we produced three AIDS educational tapes. By controlling the script and production techniques, we were able to

ensure that the tapes differed on only two dimensions: race of the announcer and the cultural “framing” of the informational message. We also assessed two relevant audience characteristics – general interracial distrust and distrust specifically of AIDS information.

We assessed both proximate and distal output variables. In the latter group were measures of the extent to which the videos affected viewers’ AIDS-related beliefs, attitudes, and behavioral intentions. Consistent with our discussion of the great-expectation fallacy, however, we did not expect dramatic changes in this group of variables. Instead, our primary focus was on proximate output variables. These included participants’ perceptions of the video (their ratings of its credibility, attractiveness, technical quality, and overall evaluation). We hypothesized that videos would be evaluated more favorably when they featured a communicator who was similar to audience members and a message that was culturally specific to the audience. Therefore, we expected African American audiences to evaluate an AIDS video with a multicultural message more favorably and to perceive it as more credible when it featured a Black announcer than when the identical script was delivered by a White announcer. We expected a video featuring an African American communicator to be even more effective when its message was culturally specific.

We also reasoned that audience members’ reactions would be affected by the extent to which they displayed high preexisting levels of racial distrust and distrust of AIDS information. We expected higher levels of preexisting audience distrust to be associated with unfavorable evaluations of videos featuring a White announcer or a multicultural message, compared to videos featuring a Black announcer and a message specific to African Americans.

We report here the findings from two studies. In Study 1, we assessed reactions to the videos among African Americans recruited in one area of Sacramento and found generally that a culturally-specific video was more effective than a multicultural video. In Study 2, we replicated the Study 1 findings with another community sample recruited from a different area of Sacramento, as well as a sample with a higher socioeconomic status, viz., African American university students. In the second study we also addressed the question of whether audience response to multicultural videos might be improved if the latter are presented in a culturally specific context.

STUDY 1

Method

The Research Setting

The research was conducted in the greater Sacramento metropolitan area. The capital of California, Sacramento is located approximately 90 miles northeast of San Francisco. In the 1990 census, the city’s population was 369,365; Sacramento County had a population of 1,041,219. Approximately 15% of the city’s residents are Black, most of them African American. Blacks represent approximately 10% of the population of Sacramento County. More than one-fourth of Black Sacramento residents live below the poverty level, compared to approximately one-tenth of Whites.

A substantial portion of the city’s African American residents live in the Oak Park or Del Paso Heights neighborhoods. Oak Park, the oldest African American neighborhood, lies near the central business district of Sacramento and consists primarily of single-family housing built early in the 20th century; many houses have been subdivided into apartments. It is the setting for most of the community-based institutions that serve Black Sacramento.

Del Paso Heights was, until recently, an unincorporated outlying area north of the city in Sacramento county. Without city zoning controls, it developed as a mixture of low-density commercial, industrial, and working class housing uses along an old major highway. There are relatively few community institutions serving the African American community in the Del Paso Heights neighborhood.

Through June, 1997, a total of 2,635 AIDS cases had been reported in the Sacramento metropolitan area (CDC, 1997, p.7). Blacks are disproportionately represented among local AIDS cases: In Sacramento County, 19% of the adults with AIDS and 48% of children with AIDS are non-Hispanic Blacks (“Epidemiology,” 1997).

Participants

Except where noted, participants for all studies reported in the present paper were African American residents of the greater Sacramento metropolitan area, including Davis. The Study 1 sample consisted of 174 adults recruited through fliers distributed throughout the Oak Park neighborhood (including community centers and churches) and advertisements placed in a local African American newspaper. The fliers and print advertisement offered payment of \$10 to African American adults (at least 18 years of age) for watching a health education videotape and

completing questionnaires, and provided a local telephone number for additional information. Interested individuals were invited to come to a community center during one of several specified times to participate in the study. All adults who came to the study site were allowed to participate.

Videos

Using our own production equipment, we created three versions of a video that provided basic information about AIDS. The video was hosted by a man in his late 30s identified as Robert Johnson. Visuals consisted of Johnson speaking directly to the camera, interspersed with graphics and illustrative footage obtained from existing AIDS educational videos. The video lasted approximately 8 minutes, and discussed each of the following topics: (1) the AIDS acronym; (2) how AIDS attacks the immune system and what this means; (3) how AIDS is caused by infection with HIV; (4) the HIV acronym; (5) the demographics of the AIDS epidemic in the USA, including that AIDS has disproportionately affected minority communities; (6) how AIDS/HIV is transmitted through infected blood and sexual fluids, which enter the body through homosexual or heterosexual intercourse without a condom or through sharing needles or “works”; (7) how AIDS is not transmitted through casual contact, with examples of casual contact provided; (8) the importance of showing compassion for PWAs; and (9) the importance of learning the facts about AIDS in order to protect oneself and loved ones.

Two different variables were manipulated across the three video versions, Robert Johnson’s race and the extent to which his message was multicultural or culturally specific (the script differences are detailed in Appendix A). One version featured a White male in the role of Robert Johnson; he delivered a multicultural message (*White Announcer/Multicultural Message*, or *WA/MM* video). In the second version, an African American man played the role of Robert Johnson and delivered the same multicultural message (*Black Announcer/Multicultural Message*, or *BA/MM* video). The announcers in the first two versions were identically dressed (they each wore a light shirt and black jacket). The third version featured the same African American man as Robert Johnson, but he delivered a culturally specific message (*Black Announcer/Culturally Specific Message*, or *BA/CSM* version). In the culturally specific version, the video’s introduction and conclusion were altered in order to make viewers’ ethnic identity and community identification more salient (see Appendix A). In addition, we slightly altered the BA/CSM

video’s scenery (a poster of African art was added to the background), the narrator’s dress (he wore a black shirt with the black jacket and a traditional Ghanaian hat and an African necklace), and the script (the announcer used first-person pronouns – “we,” “us” – when referring to the African American community). All other aspects of the production – including camera angles, graphics and visual inserts, and sound – were identical.¹

Measures

Three types of variables were assessed in the course of each video session: (1) perceptions of the video; (2) AIDS-related and race-related distrust; and (3) AIDS-related beliefs, attitudes, and behavioral intentions.²

Perceptions of the Video

Each video was rated on multiple dimensions using 101-point scales (ranging from 0, *not at all*, to 100, *extremely*). The response scales were presented in a graphic format that resembled an automobile speedometer; participants were asked to indicate their response to each item by marking the scale and writing the number in a blank space adjacent to the graphic. The videotape was rated for credibility (6 items), technical quality (5 items), overall evaluation (4 items), the announcer’s credibility (4 items), and his attractiveness (4 items). To retain the 101-point metric, scale scores were computed by summing the item ratings and dividing by the number of items. Table 1 lists the items comprising each video rating scale and the range of internal reliability (*alpha*, or α) coefficients observed across the studies reported in this paper.

Insert Table 1 about here

Levels of AIDS Distrust and Racial Distrust

We used two measures to assess levels of distrust prior to the viewing session. The first was a new 6-item measure of AIDS-related distrust, constructed to assess participants’ attributions of malevolent intent to the government in connection with AIDS (e.g., beliefs that AIDS is a government conspiracy against minorities, that the government is misrepresenting or withholding information about AIDS). Two items were taken from a previous national survey (Herek & Capitanio, 1994) and four new items were constructed on the basis of pilot data obtained from the Sacramento African American community. Responses were on a 5-point Likert-type scale, ranging from *agree strongly* to *disagree strongly*.

The items are listed in Appendix B.

