On "knowing your partner": Dangerous illusions in the age of AIDS?

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Abstract

We identified two characteristics of the impression formation process that may cause people to underestimate the riskiness of potential sexual partners. In Study 1, participants were quite confident that they could determine whether someone was lying to them about risk-related behavior when, in reality, they could not. Particularly troubling was a "truth bias" that resulted in relatively high rates of truth detection, but poor lie detection. In Study 2, increased familiarity with a target person (who actually was HIV+) caused participants to lower their estimates of the target's riskiness, despite the fact that we explicitly warned them that the target might be HIV+. We suggest that such processes may foster the illusion of knowing one's partner when one does not.

"Know your partner." Writing in 1986, the Surgeon General of the United States issued this stern injunction to sexually active Americans. Disturbed by evidence that thousands were contracting the virus that causes AIDS (HIV) through sexual contact, he urged people to exercise caution in choosing sexual partners and to refrain from engaging in unprotected sex.

Now, almost a decade after the Surgeon General's exhortation, many people have still not taken his message to heart. For example, in one sample of college students, 72% were sexually active in the previous

Correspondence regarding this article should be sent to William B. Swann, Jr., Department of Psychology, University of Texas, Austin, Texas, 78712. E-mail: SWANN@.PSY.UTEXAS.EDU. year and, of those, 44% had sex with two or more partners, using condoms only 25% of the time (Fisher & Misovich, 1990). Other researchers have confirmed that young Americans are continuing to engage in unprotected sex with multiple partners (e.g., Abler & Sedlacek, 1989; DeBuono, Zinner, Daamen, & McCormack, 1990; DiClemente, Forrest, & Mickler, 1990; Fisher & Fisher, 1992; Mangan, 1988; Miller, Turner, & Moses, 1990: Moore & Rosenthal, 1993). Such practices have undoubtedly contributed to the soaring rate of infection; recent estimates are that 1 of 100 adult men and about 1 of 800 adult women in the United States are now HIV+ (Levy, 1992).¹

To many observers, the willingness of otherwise sensible young men and women to engage in risky sex is as astonishing as it is disturbing. Paradoxically, some of the individuals who religiously fasten their seat belts before heading to a party blithely

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^{1.} When we called the Centers for Disease Control on March 21, 1995, we were informed that these figures still represent the centers' best estimate of the rates of HIV infection.

jump into bed with alluring strangers later that same evening. Such behavior raises a simple question: Why?

In this report we offer one answer to this admittedly complex question. We suggest that many practitioners of risky sex believe that they have considerable insight into the character of their prospective partners. Convinced that their insights make them invulnerable (cf. Weinstein, 1984), they take risks that they would otherwise deem unacceptable.

The Decision to Have Risky Sex

Williams et al. (1992) conducted one of the first careful studies of the rationales underlying the high-risk sexual behavior of heterosexuals (see also Ingham, Woodcock, & Stenner, 1991; Offir, Fisher, Williams, & Fisher, 1993). Using a focus group methodology, they studied how groups of four to eight students explained their own sexual behaviors. The researchers then summarized the major sentiments that emerged during the group discussions.

Students asserted that, as long as they liked and were familiar with their partner, unprotected sex was safe. For example, one student explained that "When you get to know the person . . . as soon as you begin trusting the person . . . you don't really have to use a condom" (p. 926). Another young man noted that, "I knew my partner really well before we had sex, so I didn't have to worry about her sexual history" (Williams et al., 1992, p. 926). These reports suggest that some students have taken the U.S. Surgeon General's "know your partner" mandate at face value.

We corroborated and extended the findings of Williams et al. (1992) in a recent pilot study. We asked 56 college students to list what they would look for if concerned about contracting AIDS from a potential sexual partner. As did Williams et al., we discovered that many students (36%) mentioned how well they knew their partner. In fact, familiarity was second in frequency only to the sexual background of the prospective partner (64%). Students were also quite concerned with the potential partner's honesty (30%), as well as what their partner had to say about his or her latest health exam (23%), condom and drug use (21% and 19%, respectively), and virginity (14%).

Note that the primary source of information about all of these risk factors (e.g., previous sexual activity, drug use, health, etc.) is the potential partner. This is potentially problematic because those who enter the sexual marketplace will probably be reluctant to divulge factors that would identify them as risky and may even lie about their sexual history (e.g., Cochran & Mays, 1990). This means that lie-detection ability may play a crucial role in knowing one's partner, with unskilled lie detectors being deceived.

