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Callie J. Oneese

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A QUALITATIVE APPROACH IN EXAMINING HIV/AIDS PREVENTION MESSAGES AMONG AFRICAN-AMERICAN AND LATINA LATE-ADOLESCENT FEMALES

By

Callie J. Oneese

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ABSTRACT

A QUALITATIVE APPROACH TO EXAMINE HIV/AIDS PREVENTION MESSAGES AMONG AFRICAN-AMERICAN AND LATINA LATE-ADOLESCENT FEMALES

By

Callie J. Oneese

Despite the large body of research on the antecedent factors in explaining adolescent sexually risky behaviors that can result in contracting a sexually transmitted infection (STI), the interaction of these factors that place African-American and Latina late-adolescent females at disproportionate risk of HIV infection is not yet fully understood. In addition, studies have also called for gender-appropriate, age-specific, and culturally-relevant HIV/AIDS prevention campaigns; however, there is a paucity of research studies that offer tangible models of prevention that has a utilitarian effect. To address these deficits, this study first challenges the ontological, epistemological, and methodological assumptions of conventional research designs that predominately are used in the HIV/AIDS research. Second, a qualitative design grounded in a constructivist paradigm was employed to extract the complex underpinning of sexually risky behaviors by identifying themes derived from 19 African-American and Latina female participants, between the ages of 19 and 22, in several domains, including knowledge of HIV transmission, conceptualization and behavioral practices of sex and safe sex, communication patterns with sex partners, and the utility of past and present HIV/AIDS messages. Qualitative data analysis yielded a conceptual model that accounts

for sexually risky behaviors among this specific population and that can be offered as an extension of the current Theory of Gender and Power. This study also proposes specific and relevant guidelines to compliment the existing HIV/AIDS prevention campaigns, addresses its inherent methodological limitations, and identifies innovative research avenues that will ultimately benefit populations at risk of HIV-infection.

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To all the adolescent females who are finding their voices and securing their identities

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My vision of bringing about meaningful change at the individual and societal level has evolved into many forms, one of which is the completion of this dissertation. I would not have been able to move from thought to action without the social support that I have received throughout my academic career.

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INTRODUCTION

Significance of the Problem

Despite the medical advancement in technology and treatment of HIV, the understanding of its transmission and the risk factors involved, HIV remains a significant threat to American youths. The majority of research on HIV/AIDS and adolescents has been quantified into numbers to describe the frequency, intensity, onset, and duration of the disease. These numbers have helped in identifying who is at risk, specifically African-American and Latina late-adolescent females, and to some extent, why they may be at risk. The existing literature, nevertheless, has floundered to impart a clear understanding of why these youths are still being infected with a disease that is preventable. This is largely because of the limitations in the way this pandemic has been studied, the current epistemology by which knowledge is obtained, and the present zeitgeist of theoretical framework and education-based prevention programs on which it is based. The purpose of this study is, therefore, to elicit the perceptions and experiences of African-American and Latina late-adolescent females on HIV/AIDS. The information gathered from these participants will inform the researchers, as well as the mental health and medical communities, about why this population remains at risk and what specifically is needed so that more effective prevention messages can be generated and implemented.

General Background

In the United States approximately 440,000 million people have died of Acquired Immune Deficiency Syndrome (AIDS) and nearly one million people have been infected with Human Immunodeficiency Virus (HIV) (Centers for Disease Control and Prevention

[CDC], 2001a, 2001b). AIDS is an infectious disease caused by HIV. The process that destroys the immune system cells is that it attacks the body through three disease processes: immunodeficiency, autoimmunity, and nervous system dysfunction. Immunodeficiency, for example, results from the way that the virus binds to a protein called CD4. It is found on the surface of certain subtypes of white blood cells, including helper T cells, macrophages, and monocytes. HIV attaches to an immune system cell and then replicates itself within the cell to kill it. The virus also destroys the remaining function of the CD4 cells.