The second measure assessed general distrust of Whites. It consisted of eight items from the Interpersonal Relations subscale of the Cultural Mistrust Inventory, or CMI (Terrell & Terrell, 1981). Responses were on a 5-point Likert-type scale, ranging from *agree strongly* to *disagree strongly*. The full CMI is a 48-item scale with subscales assessing distrust related to Politics and Law, Education and Training, Business and Work, and Interpersonal Relations. The Interpersonal Relations (IP) subscale was used because the items in it seemed most relevant to assessing general trust or distrust of Whites. Excluding IP subscale items that appeared to be double-barreled or that had outdated wording left eight items. In a pilot administration to 59 Sacramento-area African Americans, the 8-item subscale had acceptable reliability ($\alpha = .69$). In the three studies reported in the present paper, *alphas* for this measure ranged from .66 to .72.

AIDS-Related Beliefs, Attitudes, and Behavioral Intentions

Beliefs about HIV transmission through casual contact. Before and after watching the video, participants indicated the extent to which “an African American person in Sacramento can get AIDS” from “shaking hands with someone who has the AIDS virus,” “sharing a drinking glass with someone who has AIDS,” “being sneezed on by someone who has the virus,” and “using a public toilet.” Responses were on a 5-point scale ranging from *definitely no* to *definitely yes*, with the midpoint defined as *maybe*. Responses to the four items – all of which represent types of casual contact incapable of transmitting HIV – were summed to form a Casual Contact Beliefs scale. Higher scale scores indicate higher levels of inaccurate beliefs about the risks posed by casual contact. Across the three studies reported here, internal reliability ranged from $\alpha = .61$ to $.69$ for the pre-video administration, and $\alpha = .77$ to $.92$ for the post-video administration.

Attitudes concerning quarantine. Using a 5-point Likert-type scale, participants indicated their agreement or disagreement with the statement, “People with AIDS should be legally separated from others to protect the public health.” The item was administered before and after the video.

HIV testing behavioral intentions. After the video, participants indicated the likelihood that they would get a blood test for HIV in the next six months, using a 4-point scale ranging from *no, definitely not* to *yes, definitely*.

Stigma-reduction behavioral intentions. After the

video, participants indicated their behavioral intentions concerning future willingness to interact with PWAs using a 3-item scale developed in previous research (Herek & Capitanio, 1993). Participants were provided with three hypothetical scenarios and asked to indicate what action they would be likely to take. The situations were: (1) having a child with AIDS at the same school that their own child (or a grandchild, niece, or nephew) was enrolled; (2) working in an office where a male employee was diagnosed with AIDS; and (3) learning that a neighborhood grocer had AIDS. For each scenario, participants were provided with alternatives that indicated stigmatizing (e.g., avoidance of the person with AIDS) or nonstigmatizing (e.g., treating the PWA the same as always or going out of one’s way to help) behaviors. Scale scores could range from 0 to 3, with higher scores indicating a greater willingness to show compassion for PWAs or to avoid stigmatizing them. Internal consistency was acceptable (across samples, $.52 < \alpha < .73$).³

Risk-reduction behavioral intentions. Using two newly-constructed scenarios, the same format was used to assess behavioral intentions to reduce one’s risk for HIV after watching the video. In one scenario, participants indicated what they would do in a situation where someone whom they found very attractive wanted to have sexual relations with them, but they (the respondent) did not know whether the other person was infected with HIV. In the second scenario, participants indicated what they would do if the same person described in the previous scenario did not want to use a condom. For both scenarios, a variety of responses were provided that indicated unsafe (e.g., would have sex without a condom) or safe (e.g., would have sex only with a condom, would not have sex at all) behaviors. Unsafe behavioral intentions were scored 0 and safe intentions were scored 1. These items could not be combined into a reliable scale, probably because of a ceiling effect (roughly 85% of respondents indicated they would choose the safe behavioral alternative in each of the hypothetical situations). Consequently, the items were analyzed separately using MANOVA.

Additional Measures

Prior to showing the video, we assessed three additional variables to check for randomness of assignment to the three viewing conditions. We asked respondents a series of factual questions about HIV and AIDS, the extent to which they felt three emotions toward people with AIDS (fear, disgust, and anger), and their personal history of HIV testing. At the conclusion of the video, we assessed the

extent to which participants felt that information about AIDS is important for themselves and their community, and the extent to which they felt that their participation in the study was important for AIDS prevention generally and for the local African American community.

In addition, the questionnaire included items to ascertain each respondent's gender, age, educational level, current employment status, marital and parental status, participation in the previous election, HIV serostatus, and personal contact with a person with AIDS or HIV.⁴

Procedure

All viewing sessions were conducted in small groups (mean group size = 12 people) at a local African American community center, with one of the three versions of the video randomly assigned to each session. In most cases, two viewing sessions were conducted simultaneously in separate rooms, with participants randomly assigned to a room.

Upon arrival, the purpose of the study was explained to each participant. After answering any questions, the researcher gave each participant \$10 cash, a copy of the UC Davis Experimental Subject's Bill of Rights, and a blank questionnaire form. If multiple viewing sessions were being conducted simultaneously in that time period, respondents were randomly assigned to a session. Light refreshments were provided.

Because our pilot research led us to expect that some participants would have a low level of reading skills and would be unfamiliar with written questionnaires, we created a video to provide detailed instructions for completing the self-administered surveys. When they first arrived, participants watched a brief section of this video featuring one of the research staff involved in data collection; she welcomed participants to the study and provided them with a general explanation of the study's purpose and procedures. They then completed an initial questionnaire, consisting of self-explanatory demographic questions and some of the pretest items.

After all participants had completed the initial questionnaire, the researcher resumed showing the instructional videotape which featured members of the research team explaining how to complete the different parts of the questionnaire and reading some sections of the questionnaire aloud.⁵ At the appropriate moment, the researcher stopped the instructional videotape, played the experimental AIDS video, and then restarted the instructional tape which led participants through the video rating scales and the remainder of the questionnaire. After the

session ended, the researcher answered participants' questions. All members of the research team who interacted with participants or provided videotaped instructions were African American; they remained unaware of the study's hypotheses during data collection.

Methodological Check of Comparability of Videos

Our hypotheses predicted group differences in African Americans' video ratings because of our experimental manipulations of source and message characteristics. If observed, however, such differences might have an alternative explanation, viz., they might result simply from unintended variations in production quality. For example, although we tried to minimize any extraneous differences among the videos, it was possible that one of the two actors who portrayed Robert Johnson was more convincing or attractive than the other, or that one video was technically superior to the others.

Whereas our hypotheses predicted that a Black audience would react more favorably to the versions featuring an African American communicator and a culturally specific message, we had no reason to expect a similar pattern of reactions from a non-Black audience. We reasoned, therefore, that if a non-Black audience showed a preference for the BA/MM or BA/CSM videos, it would indicate that those videos were not equivalent in quality to the WA/MM video. It was also possible that White viewers would prefer the WA/MM video over the others because they would perceive the announcer as more similar to themselves. An audience of individuals who were neither Black nor White, however, should not display a preference for either announcer on the basis of race.

As a methodological check, therefore, we showed each video to groups of non-Black undergraduate university students (total $N = 120$) who received course credit for their participation. Almost half (47%) of the students were Asian-American, with another 38% White, 10% Latino, and 5% self-categorized as "other" (East Indian, Punjabi, and Middle Eastern). Most of them were female (76%), young adult (mean age = 21), unmarried (97%), and childless (97%). Following procedures similar to those described above for the African American viewers, each student watched one of the three videos and then rated it using the five video rating scales.

The mean video ratings were 63.53 for overall evaluation, 84.09 for video credibility, 70.66 for technical quality, 80.28 for announcer credibility, and 57.94 for announcer attractiveness. MANOVA revealed no significant differences among the

viewing conditions for any of the five rating scales. (For this sample, the statistical power of the analyses to detect differences as large as those found in the Study 1 sample below ranged from .70 to .99, depending on the rating scale). Additional MANOVAs revealed no significant differences between the video ratings of Asian American and White students.