Lie Detection in Social Interaction

Although people generally have trouble forming objectively accurate images of one another (for reviews, see Hogarth, 1975; Kahneman, Slovic, & Tversky, 1982; Nisbett & Ross, 1980; Swann, 1984; Tversky & Kahneman, 1971, 1973, 1974), lie detection seems to be an area of particular weakness. Researchers have shown repeatedly that people's ability to detect lies hovers around chance or slightly above (e.g., DePaulo, Stone, & Lassiter, 1985; Kraut, 1980; Zuckerman, DePaulo, & Rosenthal, 1981). Even professional lie catchers perform quite modestly in this arena (e.g., DePaulo & Pfeifer, 1986; Ekman, 1981; Kohnken, 1987; Kraut & Poe, 1980).

Despite people's dismal track record as lie detectors, their confidence within this domain runs high (e.g., DePaulo et al., 1985). Moreover, the more contact people have with targets, the more confident they become—despite the fact that increased familiarity does not necessarily improve accuracy (e.g., Buller, 1988; DePaulo & Pfeifer, 1986; McCornack & Levine, 1990; McCornack & Parks, 1986; for a related study involving clinicians' perceptions of clients, see Oskamp, 1965). Having said this, we acknowledge that people may be unusually adept in detecting lies about AIDS-related issues. After all, the media's extensive coverage of the epidemic has presumably made people more wary of potential sexual partners. Such wariness may improve lie detection by encouraging people to attend to channels of communication that are difficult to control (and thus diagnostic), such as tone of voice (Zuckerman, Spiegel, DePaulo, & Rosenthal, 1982). In principle, then, it is possible that the AIDS epidemic has served to bolster lie-detection abilities by fostering suspicion. We tested this possibility in Study 1.

Study 1: Detection of Lies Related to Risky Behavior

To determine how well people can detect lies related to AIDS risk status, we had college students ask fellow students (targets) a series of questions regarding their risky behavior. Targets lied half of the time. To determine if prior interaction improves lie detection, we had some participants interact with targets before the lie-detection session. We examined the ability of participants to detect lies, as well as their impressions of targets.

Method

Participants

The participants, 50 males and 53 females, took part in this study for credit in their introductory psychology class. The targets, who were students enrolled in an independent research class, had the option of becoming involved in several unrelated studies. To simulate heterosexual dating encounters, we always paired participants with targets of the opposite sex.

Procedure

Constructing low- and high-risk response profiles. Three males and three females served as targets. All had been interviewed early in the semester and told that the experiment would require them to respond to a series of questions about their sexual behavior in a truthful and nontruthful fashion. We reassured them that the only person who would have access to information about their true responses was the project coordinator, a female graduate student in her thirties. All expressed comfort with this task. We made no effort to recruit targets who were particularly good or bad liars, nor did we offer them any training in how to lie successfully. All targets remained blind to the nature and purposes of the study until we had completed data collection.

Targets first answered a series of eight questions regarding their sexual histories: (1) Do you know of anyone who has AIDS? (2) Have you been tested for AIDS? (3) Have you ever had a partner who used IV drugs? (4) Have you ever used IV drugs? (5) What is the usual length of your sexual relationships? (6) How often do you use condoms during sexual intercourse? (7) How many partners have you had intercourse with? (8) Since you have been sexually active, how frequently have you engaged in sexual intercourse?

We approached the task of creating one high- and one low-risk profile for each target by first having each person provide truthful answers to each of the eight questions. Answers usually consisted of two to three sentences. Two raters examined each target's responses and identified the four highest risk answers and the four lowest risk answers. To create the high-risk profile, we took the four highest risk answers and had the target lie to the four remaining questions in a manner that fostered the perception of riskiness. To create the low-risk profile, we took the four lowest risk answers and had the target lie to the four remaining questions in a manner that minimized his or her apparent risk. According to this scheme, then, the low-risk lies were the most serious threats to the health of the participants, followed by high-risk truths (if they were not perceived as such).