The course that HIV takes to progress to AIDS usually occurs in three stages: acute retroviral syndrome, latency period, and late-stage AIDS. The first sign of an HIV infection, referred to as the acute retroviral syndrome, is at the time the virus enters the lymph nodes; the resulting symptoms include fever, fatigue, muscle aches, loss of appetite, weight loss, skin rashes, headache, and lymphadenopathy. These symptoms impact 45 to 90% of women, who are infected with the virus. The second stage, latency period, involves a condition where the virus remains dormant for as many as ten years or more, but continues to replicate itself in the lymph nodes. The final stage, also known as the late-stage AIDS, is characterized by a sharp decline in the number of CD4+ lymphocytes, typically below 200 cells/mm3, followed by a rise in the frequency of opportunistic infections and cancers, including pneumocystis carinii pneumonia (PCP), toxoplasmosis, bacterial infections of the skin and digestive tract, cytomegalovirus (CMV), herpes simplex virus, Kaposi's sarcoma, lymphoma, and AIDS dementia complex. For women, invasive cancer of the cervix is an important diagnostic marker.

In fact, CDC in 1993 added invasive cervical cancer to the list of AIDS-defining conditions in women with HIV infection (The Body: The HIV/AIDS Resource, 1997).

Intervention and prevention are the two primary methods to address HIV/AIDS. Medical research largely focuses on determining the most effective class of medication, such as antiretroviral reverse transcriptase inhibitors and protease inhibitors, in treating the symptoms associated with the virus. Medical treatment is a form of intervention that, at best, slows the onset and progression of opportunistic infections. This method cannot prevent the inevitable: that HIV will lead to AIDS and that the multitude of opportunistic infections associated with AIDS will eventually lead to death. Lee, Fu, and Fleming (2006) cited that 50-80% of infected people will perish within 10 years of initial infection. In fact, there is no vaccine, to date, available to prevent the virus from destroying the immune system. Journal articles that are mental-health-focused, however, generally address the AIDS pandemic through prevention measures. These measures involve three major content areas in examining the problem.

To determine and to create AIDS prevention campaigns, psychology-focused research articles have first identified who is most at risk for an HIV infection. The rate of HIV infection is on the rise among young adults, especially among racial/ethnic female adolescents. According to CDC HIV/AIDS fact sheet (2004), an estimated 4,883 young people between the ages of 13-24, received a diagnosis of HIV infection or AIDS in 2004, representing about 13% of the persons given a diagnosis during that year. Approximately two-thirds of 13- to 19-year-olds with AIDS are African-American and the proportion of Latinos with AIDS is also higher than their percentage of the population (Futterman, 2003). The AIDS incidence by gender shows similar disparities among

young people (CDC, 1999). Among young adults diagnosed with AIDS between the ages of 20 and 24 and between the ages of 13 and 19, women make up 40% and 50% of the cases, respectively (Futterman, 2003). To date, women account for more than one-fourth of all new HIV/AIDS diagnoses (CDC, 2006). It is evident that HIV/AIDS in the United States has also disproportionately affected women and people of color (Futterman, 2003; Sullivan & Moreau, 2002: & Centers for Disease Control and Prevention [CDC], 1998), so much so that minority women are at the greatest risk of infection, while young women constitute the fastest growing category of new AIDS cases (Roye & Seales, 2001). According to the CDC (2006), HIV infection by the year 2002 was the leading cause of death for African-American females aged 25-34 years old, while 15% of Hispanic/Latina females are presently living with HIV/AIDS. More alarming is that the rate of AIDS diagnoses for African-American women was approximately 23 times the rate for Caucasian women and 4 times the rate for Hispanic women (CDC, 2006), yet the African-American and Latina women, combined, comprise only one-fourth of all the U.S. women.