Whereas this comparison does not prove that no unintended differences existed between the videos (indeed, such proof of the null hypothesis would be impossible), it strengthens our confidence in interpreting any differences in African Americans' reactions to the video as resulting from our experimental manipulations rather than from spurious factors.⁶

Results

Sample Characteristics

As shown in Table 2, the sample consisted of 174 individuals, most of them female, currently unmarried, a parent, unemployed, and not politically active. The median educational level was some technical school or college. Most participants reported that they personally knew (or had known) someone with AIDS or HIV. More than half had themselves been tested for HIV, almost all of them reporting a negative test result (1 participant did not know the test result).

Insert Table 2 about here

Assessment of Randomization Among Experimental Groups

Comparisons among experimental groups (using ANOVA) indicated no significant differences for prior levels of General AIDS Knowledge, Casual Contact Beliefs, feelings toward PWAs, AIDS Distrust, or general distrust of Whites. A *chi-square* test indicated no difference among experimental groups in the distribution of individuals who had been tested for HIV. The estimated statistical power to detect a medium effect size (Cohen, 1988) in these analyses with the present sample size approximated .90.

Importance Attached to the Study

After watching the video, participants overall felt that their participation in the research was important to the Sacramento African American community ($M = 82.8$ on a 101-point scale) and to AIDS prevention in Sacramento ($M = 81.4$). They also attached

considerable importance to AIDS information, both for themselves personally ($M_s = 88.6$) and for the Sacramento African American community generally ($M = 85.6$). MANOVA revealed no differences in importance ratings among viewing conditions.

Insert Table 3 about here

Hypothesis Tests

Perceptions of video. Table 3 details the mean ratings for each video. As hypothesized, audience ratings of the BA/CSM (Black Announcer/Culturally Specific Message) video were consistently the most favorable whereas ratings of the WA/MM (White Announcer/Multicultural Message) were consistently the least favorable. Significant multivariate effects were obtained for the one-way multivariate analyses of variance (MANOVAs) with the three video rating scales as dependent variables (Pillai's trace, $V = .2016$, $F(6,336) = 6.28$, $p < .001$) and the MANOVA with the two ratings of the announcer (Pillai's trace, $V = .2917$, $F(4, 340) = 14.52$, $p < .001$). Univariate F tests revealed significant effects for all five rating scales (all $ps < .05$): credibility of the video ($F = 11.04$), technical quality of the video ($F = 10.86$), overall evaluation of the video ($F = 5.18$), credibility of the announcer ($F = 28.58$) and attractiveness of the announcer ($F = 25.83$). In all cases, ratings of the BA/CSM were significantly higher than ratings of the WA/MM (using the Student Newman Keuls statistic, $p < .05$). For three of the measures (video credibility, announcer credibility, and announcer attractiveness), ratings of the BA/MM (Black Announcer/Multicultural Message) video were significantly higher than ratings of the WA/MM video. In addition, the BA/CSM video was rated significantly higher than the other two for technical quality and announcer attractiveness.

MANOVA also revealed significant interaction effects between sex of viewer and video category (Pillai's trace, $V = .1877$, $F(10, 324) = 3.36$, $p < .001$). The source of this effect was almost entirely within the WA/MM condition. Women rated the video with a White announcer more favorably than did men on four of the five criteria (overall evaluation, technical quality, announcer attractiveness, and announcer credibility). Video ratings did not differ significantly by age, educational level, marital or parental status, employment, political involvement, HIV-testing history, or knowing a person with HIV.

Distrust and video ratings. We expected viewers'

preexisting distrust concerning AIDS to affect the credibility that they attached to the videos, regardless of the video condition. To assess this effect, we constructed five regression equations using the five video ratings as the dependent variables. We entered AIDS distrust scores, along with dummy codes for the video conditions, as independent variables. We then conducted similar analyses using racial distrust scores. AIDS distrust explained 3.8% of the variance in overall credibility ratings (controlling for the different video conditions), 3.7% of the variance in ratings of the announcer's credibility, and 2.3% of the variance in overall video evaluation (all $ps < .05$). Racial distrust explained 3.0% of the variance in overall evaluations ($p < .05$).

We also analyzed multiplicative interaction effects (pre-existing distrust by dummy-coded viewing condition). Recognizing the high likelihood of Type II error in these analyses (McClelland & Judd, 1993), we set $p < .10$. We did not observe any significant effects for the interaction terms, indicating that there was no differential effect among viewing groups for AIDS distrust or general distrust of Whites.

Changes in AIDS beliefs, attitudes, and intentions. Repeated measures ANOVA indicated that participants were less likely to overestimate the risk of casual contact and to support quarantine after watching any of the videos. Mean scores for the Casual Contact Beliefs scale were 1.00 and 0.56 for pre- and post-viewing administrations, respectively ($F(1,169) = 41.44, p < .001$). Mean scores for quarantine were 2.80 (pre) and 2.53 (post); $F(1,168) = 4.75, p < .05$). Participants also displayed increased worry about contracting AIDS (pre-video mean = 3.57, post-video mean = 4.21; $F = 6.52, p < .05$) and higher estimates of their own risk for AIDS (pre-video mean = 2.31, post-video mean = 3.09, $F = 16.67, p < 0.01$) after watching the video. ANOVAs did not reveal any significant interaction effects, indicating that the videos did not have a differential impact on any of these variables. No differences were observed across groups in behavioral intentions related to stigma or risk-reduction, or in intentions to be tested for HIV.

Discussion

A community sample of African Americans judged an AIDS educational video to be significantly more credible when it featured an African American communicator rather than a White communicator. Furthermore, the video was evaluated more favorably when its message focused exclusively on the African American community. In contrast to the significant

differences in proximate output variables, differential changes in AIDS beliefs, attitudes, and behavioral intentions were not observed among the videos.

The fact that the culturally-specific AIDS video was evaluated significantly more favorably than the other videos by an African American audience (but not by White or Asian American viewers) suggests that such videos might represent an important component for increasing the effectiveness of comprehensive, ongoing programs of AIDS education. Conversely, multicultural AIDS videos might be less useful in education campaigns targeting African Americans.

We recognized that this finding required replication before it could be used to inform AIDS educational programs. Moreover, replication of the study with African American audiences from a different social stratum was highly desirable in order to determine whether the findings were generalizable beyond Blacks with relatively low socioeconomic status. To address these concerns, we conducted a follow-up study with two new samples. One sample in Study 2 was recruited in the community in a manner comparable to that for the Study 1 community sample. The other sample was recruited from African American university students, who were expected to have higher educational and socioeconomic status than the community samples.

The findings from Study 1 also raise an important practical question for AIDS education programs: If, indeed, multicultural videos (and, perhaps, other educational materials) are less effective than culturally specific programs, should existing multicultural videos simply be discarded? Or can their effectiveness be enhanced by presenting them in conjunction with other educational materials that are culturally specific? One possibility, for example, is that a culturally-specific message could prime an audience to subsequently perceive a multicultural video in a more favorable light than would be the case if the latter were simply presented alone. A priming effect might occur if the initial presentation of a culturally specific message successfully established a context that audience members perceived to be affirming of their racial identity and their membership in the African American community. Such priming might create associations between the multicultural video and the culturally-specific video that preceded it, or might increase the salience of aspects of the multicultural video directly relevant to African American audiences. Alternatively, multicultural videos may prove to be less favorably received than culturally specific videos, regardless of the context in which they are

presented.