The foregoing procedure was designed to produce all combinations of high- and low-risk lies to each of the eight questions. In virtually all cases, the resulting profiles seemed coherent and believable (for some example answers, see Appendix A). In those instances in which an answer seemed incongruous or unbelievable, we modified the set by substituting a high-risk answer for a low-risk answer or vice versa. One consequence of this procedure was that no low-risk lies were told to question 4 and no high-risk lies were told to question 6.

The considerable variety of sexual experiences and risk-related activities of the targets produced a wide variation in the sequencing of lies and truths in the low- and high-risk conditions (the exact sequence we used is available from the first author). We randomly assigned participants to the highor low-risk condition. The risk manipulation proved effective, as indicated by the fact that participants rated "high-risk" targets as being riskier than "low-risk" targets, F(1, 101) = 5.82, p < .02.

The manipulation of familiarity. The experimenter introduced the experiment as an effort to find out how people form impressions of others and get to know them. She explained further that the participant would be required to discuss some sexual topics.

After this introduction, participants in the no-interaction control condition simply sat alone quietly for 10 minutes. In contrast, participants in the interaction condition had a 10-minute getting-acquainted conversation with a person who was introduced as another introductory psychology student (actually the target). The getting-acquainted conversation was completely unstructured; usually the topic was course work, leisure activities, and the like. At no point did the conversation drift to AIDS or sexual behavior.

After the 10-minute interaction, the experimenter asked the target to leave the room with her for additional instructions. The pair returned shortly thereafter and the lie-detection interview began.

The lie-detection interview. In both the nointeraction condition and the interaction condition, the experimenter explained that the participant would be conducting a brief interview that featured eight questions. The experimenter instructed the participant to ask each question, listen to the target's reply, and then answer two questions about the target's reply. First, the participant guessed whether the target had lied or told the truth. Then, the participant indicated how likely it was that his or her guess was correct on a scale ranging from 0% to 100%.

The experimenter noted that the target would be lying some of the time and then left the room. Upon completion of the interview, participants privately completed the post-interview questionnaire. On 9point scales, they indicated how much they liked the target, how well they thought they had gotten to know the target, and how similar the target was to them.

Results and Discussion

Overall accuracy

We calculated the number of times participants accurately detected a lie or truth relative to the number of times they failed to do so over all eight trials. Overall, they guessed correctly 51.9% of the time, which is not different from chance, F < 1. This poor performance was equally evident in the interaction and no-interaction conditions, F < 1. In addition, accuracy was low regardless of the time of the semester that we conducted this research, F < 1, thus indicating that the low rates of accuracy were not due to a tendency for targets to become better liars over the course of the semester.

Despite their inability to detect lies, however, participants believed that they were quite capable within this domain. In fact, they estimated that they had correctly identified the target's response as a lie or truth fully 70% of the time. Such high levels of confidence, contrasted against their inability to identify lies, amounted to considerable overconfidence, F(1, 100) = 78.21, p < .001.

The poor performance of our participants was punctuated by a fair amount of gullibility. That is, despite the fact that we explicitly warned participants that targets would sometimes lie to them (an advantage that lie detectors often do not enjoy), they assumed that the target was telling the truth 68.4% of the time (the actual rate was 50%). This "truth bias" was statistically reliable, t(102) = 11.11, p < .002, and was just as evident in the interaction condition as it was in the no-interaction condition, F < 1. Presumably, this tendency to assume that people are telling the truth reflects the fact that, in naturally occurring settings, most people speak the truth most of the time (e.g., Grice, 1975). Indeed, researchers have shown that this truth bias is a widespread phenomenon (e.g., DePaulo et al., 1985).

Lie detection, truth detection, and accuracy in the high- and low-risk conditions

Ability to detect lies or truths could contribute to the overall accuracy scores discussed above. For people interested in avoiding AIDS, however, these two forms of accuracy are not equal: It is far more important to recognize a lie that makes a risky target seem safe (lie detection) than it is to recognize a truth that makes a safe target seem safe (truth detection). Unfortunately, the presence of the "truth bias" suggests that participants were better truth detectors than they were lie detectors. A direct examination of the relevant data supported this conclusion. Whereas truth detection was a respectable 70.1%, lie detection was a considerably more modest 33.7%, F(1, 102) = 108.40, p < .001. This same pattern held within both the low- and high-risk conditions, wherein participants performed roughly twice as well in detecting truths (78.3% and 61.5%, respectively; F(1, 101) = 12.97, p = .0005) as compared to lies (36.3% and 31.0%, respectively; F(1,101) = 1.17, n.s.)