As the population has been identified, the second phase of research is to determine the factors that explain the current AIDS pandemic. Specific factors explain how adolescents, women, and African-Americans/Latinos are at risk of HIV infection. For the adolescent subpopulation, social and financial issues surrounding the purchase of condoms, lack of condom negotiation with the sex partner, an increase in the use of chemically-altering substances, and other forms of sexual activity to contract sexual transmitted disease are risk factors that have been identified in placing these youths at risk for HIV infection. Lack of perceived power in a sexual heterosexual relationship,

being in a serial monogamous relationship that leads to the false perception of feeling guarded against the spread of STDs, and the prevention of pregnancy are the more salient risk factors leading to the increased rate of HIV infection among women. Finally, traditional gender roles and cultural norms, as well as the number of sex partners, are contributing variables risk among African-American and Latino heterosexual relationships.

The third stage of research involves incorporating the identified risk factors into an AIDS-prevention campaign targeting the population at risk of contracting sexually-transmitted diseases. Much of the research on sex education programs has shown that they are generally ineffective in decreasing the rate of infection of STDs, including HIV. The curricula for sex education programs have been limited in the content and the degree to which sex and HIV infection has been addressed, largely because of the ubiquitous belief that conservations about sex leads to increased sexual behavior. Many of the sex programs continue to focus on the consequences of being HIV infected as a means to increase fear in the hope to decrease sexual activity. The antiquated prevention campaigns have slowly evolved to incorporate a discussion of communication with adolescents' sexual partners and with their parents about condom negotiation and discussion of sex.

Statement of the Problem

Research studies on HIV/AIDS suggested that specific variables—such as age, gender, race/ethnicity, condom use, and skills in condom negotiation—intersect in a way that uniquely places African-American and Latina adolescent females at risk for STDs, including HIV infection. Furthermore, these specific populations have been empirically

shown to use condoms less often than their Caucasian counterparts. These same barriers may or may not explain the disproportionately high rate of inconsistent condom use among African-American and Latina female adolescents. No one study, thus far, has been able accurately to capture and describe the complex intersection of risk factors and barriers to condom use for these individuals. Much of the research into adolescent high-risk behaviors has focused on the prevalence and significance of a single factor (Pivnick & Villegas, 2000) and examines these factors in isolation from one another (Fasula & Miller, 2006). Fasula and Miller (2006) further contended that the interaction of these multiple social factors must be examined in relation to one another, or important sources of sexual risk for adolescents will be missed and ignored (Metzler, Noell, Biglan, Ary, & Smolkowski, 1994). It is no surprise then that the research in the area of HIV/AIDS struggles to disentangle the complexity of the interaction among the risk factors involved. This consequently affects the prevalence of AIDS (Jemmott & Jemmott, 2000).

HIV/AIDS studies that have been grounded in a conventional research design fail to address the crux of the social epidemic and obtain answers to questions such as why prevention programs have not been effective in motivating African-American and Latina female adolescents to engage in safer sex practices. The ontological, epistemological, and methodological assumptions of conventional research designs have yet to capture fully the exceedingly complex psychosocial phenomenon of AIDS prevention. Quantitative research designs struggle further with understanding the nuances and complexity of the way in which these females inconsistently use condoms that is one way to stop the spread of HIV. The limitation of the traditional scientific method that is predominately used in HIV/AIDS prevention studies may explain for such failures.

Theoretical Framework

The significance of securing a more comprehensive theoretical framework is to provide a greater direction in creating a more relevant and more practical prevention campaign for women who are at risk for HIV infection. This study critically examines the limitations of two existing, yet commonly applied, theoretical models. The argument is that such models mainly account for intrapsychic and individualistic factors, namely self-efficacy, while excluding other equally relevant variables, such as social and environmental factors. Wingood and DiClemente (2000) further asserted that interventions for women are less than optimally effective if the existing models fail to account for the social and environmental factors that impact the lives and the safety of these young women.