To address this question, we produced a second set of AIDS videos that presented more extensive information about personal risk reduction, condom use, and partner negotiation than the videos utilized in Study 1. We designed these videos to be shown after viewers had already seen one of the videos used in Study 1. We refer to them, therefore, as *follow-up* videos. Two versions of the follow-up video were produced, each using footage from existing AIDS videos interspersed with original graphics explaining facts about HIV. One version featured visuals exclusively of Blacks (the *culturally-specific follow-up*, or *CSF*), whereas the other version featured visuals of people from a variety of racial groups (the *multicultural follow-up*, or *MF*). We showed either the CSF or MF tape to participants in the new samples after they watched one of the three videos from Study 1 (which we refer to hereafter as *priming* videos).

Based on the results of Study 1, we expected the culturally-specific priming video to be regarded the most favorably, and the multicultural priming video featuring a White announcer to be regarded the least favorably. Consistent with that pattern, we also hypothesized that viewers would perceive the culturally-specific follow-up video to be more credible and would rate it more positively than the multicultural follow-up. Based on our priming hypothesis, we expected ratings of the multicultural follow-up video to be more favorable when it was preceded by the culturally-specific priming video (BA/CSM) or, to a lesser degree, the multicultural priming video that featured a Black announcer (BA/MM).

Finally, we also wished to further explore the social psychological processes that may underlie differential perceptions of AIDS educational programs. In addition to assessing audience characteristics related to racial distrust and distrust of AIDS information, we assessed the extent to which the follow-up video evoked feelings of concern about participants' own well-being, the well-being of a loved one, and the African American community. We also used a recall measure to assess the extent to which participants attended to the follow-up video. We hypothesized that differences in perceptions of the follow-up video would be associated with differences in the extent to which it evoked feelings of concern and was attended to by viewers.

STUDY 2

Method

Participants

Data were collected from two samples. First, in order to replicate and extend the findings from Study 1, a new *community sample* was recruited. It consisted of 173 adults recruited primarily in the Del Paso Heights neighborhood of Sacramento through procedures similar to those used in Study 1.

Second, to assess the generalizability of the Study 1 findings to African Americans from a different social stratum, a *campus sample* was recruited. It consisted of 143 African American students and their friends who were recruited from the campuses of UC Davis and California State University at Sacramento. Participants in the campus sample were contacted through announcements made at meetings of various African American organizations and by leaflets distributed on the campuses. As with the other two samples, the fliers and announcements offered payment of \$10 to African American adults (at least 18 years of age) for watching a health education videotape and completing questionnaires. Campus volunteers were directed to call a local telephone number for additional information and to arrange to participate in one of the video sessions.

Videos

The same videos were shown to both the community and campus samples. The priming tapes were the same three videos used in Study 1. After the priming tape, all viewers watched one of two AIDS risk-reduction tapes, both of which were developed by editing footage from existing AIDS videos in combination with original graphics and titles. The topics covered included how HIV can be transmitted, how transmission can be prevented, how to use a condom, and strategies for negotiating condom use with one's sexual partner. The visuals in one tape depicted individuals from a variety of racial backgrounds, including African American and White. The individuals seen in the other tape were all African American. Both tapes lasted approximately 11 minutes.⁷

Measures

The same set of measures was used with both the community and campus samples. In addition to the measures from Study 1, two new types of assessments were included to explore the psychological processes that might underlie ratings of the follow-up video. First, we used three 3-item scales to assess the extent to which the follow-up

video evoked feelings of concern about participants' own well-being, the well-being of a loved one, and the African American community (see Table 4). The items in these scales used the same 101-point response scale described earlier for perceptions of the videos. Second, to assess the extent to which participants attended to the follow-up video, we measured recall of the video's content. Participants indicated whether or not they remembered seeing each of eight different sequences in the videos. In both follow-up conditions, four of the described sequences actually occurred in the video that the participant watched whereas the other four did not. Scoring was accomplished by summing the number of correct answers (i.e., accurate recall that a particular sequence was or was not shown in the video).

Insert Table 4 about here

Procedure

Identical procedures were followed with both the community and campus samples. All of the study procedures and stimuli were identical to those used in Study 1, except that the follow-up video was shown to participants after they completed their ratings of the priming video. Because the follow-up video had no announcer, the two scales assessing announcer ratings were not used in its evaluation. All viewing sessions were conducted in small groups at a local African American community center (community sample) or in a UCD or Sacramento State University classroom (campus sample). After participants rated the follow-up video (using the same items for video credibility, technical quality, and overall evaluation as in Study 1), they completed the follow-up measures as in Study 1.

Results

Sample Characteristics

As shown in Table 2, the community sample ($N = 173$) was demographically similar in most respects to the Study 1 sample, except that the Study 2 community sample had a slightly lower educational level and was somewhat more likely to have been tested for HIV or to know a person with AIDS or HIV. Like the two community samples, the campus sample ($N = 143$) was predominantly female. In contrast to the community sample, however, the campus participants were younger, more educated, largely unmarried and childless, employed, and politically active. Slightly fewer than half had been

tested for HIV or personally knew a PWA.

Assessment of Randomization Among Experimental Groups

Comparisons among experimental groups (using ANOVA) indicated no significant differences for prior levels of General AIDS Knowledge, Casual Contact Beliefs, AIDS Distrust, or general distrust of Whites.⁸ A *chi-square* test indicated no difference among experimental groups in the distribution of individuals who had been tested for HIV. In the community sample, participants in the BA/CSM condition scored significantly higher on negative feelings toward PWAs than did those in the WA/MM condition ($M = 3.62$ and 2.24 , respectively, $F(2,170) = 3.71$, $p < .05$).

Importance Attached to the Study

After watching both videos, participants overall felt that their participation in the research was important to the Sacramento African American community ($M_s = 86.83$ and 81.7 on a 101-point scale for the community and campus samples, respectively) and to AIDS prevention in Sacramento ($M = 85.13$ and 77.0). They also attached considerable importance to AIDS information, both for themselves personally ($M_s = 86.66$ and 86.1) and for the Sacramento African American community generally ($M = 87.09$ and 87.7). MANOVA revealed no differences among experimental conditions.

Perceptions of Priming Video

As in Study 1, a significant multivariate effect was obtained with both samples for the one-way multivariate analyses of variance (MANOVAs) with the three video rating scales (for the community sample, Pillai's trace, $V = .1791$, $F(6,334) = 5.47$; for the campus sample, $V = .1886$, $F(6,274) = 4.76$, both $ps < .001$) and the two announcer rating scales (for the community sample, Pillai's trace, $V = .3221$, $F(4,334) = 16.30$; for the campus sample, $V = .3786$, $F(4, 268) = 15.65$, both $ps < .001$) as dependent variables. Univariate F tests revealed significant effects for all five rating scales (all $ps < .05$; see Table 3): credibility of the video ($F_s = 9.53$ for the community sample and 14.90 for the campus sample), technical quality of the video ($F_s = 12.45$ and 6.54), overall evaluation of the video ($F_s = 13.25$ and 3.84), credibility of the announcer ($F_s = 27.17$ and 36.23) and attractiveness of the announcer ($F_s = 31.79$ and 27.74). Ratings of the BA/CSM were significantly higher than ratings of the WA/MM for all five rating scales (see Table 3). For three of the measures (video credibility, announcer credibility, and announcer attractiveness), ratings of the BA/MM

were significantly higher than ratings of the WA/MM for both samples. In contrast to Study 1, video ratings did not differ significantly by participants' sex in either the community sample or campus sample. Nor did they differ by age, educational level, marital or parental status, employment, political involvement, HIV-testing history, or knowing a person with HIV.