Overall accuracy was greater in the lowas compared to the high-risk conditions (57.3% and 46.3%; respectively, F(1, 101)= 11.22, p < .002). Conceivably, participants remained more attentive to targets in the low-risk condition because none of their responses discounted them as possible dates. In the high-risk condition, however, one high-risk answer may have been enough to disqualify them from consideration. Details regarding the effects of order, target, and their interaction appear in Appendices B and C.

Impressions of the target

Those who interacted with the target before the lie-detection session liked that target more than those who did not, F(1, 96) =17.62, p < .001 (Xs = 7.43 and 6.51, respectively), and they felt that they had gotten to know the target better, F(1,96) =14.43, p < .001 (Xs = 4.65 and 3.53, respectively). Interacting did not increase perceived similarity to the target, however, F(1,96) =1.55, n.s.

These effects may seem surprising, given that interacting with the target did not diminish judgments of riskiness on the measures of lie detection. This probably reflects the fact that participants made each truth/lie judgment immediately after receiving an answer to each question. This procedure surely focused their attention onto the answer itself and away from thoughts of their interaction with the target. Such a focus also makes sense in light of the fact that the targets' answers to questions about sexual riskiness were obviously more diagnostic of sexual riskiness than the information that targets received in the interaction.

Gender effects

Overall, men and women performed on a par with one another. Closer examination of the data, however, revealed that gender interacted with the manipulation of riskiness, whether we examined lie detection, F(1, 99) = 4.77, p < .04, truth detection, F(1, 99) = 7.57, p < .008, or overall accuracy, F(1, 99) = 13.42, p < .0005. The pattern of means was similar for all three measures. Males outperformed females in the low-risk conditions on the measures of lie detection.

tion (Ms = 44.2 and 28.2, respectively) and overall accuracy (Ms = 63 and 51.9, respectively), Fs(1,51) > 5.42, ps < .03. Females outperformed males in the high-risk conditions on truth detection (Ms = 70.2 and 52.1, respectively) and overall accuracy (Ms = 51.9 and 40.1, respectively), Fs (1,48) > 7.29, ps < .004. Therefore, when paired with targets of the opposite sex, men outperformed women in detecting lies, but women were better than men in detecting truths. The vulnerability of women to the lies of men is particularly troubling when one considers that their male partners may lie to them as a means of luring them into bed. We will have more to say about these findings in the general discussion section.

In summary, the results of Study 1 suggest that participants had no idea when targets were lying to them. Moreover, although interacting with the target before the lie-detection session bolstered participant's feeling that she or he knew the target, it did nothing to improve lie-detection ability. These findings point to another possible problem with the "know your partner" strategy. If increased familiarity fosters a feeling of knowing one's partner without a concomitant increase in the accuracy of their impressions, then, as people get to know one another, they may become increasingly convinced that their partners are uninfected even if this is untrue. We tested this possibility in Study 2.

Study 2

Past research suggests two independent reasons why increased familiarity with a person may reduce that person's apparent riskiness. Research on the effects of "mere exposure" (e.g., Zajonc, 1968) has suggested that simply being exposed to a neutral or positive stimulus makes it more "perceptually fluent" (Jacoby & Kelley, 1987), and fluency can, in turn, be misattributed to stimulus attributes such as "likable" (see Bornstein, 1989; Bornstein & D'Agostino, 1994.) In a similar fashion, increased fluency could also promote perceptions of physical health. Alternatively, familiarity may reduce apparent riskiness by triggering an overgeneralization process. For example, learning that a target person has "normal" life experiences might trigger an implicit personality theory (e.g., Schneider, 1973) that leads perceivers to conclude that the target is "normal" in all respects—including HIV status.

To test these possibilities, we had participants view a videotape of a target person. In the baseline control condition, participants saw the target momentarily. In the mere-exposure condition, they saw the target for a minute. In the familiarity condition, they witnessed the target discuss her background and interests for a minute.

We also included two additional comparison conditions to assess sensitivity to diagnostic (i.e., AIDS-relevant) information. In the diagnostic condition, participants witnessed the target give a 1-minute account of her infection with the AIDS virus. Participants in the familiarity/diagnostic condition witnessed a tape that included the material in both the familiarity and diagnostic conditions. In all conditions, after viewing the tape, participants rated the probability that the target was HIV+, as well as how much they liked her, thought that they knew her, and felt similar to her.