The Theory of Gender and Power is a newly emerging theoretical framework that illustrates that sexual inequality and power imbalances increase women's vulnerability to acquire HIV by addressing the larger contextual issues relating to women's lives. The theory recognizes that societal and institutional barriers first need to be scrutinized in order for behavioral change to occur at the individual level. The Theory of Gender and Power, first developed by Robert Connell in the 1980s, has been extended and elaborated by Wingood and DiClemente (2000) to identify exposures and risk factors that increase women's vulnerability to HIV.

Research Questions

This study is divided into three major sections. The first major section, HIV Knowledge, determines the extent to which the female participant has knowledge about the transmission of HIV and to what extent these young people think of themselves in

relation to HIV. The second major section, Thoughts and Behaviors about Sex, Safe Sex, Participants' Past and Present Sexual Experiences, and Communication Patterns with Sex Partners, is further divided into four subsections: Definition of Sex, Personal Account of Past and Present Sexual Experiences, Definition of Safe Sex, and Communication Patterns with Sex Partner. The third major section, Effectiveness of Past and Present HIV/AIDS Messages, includes Types of Past HIV/AIDS Messages, Types of Present HIV/AIDS Messages, and Suggestions to Increase Consistent Condom Use and HIV Awareness. These three primary areas of inquiry are based on three critical research questions and they are as follows:

1. To what degree are the thoughts of these young people congruent with their behaviors regarding safe sex practices?
2. What are the similarities and differences between African-American and Latina females' experiences and thoughts about HIV, sex, safe sex, sexual experiences, communication patterns with sex partners, and proposal of more effective messages?
3. What kinds of prevention messages can be derived from the clinical observations made from the data and their own candid perspective in what needs to happen to halt the spread of HIV and increase consistent condom use?

The results from the data analysis will have a direct bearing on the Theory of Gender and Power, as well as creating concrete HIV/AIDS prevention programs that are culturally-relevant, gender-appropriate, and age-specific to the target group of interest (Morrison-Beedy, Carey, Lewis, & Aronowitz, 2001).

CHAPTER 1: REVIEW OF LITERATURE

> Carla is 15 years old, lives in San Francisco, and admitted to having at least 15 sexual partners. Tracy, a 17-year-old, confessed to worrying about AIDS by stating, "Well, I do worry about AIDS. Actually, the anxiety never leaves me," but her fears are insufficient in preventing her from engaging in sexual activities, as she continues confessing, "But I still have sex." The problem is that it is seldom simple: One by one, the same girls who began the conversation with me by boasting of how many sexual partners they had had in a school year ended stories of longing, shame, and loss. "I just felt like nobody cared about me," says Carla, whose mother is a widow. Carla lost her virginity at 13, got pregnant at 14, and gave up her baby for adoption last May because she says she was not prepared to be a parent. "Mom and I rarely spent time with each other—and when I did see her, we constantly argued. I just wanted to feel better to feel close to someone," she said (Budord, 2002, p. 212).

Carla and Tracy are no different from "typical" female adolescents. Their attitudes and behaviors reflect current statistics for sexually active adolescents (Buford, 2002). Heterosexuals who are between the ages of 15 and 24 are most at risk for contracting HIV/AIDS (Masters, Johnson, & Kolodony, 1988), as sexual intercourse among adolescents continues to account for the majority of new AIDS cases (Brown, Lourie, & Pat, 2000). Three million adolescents contract sexually transmitted infections (STIs) annually (Haignere, Gold, & McDanel, 1999). In fact, 25% of the estimated 12 million new sexually transmitted diseases (STDs) cases reported annually are among adolescents aged 15-19 years (Boyer et al, 2000; Crosby et al, 2000). Currently, AIDS is the sixth leading cause of death among adolescents (Langer & Girard, 1999).

Historical Overview of HIV/AIDS

The trends in the populations at risk for HIV infection and the prevention campaigns to impede the spread of HIV have shifted since the first cases of AIDS were detected in the early 1980s (Shilts, 1987). At that time, the origin, transmission,

progression, and treatment of the disease were the primary areas of interest, largely because they were unknown. The only knowledge of AIDS at the time of its discovery was that people were dying from it.