Insert Table 5 about here

Perceptions of Follow-up Video

As hypothesized, the culturally-specific follow-up video was rated consistently higher than the multicultural follow-up for credibility, technical quality, and overall evaluation (see Table 5). A significant multivariate effect was observed (for the community sample, Pillai's trace, $V = .1141$, $F(3,164) = 7.04$; for the campus sample, $V = .3220$, $F(3,133) = 21.05$, both $ps < .001$), and all three univariate effects were significant (all $ps < .001$): for the follow-up video's credibility (for the community sample, $F(1,166) = 18.55$; for the campus sample, $F(1,135) = 31.48$), its technical quality ($F_s = 14.90$ and 55.89 , respectively), and its overall evaluation ($F_s = 11.25$ and 47.30). Ratings did not differ significantly by participants' demographic characteristics in either the community sample or campus sample.

Responses to the items assessing concerns evoked by the videos suggested that the multicultural follow-up aroused lower levels of community identification than did the culturally-specific follow-up (see Table 5). In both samples, viewers of the multicultural follow-up reported feeling significantly less concern about the African American community than did viewers of the culturally-specific follow-up, regardless of priming video condition (for the community sample, $F(1,165) = 4.29$, $p < .05$; for the campus sample, $F(1,131) = 28.12$, $p < .001$). In the campus sample (but not the community sample), a similar pattern was observed for the follow-up video's effects on viewers' concerns for their own well-being ($F = 6.68$, $p = .01$) and that of a loved one ($F = 9.23$, $p < .01$).

Priming Effect of First Video

Ratings of the follow-up video tended to be less favorable overall when it was preceded by the priming video featuring the White announcer than by the culturally-specific priming video (main effect for priming video: for the community sample, Pillai's trace, $V = .0807$, $F(6,330) = 2.31$, $p < .05$; for the campus sample, $V = .1031$, $F(6,268) = 2.43$, $p <$

$.05$). Ratings of the multicultural follow-up appeared to be most favorable when it was preceded by the culturally specific priming video (BA/CSM). This effect was most pronounced in the campus sample, in which the follow-up ratings of the multicultural video were least favorable when it was preceded by the priming video that featured a White announcer (for the interaction effect, Pillai's trace, $V = .1564$, $F(6, 268) = 3.79$, $p < .001$), with significant univariate F_s for overall evaluation of video 2 ($F(2, 135) = 7.67$, $p = .001$), credibility of video 2 ($F = 6.82$, $p < .01$), and technical quality ratings of video 2 ($F = 4.10$, $p < .05$). In the community sample, ratings of the multicultural follow-up tended to be less favorable when it was preceded by either multicultural priming video (whether the announcer was White or Black) than when it was preceded by the culturally-specific priming video; the interaction effect was marginally significant (Pillai's trace, $V = .0661$, $F(6,330) = 1.88$, $p = .08$), with significant univariate F_s for overall evaluation ($F(2,166) = 4.22$, $p < .05$) and technical quality ratings ($F = 3.86$, $p < .05$) of the follow-up video.

These patterns are consistent with the hypothesized priming effect: Watching the culturally-specific priming video apparently increased the favorability ratings of the follow-up, even when it had a multicultural focus.

Distrust and Video Ratings

Priming video. As in Study 1, we constructed two sets of regression equations for each sample with the five video ratings as the dependent variables. In one set of equations, we entered AIDS distrust scores on the first step – along with dummy codes for the priming video conditions – as independent variables; on the second step, we entered scores for multiplicative interaction effects (distrust by priming condition). In the second set of equations, we followed the same pattern with racial distrust scores substituted for AIDS distrust.

In the community sample, ratings of the video and the announcer tended overall to be less favorable among respondents with higher levels of distrust. However, this pattern was reversed among respondents in the BA/CSM condition. Considering first the analysis of AIDS-related distrust, the unstandardized regression coefficients were statistically significant for the distrust-by-prime interaction for the video's overall evaluation, announcer credibility, and announcer attractiveness ($bs = 1.3847$, 1.2863 , and 2.3473 , respectively; all $ps < .05$). The same pattern was observed for racial distrust ($bs = 1.1109$, 1.3922 , and 2.4458 ,

respectively; all $ps < .10$). The interaction terms accounted for between 1.7 and 3.4% of the variance in the respective video rating variables beyond that explained by distrust and the priming condition. The patterns for ratings of video credibility and technical quality were similar but not statistically significant.

In the campus sample, distrustful viewers similarly tended to rate the video more favorably in the BA/CSM condition than in the other conditions, but the interactions were not statistically significant.

Follow-up video. When we examined the relationships between distrust and ratings of the follow-up videos, we found the same pattern for the relationship of racial distrust to ratings of the follow-up video's credibility. In the community sample, higher levels of racial distrust predicted lower credibility ratings for the multicultural video ($b = -.3370$, n.s.) but higher credibility for the racially targeted video (for the interaction term, $b = .7366$, $p = .10$). For the community and campus samples' other ratings of the follow-up video, the patterns were generally similar but not statistically significant.

Changes in AIDS Beliefs, Attitudes, and Intentions

Repeated measures ANOVA indicated that participants were less likely to overestimate the risk of casual contact after watching a video. In the campus sample, means were 0.64 (pre) and 0.27 (post) ($F(1,139) = 46.92$, $p < .001$). The post-viewing change in beliefs did not differ among the three video conditions in the campus sample. In the community sample, in contrast, a significant interaction effect for changes in casual contact scores was observed between the priming video condition and the follow-up video condition. For the 3-way interaction (prime by follow-up by pre/post), $F(2,164) = 3.81$ ($p < .05$). The greatest increase in knowledge about casual contact occurred among those who watched the BA/CSM priming tape and the culturally-specific follow-up (means = 1.317 before and 0.317 after, change = -1.0). The least change occurred among those who watched the WA/MM priming tape and the culturally-specific follow-up (means = 0.886 before and 0.515 after, change = -0.371), with other groups displaying intermediate levels of change (ranging from -0.49 to -0.685).

Consistent with our expectations about the limited efficacy of a single brief intervention, other changes were more modest. As in Study 1, participants displayed a reduction in support for quarantine after watching the video, regardless of viewing condition (for the community sample, $F(1,166) = 5.34$; for the campus sample, $F(1,139) =$

21.25; $ps < .05$). In the community sample (but not the campus sample), we also observed marginally significant effects for risk-reduction and stigma-reduction intentions. Regardless of the follow-up video, community participants who watched the BA/CSM video displayed greater intention to reduce their HIV risk in sexual encounters than did the viewers of the BA/MM video, who in turn displayed greater risk-reduction intentions than viewers of the WA/MM video ($p = .08$). In the area of stigma reduction, viewers of the culturally-specific follow-up displayed greater compassion for PWAs than did viewers of the multicultural follow-up ($p = .07$). No significant effects were observed for ratings of one's own risk for AIDS, personal worry about contracting AIDS, or intentions to be tested for HIV in either sample.

Recall of Follow-up Video Content

Analysis of variance (ANOVA) revealed a significant difference in accurate recall between follow-up video conditions for both samples. Participants who saw the culturally-specific follow-up recalled more information about its content than did those who saw the multicultural follow-up. In the community sample, $M_s = 4.96$ and 3.18, respectively ($F(1,167) = 215.35$, $p < .001$). In the campus sample, $M_s = 5.23$ and 3.18 ($F(1,137) = 473.33$, $p < .001$).

General Discussion

In this series of studies, African American adults from the greater Sacramento-Davis area responded more favorably to AIDS videos that featured a Black communicator rather than one who was White, and a culturally specific message rather than a multicultural message. Videos with a Black communicator and culturally specific message were evaluated as more credible, as technically superior, and more favorably generally. In addition, the Black communicator was perceived to be more attractive and credible than a White communicator. The same effects were observed in different social strata of African Americans, suggesting that they are not specific to a particular socioeconomic group. However, similar effects were not observed among Asian American and White viewers, which suggests that the observed patterns reflect group differences in perceptions of the video (rather than, for example, objective differences in the tapes' technical quality or the actors' attractiveness or skill).