Two additional features of our design deserve comment. First, we assumed that people would be quite unaware of--and thus unable to correct for-the processes through which familiarity would reduce perceived risk. To provide a relatively stringent test of this possibility, before making their ratings, participants learned that there was a 50-50 chance that the target in the videotape was HIV+. We reasoned that this information would make them particularly wary of extraneous influences that might distract them from the truth. Second, to test the possibility that an HIV+ person might exhibit some extremely subtle cues regarding their risk status, we selected a target who was HIV+ (but who showed no obvious signs of being ill).

Method

Participants

The subjects, 75 males and 82 females at the University of Texas at Austin, participated for credit in their introductory psychology class. As there were no main or interactive effects of gender, we will not discuss this variable any further.

Procedure

The experimenter introduced participants to a study of impression formation. He explained that the participants would be forming an impression of someone who had been videotaped in a previous experiment.

Videotape presentation. Participants saw a videotape of an attractive female who was HIV+. Participants witnessed either (a) a still picture of the target for 2 seconds (control); (b) the same picture for 1 minute (mere exposure); (c) a 1-minute video in which the target discussed innocuous information about her background and interests (familiarity); (4) an emotional 1-minute video in which the target discussed how she contracted the HIV virus and how it had changed her life (diagnostic); or (5) a 2-minute video that included the discussion of background and interests, followed by the discussion of how she contracted the HIV virus and how it changed her life (familiarity/diagnostic). A transcript of the video in the familiarity and diagnostic conditions can be found in Appendix D. (The original design also included a second baseline control in which an HIV+ male was viewed for 2 or 60 seconds. Impressions of the male stimulus person were virtually identical to impressions of the female target.)

Post-questionnaire. After presenting the videotape, the experimenter noted that "we have vidoetapes of several target persons and half of them are HIV+." He then had participants rate the probability that the target was HIV+ on a scale ranging from 0% to 100%. In addition, participants also indicated, on 9-point scales, (1) how much they liked the target, (2) how well they thought they had gotten to know the target, and (3) how similar the target was to them.

Results

Did exposure to, or familiarity with, the target reduce her apparent riskiness? An overall analysis of variance (ANOVA) of estimates of riskiness revealed a reliable effect of our manipulation, F(4, 102) = 6.67, p <.001. The means displayed in column 1 of Table 1 indicate that participants in the familiarity condition perceived the target as less likely to have HIV than those in the control group. In contrast, participants in the diagnostic condition rated the target as more likely to have HIV than did those in the control group. Finally, participants in

	Probability target is HIV+	Got To Know	Liking
Baseline control	50.3 _b	1.59 _a	5.09 _a
Mere exposure	49.7 _b	1.93	5.04
Familiarity	36.3 _a	$3.67_{\rm h}$	5.86 _{ab}
Diagnostic	65.3°	3.33h	5.86 _{ab}
Familiarity/Diagnostic	60.2_{cb}	$4.14_{\rm h}$	6.32 _h

Table 1. Study 2: Impact of familiarity and mere exposure on perceptions of a risky target

Note: Common subscripts within columns indicate that means are equal according to a two-tailed t-test with an alpha of .05.

the mere-exposure condition and the familiarity/diagnostic condition did not differ from controls.

As can be seen in column 2 of Table 1, our manipulation influenced participants' ratings of how well they knew the target, F(4, 101) = 14.66, p < .001. The means show that participants felt that they got to know the target more in the familiarity, diagnostic, and familiarity/diagnostic conditions than in the control and mere-exposure conditions. A similar, albeit slightly weaker, pattern emerged when we examined liking for the target, F(4, 103) = 3.21, p < .02 (see column 3 of Table 1). Our manipulations had no impact on perceived similarity, F =1.46, n.s. Finally, there were no main or interactive effects of gender in any of the analyses.