The first misconception that had Americans standing at attention was learning that mosquitoes were potential carriers of HIV, which tapped into everyone's fears, suggesting that everyone was at risk. It was because of this belief that HIV/AIDS first became a national concern in the United States. The scientific community has since proved that there was no validity to this assertion. Later, it was believed, particularly at the onset of this epidemic that the spread of infection that AIDS only occurred within the homosexual male communities. Historically, HIV was first defined as "Gay-Related Immune Deficiency" (GRID) (Shilts, 1987). In the early 1980s the medical community was ignorant of the etiology and mode of transmission of the virus, and the health field prematurely referred to it as a "gay disease" that affected primarily White gay men (Koenig & Clark, 2004). The majority of American people was subsequently under the assumption that because they did not engage in certain types of sexual acts (i.e., homosexual sex), they were immune from infection and therefore had no reason to demand research attention and medical support. Receiving funding and appropriate media coverage became less of a salient concern because gay's issues were equivalent to being marginalized by the dominant culture.

Three decades into the AIDS pandemic (Dudley et al., 2002), many of the questions surrounding HIV/AIDS have been addressed. We now know that HIV is the cause of AIDS, and there is approximately a 10- to 15-year incubation period (Jemmott & Jemmott, 2000) during which the virus breaks down the immune system and

opportunistic infections develop (e.g., cancers and pneumonia). We also know that in a majority of cases the virus ultimately leads to death. Finally, we know four body fluids (blood, semen, vaginal fluids, and breast milk) carry the virus, and these fluids are commonly transmitted either by risky sexual (e.g., vaginal, oral, and anal sex) or drug-related behaviors (e.g., intravenous needle use).

These commonly known facts have given the general public a better understanding of how HIV/AIDS is transmitted and a greater sense of control over this disease. Since it is now understood that HIV cuts across the lines of sexual orientation and sexual preferences, AIDS and HIV have become household terms. However, in spite of the increased awareness of the disease and mode of transmission, the population at large still fails to recognize that they, themselves, could be at risk.

Although the general fear of HIV/AIDS has declined, there has been a recent resurgence of attention paid to specific subpopulations who are at a particularly high risk of HIV infection. The majority of new cases now consist of women, minorities, and youth, most of whom report that they contracted the virus through heterosexual activity (CDC, 2000). A number of studies provide supporting evidence that a primary mode of transmission of HIV is through heterosexual activity (Langer & Girard, 1999; Faryna & Morales, 2000; Salina et al., 2000), while cases among homosexuals account for a decreasing percentage of all new cases (Metro Teen AIDS, 2000). Furthermore, these studies unequivocally eradicate the myth that "AIDS is a gay disease"—an oft-repeated refrain in the early days of AIDS. Today's message is clear: anyone, youths included, who engages in sexual activity is not exempt from the potentiality of contracting HIV.

Youths Engaging in Sexual Activity

Many studies have examined the frequency and prevalence of adolescents engaging in sexual activity. A national survey revealed that over half of their participants became sexually active by the age of 14 (Faryna & Morale, 2000). According to the national Youth Risk Behavior Surveillance Survey (YRBSS), approximately 48.4% of high-school students have had sexual intercourse with nearly equal rates reported between males (48.9%) and females (47.7%). In addition, 16% of the same students reported that they have had four or more sexual partners (17.6% of males compared with 14.1% of females) (Cobb et al., 2002; Boyer et al., 2000; Crosby, DiClemente, & Wingood, 2002; Faryna & Morales, 2000; Crosby, Leichliter, & Brackbrill, 2000; and Everett et al., 2000) Given the prevalence of risky sexual behavior among adolescents (e.g., sexual intercourse, multiple sexual partners, and inconsistent use of barrier-method contraceptives) (Boyer et al., 2000), it is of no surprise that the rate of STDs has been highest among adolescents (Jemmott & Jemmott, 2000).