Because convenience samples were utilized in the present study, it cannot be known to what extent the findings are generalizable to the African American population of the Sacramento area, much less to all African Americans in the United States. However,

perceptions of the videos were strikingly similar across the three samples – one recruited from an older central-city African American neighborhood; another from a newer, outlying African American neighborhood; and the third from two public university campuses. Although sex differences were observed in Study 1 (males tended to rate the WA/MM tape less favorably than females), they were not replicated in Study 2. No relationships were observed between reactions to the video and respondents' other demographic characteristics. Based on these findings, we believe that the commonalities across samples are more striking than the relatively minor differences we observed. The effects appear to be relatively stable and not specific to a particular African American sample.

Whether similar patterns would be observed among African Americans in other communities and geographic regions and with specific subgroups of the African American population (e.g., sexually-active young adults who are not attending school) remains an empirical question. However, the present findings are consistent with previous studies of AIDS videos targeting inner city African American youth in the Northeast (Stevenson & Davis, 1994; Stevenson, Gay, & Josar, 1995) and African American adults in Chicago (Kalichman et al., 1993), with social science knowledge about effective AIDS interventions (Jemmott & Jones, 1993; Kalichman, 1996), and with social psychological findings about persuasion and communication (McGuire, 1985). Given these consistencies, tentative generalizing from the present sample to the larger African American population seems appropriate.

Our finding of consistent significant differences in proximate outcomes across viewing conditions suggests that cultural sensitivity is better achieved through a culturally-specific video than a multicultural video. Whether culturally specific videos are also superior at eliciting changes in distal outcomes – such as long-term AIDS-related attitudes, beliefs, and behaviors – cannot be determined from the present data set. The overall lack of differential outcomes in most distal variables across the three samples suggests that, as expected, a single exposure to a brief video is unlikely to have a substantial impact on viewers' attitudes, beliefs, and behaviors. However, it is reasonable to assume that influencing proximate outputs – including an audience member's likelihood of attending to the message, finding it interesting, thinking about it, and believing it – is necessary, albeit not sufficient, to effect long-term changes of a more dramatic nature.

The results presented here have important

implications for the design of AIDS educational videos and possibly for AIDS education in general. Many existing videos are produced for multiracial audiences and adopt a multicultural approach. The present studies suggest that such videos may not be highly effective with African American audiences. The information that they provide is not likely to be perceived as credible by a significant number of Black viewers and, consequently, they may be relatively unsuccessful in imparting information about HIV. Black viewers' preexisting distrust concerning AIDS and toward Whites in general are likely to affect their perceptions of such videos. In light of these findings, we tentatively encourage AIDS video producers – and the AIDS educators who use them – to utilize culturally specific messages when doing so is practical.

The findings also offer hope, however, for continuing to utilize existing multicultural videos and other materials. Such materials may be useful if they are presented within a culturally-specific context. Educators working with an African American audience, for example, could conduct their educational sessions in a Black-identified setting (e.g., a community center), ensure that all of the educators and staff are African American, and begin the sessions with presentations and discussions that focus specifically on the problem of AIDS in the African American community. After establishing such a context, multicultural videos might be useful if they represent only a small portion of the materials used in the program. Similarly, multicultural AIDS educational messages on broadcast television may be more effective for African American audiences if they are embedded within programming blocks that specifically target Black audiences.

In addition to documenting that differences in the race of the communicator and the focus of the message were associated with different perceptions of a video, the present study offers insights about the psychological processes that may underlie differential perceptions of AIDS educational programs. The findings in Study 2 suggest that the combination of a Black source and a culturally-specific message was necessary to counteract preexisting distrust, which many African Americans feel about AIDS and toward White society (Herek & Capitanio, 1994; Stevenson, 1994; Turner, 1993). Furthermore, videos featuring exclusively African American images were better able to evoke concern about one's community and (in the campus sample) concern for oneself and loved ones. Finally, African American audiences attended more closely to a video with an exclusively African American focus and, consequently, better

remembered its content. Similar patterns have also been reported by Kalichman and Coley (1995) with a sample of African American women who watched a single videotape. Future research should assess more fully the psychological variables that underlie perceptions of AIDS educational messages. In addition to measuring recall of content and the specific types of concern evoked by such messages, for example, subsequent studies might include assessments of the extent to which a video stimulates the viewer to think about relevant counterarguments and supportive arguments, or results in the acquisition of relevant skills (e.g. use of a condom, negotiation with partner).

The present study should be understood as an investigation of only one small piece of a much larger and extremely complex set of issues that affect African Americans' responses to the HIV epidemic. As a field experiment, the number of variables that could be assessed was necessarily limited. Many variables potentially relevant to AIDS education were necessarily left unexplored. In future research, valuable data could be obtained by using a design similar to that of the present study but manipulating other source variables (e.g., gender or age of the communicator) and message variables (e.g., presentation of information through musical or dramatic formats rather than didactic presentations). A variety of other audience characteristics could also be profitably examined. For videos targeting African Americans, for example, relevant receiver variables might include personal experience with the AIDS epidemic or with a PWA, heterosexuals' attitudes toward homosexuality, and attitudes and experiences concerning drug use (e.g., Dalton, 1989; Herek & Capitanio, 1995, 1997; Hetherington, Harris, Bausell, Kavanagh, & Scott, 1996; Thomas & Quinn, 1993).

As the AIDS epidemic expands and African Americans continue to be disproportionately affected by HIV, prevention efforts in the Black community will assume ever increasing importance. Videos represent only one component of ongoing, comprehensive AIDS education efforts that utilize a variety of methods for imparting information and promoting risk reduction. The findings reported here indicate that videos designed for such educational programs are more likely to be effective when they feature members of the community in front of the camera and deliver culturally-specific messages. More broadly, the present study suggests that AIDS interventions will have a better chance for success when they are delivered primarily or exclusively by members of the community, and are conducted within a context of cultural identity and community

values.

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Notes

¹ By its nature, the culturally specific message had to be delivered by an African American communicator. Consequently, a fully-crossed design (which would have included a White announcer delivering the culturally specific message) was not possible.

² Because many of the participants in our study had never attended college, they were not accustomed to completing self-administered questionnaires (SAQs) in the way that college student samples usually are. Consequently, they tended to need more time to complete their SAQs than would be the case with college students, and their responses often displayed less consistency than is typical with students. We conducted extensive pilot research in the Sacramento African American community before finalizing our questionnaires. In that research, we often obtained very low *alpha* coefficients for scales that we had used successfully with more highly educated samples in the past. Most of the *alphas* reported here are in the range of .60 to .90, which we judged to be acceptable.

³ Because these items included several response alternatives, they required considerably more time than other items, especially from respondents with low-level reading skills. To reduce respondent fatigue, we administered them only in the post-video questionnaire.

⁴ We did not assess sexual orientation because our pilot research indicated that many respondents were likely to take offense at any questions about their sexuality or past sexual behavior. Given our focus on issues related to credibility, we were reluctant to include items in the questionnaire that might arouse feelings of animosity or distrust. It was the impression of our field staff (including several staff

members who were well-connected to the Sacramento area African American gay community) that the vast majority of participants in the study would have identified themselves as heterosexual in response to a question about their sexual orientation. Because of our randomized design, the few participants who might have identified as gay, lesbian, or bisexual could be expected to have been distributed randomly across viewing conditions.