We were somewhat surprised that merely being exposed to a target person had no impact on perceived riskiness. Although this may mean that mere exposure does not influence perceptions of HIV riskiness, it may also reflect our decision to depart from the standard mere-exposure manipulation in an effort to ensure that our manipulation of mere exposure paralleled our manipulation of familiarity. Conceivably, a slightly different manipulation of mere exposure may have been more effective. For example, mere-exposure manipulations are usually much briefer than ours; indeed, longer exposure times seem to diminish the effectiveness of such manipulations (Bornstein, 1989). Also, mere-exposure manipulations often consist of presenting stimuli repeatedly rather than for a single extended exposure as we employed.

Whereas mere exposure to the targets did not reduce the target's apparent riskiness, familiarity with their background did. In a sense, this finding is reassuring. That is, our participants were clearly basing their judgments on a certain logic ("Hearing someone tell me about herself makes me better understand her"). Unfortunately, their logic was flawed because such information does not necessarily bear any relation to that person's HIV status.

Of course, the fact that information presented in the familiarity condition lowered perceptions of HIV riskiness raises the possibility that this information was related to HIV risk. To check this possibility, we had an independent group of 39 participants rate the extent to which each of the statements made in the familiarity condition (see Appendix D) influenced whether they thought that the speaker was HIV+ on 3point scales (A =reduces HIV risk; B =no effect; C = increases HIV risk). We then employed a Kolmogorov-Smirnov goodness-of-fit test with a criterion of p < .25 for rejection of the null hypothesis (that items did not affect AIDS risk). This procedure led us to delete two items from the tape: "I grew up in a small town in Maine" and "My family was upper middle class" (p values were between .1 and .2). When we had a fresh group of 17 participants view the new tape, their responses did not differ from those who participated in the original familiarity condition: all Fs < 1. This finding laid to rest our concern that some of the information presented in the familiarity condition was diagnostic of HIV risk.

Our findings suggest that people base their assessments of riskiness on a "what is familiar is safe" assumption-an assumption that is as untrue in many real-world contexts as it was in our experimental context. To be sure, our findings do suggest that diagnostic information may counter the effect of familiarity: participants in the familiarity/diagnostic conditions rated the target as more risky than did those in the familiarity condition. Nevertheless, even when the target tearfully recounted how the HIV virus had changed her life, participants assigned probabilities of only 65% and 60% to her having the virus (in the diagnostic and familiarity/diagnostic conditions, respectively). To be sure, the fact that we told subjects that there was a 50–50 chance that the speaker was HIV+ may have contributed to this effect. Nevertheless, the absolute magnitude of adjustment in the diagnostic conditions (10% to 15%) was no greater than it was in the familiarity condition (14%) in which they received exclusively *non*diagnostic information. Apparently, even when confronted with direct evidence of infection, people are reluctant to conclude that someone who looks perfectly normal and healthy could be infected with the HIV virus.

Discussion

The AIDS epidemic has placed sexually active persons in an unenviable position. Abstinence, the most reliable means of avoiding infection, has garnered few supporters. The next safest route—condom use—has fared only slightly better (e.g., Aronson, Fried, & Stone, 1991). Instead, most people seem to have chosen to continue having unprotected sex, while reassuring themselves that they "know their partner."

Our research was designed to illuminate several processes that might influence the effectiveness of this "know your partner" strategy. Study 1 was based on the assumption that, even if people are able to overcome the embarrassment and anxiety associated with inquiring about potential partners' risk status, their partners may lie to them (Cochran & Mays, 1990). Our findings suggest that such lies may be effective, for our participants were unable to detect them. This is important, because it means that people interested in assessing the riskiness of their partners may be unable to distinguish nondiagnostic lies from diagnostic truths. Considered together with the fact that people base their judgments of riskiness on what potential partners say about themselves (as in our pilot investigation and the Williams et al., 1992, study), these data seem especially troubling.

Skeptics could argue that participants in Study 1 were handicapped by the fact that they scarcely knew the person who lied to them. People who know one another quite well, they might argue, can easily tell if their partners are lying to them. Although this argument is plausible in principle, relevant data undermine it. For example, our findings show that, although interacting with the target before the lie-detection session tended to convince participants that they knew the target, it did nothing to improve lie detection. Furthermore, researchers have found that, as people become more involved with one another, their confidence in their ability to detect lies goes up, but their actual lie-detection ability either remains stable or actually declines (e.g., Buller, 1988; Knapp, 1984; McCornack & Levine, 1990; McCornack & Parks, 1986, 1990; but see also Brandt, Miller, & Hocking, 1980).