In fact, late adolescents and young adults account for one of the fastest growing categories of HIV and AIDS cases (Chernoff & Davison, 1999). As of 1999, the Center for Disease Control and Prevention (2000) reported that approximately 406,980 people under the age of 25 are living with HIV and AIDS. This is equivalent to wiping out an entire metropolitan city, such as Atlanta, GA (pop. 394,817; World Almanac, 2006). Haignere et al. (1999) reported that among 20- to 24-year-olds, there were 19,997 AIDS cases in the U.S. and 11,818 others known to be HIV-positive, most of who probably contracted HIV as teenagers. One study showed that one-fourth of all new HIV infections occur among those under the age of 22 (Brown et al., 2000). Even more

alarming is that cases often go underreported because so many who are infected do not get tested and the number of infections is on the rise.

Understanding adolescent development from a psychosocial perspective may explain, to some degree, the reasons that adolescents engage in risky sexually behavior. While many adolescents wrestle with the physical changes of their bodies, they also contend with society's demands for social and emotional maturity (Weiten & Lloyd, 2000). G. Stanley Hall described this period of time as "storm and stress," where turmoil and emotional upheaval are common struggles for boys and girls as they become adolescents. The process of entering into this stage often results in separation from their parents while engaging in risky experimentation (Pivnick & Villegas, 2000). According to Erik Erikson's eight psychosocial stages of human development, adolescents' critical crisis is struggling and coming to terms with their identity (Weiten & Lloyd, 2000). Solidifying one's identity also entails making independent choices, one of which is making the decision to become sexually active (Jemmott & Jemmott, 2000; Weiten & Lloyd, 2000). Therefore, most health and medical professionals and communities understand that prevention must not solely focus on abstinence, as it is incongruent with the teen's psychosocial development. Instead information on prevention to acknowledge other forms of protective measures is needed. The attention in most contemporary research articles focuses on the use of condoms.

An Alternative to Abstinence: Latex Condoms

Condoms act as a mechanical barrier, preventing pregnancy and bacterial and viral STIs (Hatcher et al., 2002; Haignere et al., 1999). Haignere et al. (1999) observed that 93-99% of condoms do not allow the passage of HIV, sperm, or other microscopic

organisms. Consistent condom use has remained the preferred method for prevention of STDs (including HIV) and pregnancy (Crosby et al., 2002; Jemmott & Jemmott, 2000).

Many adolescents do not use condoms on a consistent basis (Jemmott & Jemmott, 2000). According to the 1997 YRBSS, condom use during the student's last sexual encounter was reported to be 56.8% (Boyer et al., 2000). Another study confirmed similar statistical results of inconsistent condom use, showing that among the sexually active high-school students they sampled, 58% reported using a condom at their last sexual encounter, but fewer used a condom on every occasion (Tschann et al., 2002). In order to understand better these troubling statistics, research has expanded to examine the underlying barriers to consistent condom use.

Even though adolescents think of themselves as "invincible" to the consequences of risky behavior, they are not invincible to feelings of embarrassment when purchasing condoms (Tschann et al., 2002; Roye & Seals, 2001). Other barriers that may explain inconsistent condom use include, but are not limited to, lack of contraception knowledge, cost, availability, interference with pleasure, and negotiations with partners (Faryna & Morales, 2000).

Another risk factor contributing to lower rates of condom use is youths engaging in risky sexual behavior while under the influence of various forms of substances (e.g., alcohol and drugs) (Newman & Zimmerman, 2000). Newman and Zimmerman reported that youths who engage in high levels of sexual activity and do not consistently use condoms engage in more AOD (Alcohol and Other Drugs) use during sexual encounters than youths who engage in less risky sexual behavior. In addition, a study that examined the relationship between number of sexual partners and health risk factors found that

alcohol use was the only risk behavior that was significantly related to an increase in the number of sexual partners for all race/gender groups (Valois, Oeltmann, Waller, & Hussey, 1999).