⁵ To reduce response bias, we minimized the connection between the research staff members involved in data collection and the group that had produced the AIDS videos. To this end, production techniques were employed for the instructional tape to make it appear quite distinct in origin from the AIDS priming and follow-up tapes. Overall, the instructional tape quality was similar to that of a videotaped classroom lecture using a single stationary video camera, with adequate audio and visual quality for guiding participants through the experimental session. The AIDS tapes, in contrast, were intended to have a more professional appearance; they used a variety of camera angles, included numerous visual inserts and professional-quality graphics to illustrate points, had high-quality sound, and included opening and closing credits with music.

⁶ We recognize that the student sample used for this methodological check differed from the community sample in important respects other than race, including socioeconomic status. However, the similar response patterns observed among the three African American samples described in this paper (one of which was a campus sample with similar socioeconomic status to the non-Black sample used for the methodological check) are consistent with our conclusion that the videos were perceived differently by African Americans than by non-Blacks.

⁷ As in Study 1, we showed the follow-up video to a group of non-Black undergraduate students (total $n = 101$) who received course credit for their participation. No significant differences were observed among the viewing conditions for any of the three rating scales. (For this sample, the statistical power of the analyses to detect differences as large as those found in the Study 2 samples of African Americans ranged from .70 to .90, depending on the rating scale).

⁸ Throughout the following section, separate statistical analyses were conducted for data from the campus and community samples.

Table 1
Video Rating Scales

Overall Evaluation (.81 < α < .92)

1. How interesting was the video to you?
2. How much was the video directly meaningful to you personally?
3. How much did you feel the video respected your intelligence?
4. How much did you like the video overall?

Technical Evaluation (.78 < α < .91)

1. How much did you like the way the video looked (the visual quality)?
2. How much did you like the way the video sounded (the audio quality)?
3. How well could you hear the words spoken in the video?
4. How well did you feel you understood the meaning of all the words used in the video?
5. How “professional” did you feel the video was?

Video Credibility (.86 < α < .91)

1. How much did you trust what the video said about AIDS?
2. How much did you believe what the video said about AIDS?
3. How much did you feel the video gave correct information about AIDS?
4. How much did you feel the people who made the video were experts about AIDS?
5. How much did you agree with what the video said about AIDS?
6. How much did you feel the video gave all the important facts about AIDS?

Announcer Credibility (.88 < α < .90)

1. How much did you trust him?
2. How much did you believe what he said?
3. How much did you feel he knew what he was talking about?
4. How much did you agree with what he said?

Announcer Attractiveness (.82 < α < .88)

1. How much did you feel you would like to meet him in person?
2. How much did you like the way that he looked (his physical appearance)?
3. How much did you like the sound of his voice?
4. How much did you like the speed at which he spoke?

Table 2
Sample Characteristics

	STUDY 1 (Community)	STUDY 2 (Campus)	STUDY 2 (Community)
<i>n</i>	174	143	173
<i>Gender</i>			
% Female	56%	58%	63%
% Male	44%	42%	37%
<i>Age (mean)</i>	37	24	35
<i>Education</i>			
Median grad.	Some tech/college	Some college	High school
% with Bachelor's degree	5%	10%	4%
% with no College/Tech school	46%	6%	53%
<i>Marital Status</i>			
% Married	23%	3%	24%
% Single	46%	89%	43%
% Separated/Divorced	28%	8%	28%
% Widowed	3%	0%	5%
<i>Children</i>			
% with children	88%	15%	83%
Median number children	3	2	3
<i>% Employed (previous week)</i>	26%	66%	30%
<i>% Voted in last major election</i>	47%	61%	38%
<i>HIV Testing</i>			
% Tested	54%	39%	46%
HIV + (<i>n</i>)	3	0	1
<i>% Know PWA or PWHIV</i>	56%	41%	40%

Table 3
Mean Ratings of the Priming Video

Rating Scale		White Announcer/ Multicultural Message (WA/MM)	Black Announcer/ Multicultural Message (BA/MM)	Black Announcer/ Culturally-Specific Message (BA/CSM)
<i>Cell n</i>				
STUDY 1 (Community)		61	62	51
STUDY 2 (Campus)		51	45	45
STUDY 2 (Community)		61	58	49
<i>Video Credibility</i>				
STUDY 1 (Community)	<i>M</i>	75.55 ^a	85.78 ^b	87.62 ^b
	<i>sd</i>	(20.00)	(11.55)	(10.14)
STUDY 2 (Campus)	<i>M</i>	75.87 ^a	85.17 ^b	90.41 ^c
	<i>sd</i>	(16.22)	(13.77)	(7.10)
STUDY 2 (Community)	<i>M</i>	78.09 ^a	85.63 ^b	90.50 ^b
	<i>sd</i>	(19.58)	(13.61)	(9.88)
<i>Overall Evaluation</i>				
STUDY 1 (Community)	<i>M</i>	72.20 ^a	77.87	83.94 ^b
	<i>sd</i>	(23.42)	(17.16)	(12.58)
STUDY 2 (Campus)	<i>M</i>	64.44 ^a	72.28	76.12 ^b
	<i>sd</i>	(22.82)	(19.22)	(21.06)
STUDY 2 (Community)	<i>M</i>	72.72 ^a	81.47 ^b	88.02 ^c
	<i>sd</i>	(19.65)	(15.83)	(8.88)

Table 3 (continued)

Rating Scale		White Announcer/ Multicultural Message (WA/MM)	Black Announcer/ Multicultural Message (BA/MM)	Black Announcer/ Culturally-Specific Message (BA/CSM)
<i>Technical Quality</i>				
STUDY 1 (Community)	<i>M</i>	75.55 ^a	78.02 ^a	87.87 ^b
	<i>sd</i>	(18.48)	(13.91)	(7.22)
STUDY 2 (Campus)	<i>M</i>	68.01 ^a	73.44	79.73 ^b
	<i>sd</i>	(20.36)	(11.82)	(13.30)
STUDY 2 (Community)	<i>M</i>	73.22 ^a	82.10 ^b	84.85 ^b
	<i>sd</i>	(14.06)	(13.36)	(11.41)
<i>Announcer Credibility</i>				
STUDY 1 (Community)	<i>M</i>	70.98 ^a	88.05 ^b	90.71 ^b
	<i>sd</i>	(22.46)	(12.21)	(9.86)
STUDY 2 (Campus)	<i>M</i>	60.90 ^a	84.45 ^b	88.62 ^b
	<i>sd</i>	(23.27)	(13.78)	(10.64)
STUDY 2 (Community)	<i>M</i>	69.67 ^a	84.08 ^b	93.54 ^c
	<i>sd</i>	(23.72)	(15.59)	(7.07)
<i>Announcer Attractiveness</i>				
STUDY 1 (Community)	<i>M</i>	50.91 ^a	71.19 ^b	81.43 ^c
	<i>sd</i>	(25.70)	(23.24)	(18.79)
STUDY 2 (Campus)	<i>M</i>	39.34 ^a	64.86 ^b	70.79 ^b
	<i>sd</i>	(25.44)	(17.59)	(20.82)
STUDY 2 (Community)	<i>M</i>	50.42 ^a	76.35 ^b	82.68 ^b
	<i>sd</i>	(29.12)	(20.27)	(18.89)

M = mean; *sd* = standard deviation. Within rows, values with different superscripts are significantly different from each other (Student Newman Keuls, $p < .05$).

Table 4
Additional Ratings Measures For Study 2

Concern for Self (.64 < α < .76)

1. How much did the video make you feel afraid while you watched it?
2. How worried for yourself did you feel while you watched the video?
3. How much did the video make you think about whether or not you are at risk for getting AIDS?