Why are people no better at detecting the lies of those whom they know well? Conceivably, as people become better acquainted, increments in trust makes them less vigilant, thus impairing their ability to detect lies. Such diminutions in vigilance may be even more exaggerated when it comes to intimate relationships because of an unwillingness to associate a lover with a fatal disease. For example, one participant in the study by Williams et al. (1992) remarked that "Because I love her...it's kind of hard to think [about AIDS]"(p.926).

Whatever the source of this lack of vigilance and associated inability to detect lies, heterosexual women may be particularly susceptible to it. We found that, although women and men were equal to one another in overall accuracy, men sometimes outperformed women in detecting lies, while women sometimes excelled in detecting truths. Such a tendency, in combination with a tendency for men to use lies as a strategy of seduction, may heighten the risk at which women are placed.

The results of Study 2 offer yet another reason why getting to know a partner may make it difficult to recognize that partner as risky. Merely hearing the target share a few innocuous facts about herself (but not simply seeing her for a while) diminished the apparent riskiness of the target and led to the perception that the target was not infected with the AIDS virus. This tendency to use familiarity to make judgments of healthiness could lead to a false sense of security. Furthermore, when coupled with an inability to distinguish lies from truths, this tendency could conceivably cause people to perceive an unrelenting liar as progressively less risky over time.

Implications

Past studies of impression formation have suggested that people have great difficulty at forming accurate images of one another (e.g., Nisbett & Ross, 1980; Tversky & Kahneman, 1974). Some have critiqued such conclusions by noting that they are based almost exclusively on the results of studies in which participants are asked to make judgments about issues or people that they do not care about. If one wants to know how accurate people *really* are, the argument goes, one must up the ante by having people make judgments that matter to them.

Although there are surely instances in which raising motivation will foster accuracy (e.g., Tetlock, 1987), we suggest that this will probably be true only if people are able to monitor and properly analyze the process under consideration. In our research, participants presumably were unable to detect lies about AIDS risk status, not because they did not care about the issue (few Americans are nonchalant about the AIDS epidemic), but because they did not know what to look for (e.g., nonverbal cues). Similarly, our participants were probably unable to correct for the influence of familiarity on their judgments because the processes behind these judgments operated outside of their awareness. For these and related reasons, shifting the judgmental task to a domain in which the motivational stakes are high will not necessarily enable people to avoid the illusion of insight.

Although one must be careful in generalizing our findings to the world outside the psychological laboratory, our results are hardly reassuring to those who routinely base their decision to engage in unprotected sex on the assurances of potential sexual partners. Instead, our findings and related work on the person-perception process raise the possibility that people's faith in their ability to "know their partner" may sometimes be terribly—and tragically—unfounded.

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APPENDIX A

Examples of Answers to Questions in Study 1

High risk

(1) "Since I've been in college I've met two people who had the virus. A close family friend recently died of AIDS; my uncle died two years ago because of AIDS he contracted as a homosexual."

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- (2) "No, I hate blood tests. Plus, the guys I've been with have been nice looking, normal guys—I can't imagine them having AIDS."
- (3) "Yes, I used to date a girl back in Virginia who used IV drugs. Now, whether or not she used them on a regular basis I'm not sure. She just happened to take

me to a party once where some acquaintances of hers were shooting up. That's where I first saw her use IV drugs."

- (4) "Yeah, I tried it when I was in high school. My friends and I kind of went through a 'we'll try anything' stage—it was really crazy now that I think back on it."
- (5) "In high school, my relationships lasted about four months. Since I've been in college, I've experienced a couple (about six) one-night stands. My sophomore year I had a serious boyfriend that lasted about eight months."
- (6) "I've only used condoms on a few occasions when the girl has insisted. Personally I do not like the way condoms feel, and I don't seem to be able to ejaculate with them."
- (7) "The total number is about twelve this includes my teenage years in high school and my freshman year in college where I had a couple of one-night stands."
- (8) "Well, ever since I've been sexually active I've had sex basically whenever I could get it. When the opportunity presents itself I figure I might as well take advantage of it because not only do I really enjoy sex, but I never know when I may get to engage in it again.

Low risk

- (1) "No, I've never met anyone personally who has AIDS."
- (2) "No, I never felt I really need to because I'm in a monogamous relationship. My boyfriend had a lot of blood work done a while back when he developed an ulcer and he tested negative for AIDS.
- (3) "No, never . . . at least that I know of."
- (4) "No, putting a needle in myself really grosses me out, plus I think you can get addicted really quickly."
- (5) "So far, I've only had one other partner besides my boyfriend and we've been going out for three years."
- (6) "I always use condoms during sexual intercourse. Not only do I like to avoid the risk of contracting a STD, but I really don't want to deal with impregnating some girl."
- (7) "I've had two partners."
- (8) "Since I've been sexually active I've had sexual intercourse usually about once a week on average with the girls I seriously dated."

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		Lie De	stection			Truth De	tection		Overall A	ccuracy
ltem Number	Low-Risk Unfamiliar	Low-Risk Familiar	High-Risk Unfamiliar	High-Risk Familiar	Low-Risk Unfamiliar	Low-Risk Familiar	High-Risk Unfamiliar	High-Risk Familiar	Accuracy	SD
1	11.1 (9)	27.3 (11)	25.0 (16)	11.8 (17)	93.8 (16)	88.2 (17)	87.5 (8)	77.8 (9)	52.4	50.2
2	9.1(11)	35.7 (14)	0.0(12)	15.4(13)	71.4 (14)	64.3 (14)	91.7 (12)	76.9 (13)	46.6	50.1
3	38.5 (13)	33.3 (15)	38.5 (13)	61.5(13)	100.0(12)	84.6 (13)	72.7 (11)	61.5(13)	60.2	49.2
4	(0)	0.0(0)	36.0 (25)	34.6 (26)	92.3 (26)	92.3 (26)	0.0(0)	0.0(0)	64.1	48.2
5	33.3(9)	12.5(8)	37.5 (16)	31.3(16)	62.5(16)	75.0 (20)	37.5 (8)	70.0 (10)	48.5	50.2
6	24.0 (25)	39.3 (28)	0.0(0)	(0)	0.0(0)	0.0(0)	48.0 (25)	56.0 (25)	41.7	49.6
7	58.3 (12)	53.8(13)	54.5 (11)	41.7 (12)	53.8 (13)	53.3 (15)	23.1(13)	64.3 (14)	50.5	50.2
8	65.0 (20)	27.3 (22)	40.0 (5)	14.3(7)	80.0 (5)	50.0(6)	57.9 (19)	68.4 (19)	51.5	50.2

APPENDIX C

Truth/Lie Detection by Target

ITURN LIE DERECHON	oy target						
	Target 1	Target 2	Target 3	Target 4	Target 5	Target 6	Overall
Truth Detection							
Low Risk	84.4	72.2	88.9	72.5	65.6	86.1	78.3
High Risk	50.0	62.5	47.5	70.0	78.6	63.9	61.5
Lie Detection							
Low Risk	59.4	44.4	30.6	20.0	31.3	36.1	36.3
High Risk	40.6	45.8	7.5	30.0	28.6	41.7	31.0
Certainty							
Low Risk	72.8	76.1	LLL	9.69	62.9	62.5	70.5
High Risk	71.1	73.1	72.1	63.8	67.7	69.4	69.4
Overall Accuracy							
Low Risk	71.9	58.3	59.7	46.3	48.4	61.1	57.3
High Risk	45.3	54.2	27.5	50.0	53.6	52.8	46.3

APPENDIX D

Transcript of Tape used in Study 2

Familiarity

I had a lot of friends when I was in junior high and grade school—a lot of friends. We'd have slumber parties and go shopping and play with dolls. I really loved dolls. We were all athletic. I hung out with the jocks and stuff, and I was into field hockey and horseback riding and all kinds of things like that—and the whole social part of it. I've had about a thousand jobs since age 15—it's been three years. (laughs). All kinds of restaurant work. I worked in pet stores—I like animals.

Diagnostic

I slept with a guy when I was 15. We discussed birth control; we didn't discuss condom use. I found out a week after being exposed to the virus by him that he was infected. I was told by many people, including my aunt, who is a registered nurse, that the chances were one in a million through three or four encounters that I would become infected. It's just like such crap (laughs), but, uhm, that's what most people believed then. So I didn't expect a positive result. I really didn't. We all have that whole immortality wall that we put up. I remember feeling, when I first found out, "I'm 15 years old and I don't want to die." And I remember screaming it to my parents.