Concern for Loved One (.64 < α < .78)

1. How worried for someone you love did you feel while you watched the video?
2. How much did the video make you want to talk about AIDS to someone you care about?
3. How much did the video make you want to try to get someone you care about to protect themselves from AIDS?

Concern for Community (.70 < α < .82)

1. How worried for the African American community did you feel while you watched the video?
2. How much did the video make you feel concerned about the African American community?
3. How much did the video make you feel proud to be a part of the African American community?

Table 5
Mean Ratings of the Follow-up Videos (Study 2)

Rating Scale		Culturally Specific Follow-up		Multicultural Follow-up	
		Campus (<i>n</i> = 69)	Community (<i>n</i> = 89)	Campus (<i>n</i> = 74)	Community (<i>n</i> = 83)
Video Credibility	<i>M</i> sd	87.54 ^a (10.89)	86.29 ^b (13.18)	74.21 ^a (18.43)	77.71 ^b (18.29)
Overall Evaluation	<i>M</i> sd	82.79 ^a (17.46)	81.30 ^b (16.07)	58.94 ^a (24.80)	70.07 ^b (26.14)
Technical Quality	<i>M</i> sd	79.83 ^a (15.60)	81.74 ^b (12.13)	58.13 ^a (20.91)	71.44 ^b (21.75)
Concern for Self	<i>M</i> sd	42.29 ^a (26.76)	45.15 (31.22)	31.63 ^a (23.62)	46.77 (26.41)
Concern for Loved One	<i>M</i> sd	66.28 ^a (24.52)	71.13 (28.69)	52.60 ^a (28.86)	71.95 (23.00)
Concern for African American Community	<i>M</i> sd	78.24 ^a (18.23)	81.20 ^b (20.97)	55.57 ^a (30.62)	74.54 ^b (22.62)

M = mean; sd = standard deviation. Within rows for each study, ratings that share the same superscript are significantly different from each other ($p < .05$).

Appendix A

Script Differences Between the Multicultural and Culturally Specific Videos

Multicultural Message Script (excerpts)

OPENING: Hello, my name is Robert Johnson, and I want to talk to you for a few minutes about a problem that threatens us all. You know, Americans have faced many challenges in our history. World wars, poverty, natural disasters, prejudice and discrimination, and just learning how to live together and make our democracy work. Today we still have lots of problems. As the 21st century approaches, we're struggling to solve them, just as we've always done. But since the early 1980s, a new menace has come on the scene. That menace is AIDS. AIDS stands for Acquired Immunodeficiency Syndrome....

AIDS DEMOGRAPHICS: For years, many Americans believed that AIDS was only a disease of White gay men. Some still do. But the truth is that AIDS is a dangerous threat to everyone. Straight and gay, men and women, young and old. AIDS is especially a problem for Black and Hispanic Americans. Since the beginning of the epidemic, approximately 350,000 Americans have been diagnosed with it.... Now, Blacks make up only about 12 percent of the population in the United States, and Hispanics only about 6 percent. But 31 percent of people with AIDS are Black, and 17 percent are Hispanic. 31 and 17 percent. When we talk about children with AIDS, minority groups are even more at risk. Approximately 5000 children and babies have been diagnosed with AIDS.... More than 20 percent of the children with AIDS in the United States are Hispanic. And more than half – 55 percent – are African American. AIDS is now one of the leading killers of Americans – men, women, and children. We don't know exactly where AIDS came from or exactly why it is happening here and now. We don't know how to cure AIDS or how to stop HIV once it gets inside a person's body. We don't yet know how to save those men, women, and babies with AIDS. But we do know exactly how people get infected with HIV....

CLOSING: AIDS threatens us all. It's up to each of us to respond to it. We must each take responsibility for stopping the spread of AIDS. We have to educate ourselves about AIDS and we have to raise the consciousness of all Americans about the disease. We each need to examine our own behaviors. If we're at risk for AIDS through sharing needles or having unprotected sex, we must change our behaviors.

Whether we are personally at risk or not, we all must help our children, our families, our friends, and our neighbors to protect themselves from HIV. And we must reach out with love and compassion to our loved ones and neighbors who have AIDS. It's up to each one of us to learn about AIDS – to protect ourselves and to protect our loved ones.

Culturally-Specific Message Script (excerpts)

OPENING: Hello, my name is Robert Johnson, and I want to talk to you for a few minutes about a problem that threatens the African American community. Blacks in the United States have always had to stick together, just to survive as a people. For years, segregation and legal discrimination once kept us second class citizens. Today, we are still confronted with racism and oppression in our daily lives. We still face racial violence and hatred aimed at our community. But we are successfully overcoming the obstacles placed in our path. By hard work and pulling together, we are asserting our full citizenship and developing our community in ways that benefit us as a people. Now a new menace threatens us as Blacks; that menace is AIDS. AIDS stands for Acquired Immunodeficiency Syndrome....

AIDS DEMOGRAPHICS: For years, many African Americans believed that AIDS was only a disease of White gay men. Some still do. But the truth is that AIDS is a dangerous threat to all of us in the Black community. Since AIDS was first discovered in 1981, approximately 350,000 Americans have been diagnosed with it.... Now, we make up only about 12 percent of the population in the United States. But of the 350,000 people with AIDS, 31 percent are Black. 31 percent. When it comes to children with AIDS, we are even more at risk. Approximately 5000 children and babies have been diagnosed with AIDS.... More than half of them -- 55 percent -- are African American. AIDS is now one of the leading killers of African American men, women, and children. We don't know how to cure it or how to stop HIV once it gets inside a person's body. We don't know exactly where AIDS came from or exactly why it is happening here and now. Different folks in our community have lots of different opinions about that. But whatever you believe about where AIDS came from, you've got to understand that it's here now, and it's killing us, and we've got to stop it....

CLOSING: Our community is under attack – by racism, poverty, drugs, violence. Now we have to add AIDS to that list. We must respond to it or it will wipe us out. Each of us must take responsibility for doing whatever we can to stop the spread of AIDS in the Black community. We each need to examine our own actions – and if we’re at risk for AIDS through sharing needles or having unprotected sex, we must change our behaviors. We’ve got to raise the consciousness of all Black people about this disease. We’ve got to help our children, our families, our friends, and our neighbors to protect themselves from HIV. And we’ve got to reach out with love and

compassion to Black people who are living with AIDS. We must fight for more and better services for them. Just as we’ve done so many times in the past, African Americans must now come together with a singular purpose – this time, to stop the spread of AIDS in our community. It’s up to each one of us to learn about AIDS – to protect ourselves, to protect our loved ones, and to protect our people.

Note. Except for the sections printed in this table, the scripts for the two messages were identical.

Appendix B

Measures of AIDS-Related Distrust and General Distrust of Whites

AIDS-Related Distrust (.71 < a < .76)

1. The government is lying to African Americans about AIDS.
2. AIDS is part of a government plot against Blacks.
3. Personally, I believe doctors and scientists when they say that you *can't* get AIDS through casual social contact.
4. The government is *not* telling us the whole story about how AIDS is spread.
5. The government is using AIDS to experiment on African Americans.
6. The government is using AIDS as a way of killing off minority groups.

General Distrust of Whites (Cultural Mistrust Inventory, Interpersonal Relations Subscale) (.66 < a < .72)

1. Blacks should be suspicious of a White person who tries to be friendly.
2. There are some Whites who are trustworthy enough to have as close friends. (Reversed)
3. It is best for Blacks to be on their guard when among Whites.
4. Whites are as trustworthy as members of any other ethnic group. (Reversed)
5. Whites can rarely be counted on to do what they say.
6. Whites are usually honest with Blacks. (Reversed)
7. Whites will say one thing and do another.
8. Whites will usually keep their word. (Reversed)