To complicate further the issue of inconsistent condom use, adolescents fail to recognize that oral and anal sex are potential means of contracting a STI. Booeloo and Howard (2002) argued that the prevalence of adolescents engaging in unprotected oral sex is enough to cause concern about STI transmission. Approximately 33%-59% of high school adolescents reported giving or being a recipient of oral sex (Prinstein, Meade, & Cohen, 2003). Recent medical reported emphasize that unprotected oral sex is a more frequent cause of HIV transmission than is generally recognized. In addition, it has been shown that adolescents will engage in oral sex sooner than in penile-vaginal intercourse. Past studies have shown that 53% of males and 42% of females have experienced oral sex, and among the adolescents who have not experienced vaginal sex, 25% of males and 15% of females have reported experiencing oral sex (Newcomer & Udry, 1985).

According to Braithwaite, Stephens, Sumpter-Gaddist, Murdaugh, Taylor, & Braithewaite (1998), heterosexual adolescents limit their condom use to sexual intercourse, which they defined as vaginal penetration. They asserted that condom use is not a utilitarian response to a given situation, but more of a response to habitual associations and learned behavior with specific sex acts (e.g., vaginal penetration). This creates a concern given that using condoms only during vaginal penetration leads to taking fewer safety precautions during sexual engagements.

Not only have the adolescents not taken into account other forms of sexual behaviors, the research community has also fallen short in this area as well, specifically

on understanding the ways adolescents protect themselves during oral sex (Prinstein et al., 2003). The researchers limit the definition of sexual activity to penile-vaginal penetration. Boekloo and Howard (2002) reported that oral sex is not specifically measured in most health surveys of adolescents. Minimizing the importance of using condoms during other forms of sexual acts in research studies has a direct bearing on intervention programs. Braithewaite et al. (1998) reported that few interventions target condom use during oral and anal sex, especially among heterosexual African-American adolescents and young adults.

Though abstinence was originally the focus for most sex-education programs, the study of condom use has gained approval and support over the years as the most effective means to prevention; yet, barriers to condom use still exist. The barriers to inconsistent condom use, as well as the incidence rate for using condoms, have been explored, but complicating this area of study are the perceptions of the types of activities that constitute sexual behaviors, which may also act as a predictor to consistent condom use.

Women: At a Greater Risk of HIV Infection

Heterosexual intercourse and inconsistent condom use account for more than half of the women, including female adolescents, currently diagnosed with AIDS. AIDS has become one of the five leading causes of death in women (Salina, et al., 2000; Hader et al., 2001; CDC, 2006), and approximately 37% of reported adolescent AIDS cases have been among female adolescents (Jemmott & Jemmott, 2000). Females are, in general, at greater risk of infection than their male counterparts because of biological and social reasons. Heterosexual intercourse continues to place women at risk for HIV transmission, and is identified as the route of transmission for infection in more than half

of the women currently diagnosed with AIDS (Salina, et al., 2000; Hader et al., 2001). Biologically, vaginal sex has been proven to be more efficient in transmitting this virus and more likely to transmit the virus from men to women than from women to men (Faryna & Morales, 2000; Salina et al., 2000; CDC, 2006). In addition, studies indicate that both women and female adolescents use condoms primarily for preventing pregnancy, rather than for preventing STD infections. Condoms seems to be an abandoned method when other forms of contraception are adopted (Crosby, DiClemente, Wingood, Sionean, Harrington, Davies et al., 2002; Cabra et al., 2001).

From a social perspective, barriers to condom use have a greater impact on women than on men in heterosexual relationships (Newman & Zimmerman, 2000). Gender and power are two social constructs that need to be considered as additional risk factors (Amaro, 1995; Cash, 1996). Gender and power may explain why some women compromise their ability to refuse heterosexual sex and negotiate condom use (Newman & Zimmerman, 2000). Because there are differences in perceived or actual power within intimate sexual relationships, women are less likely to initiate condom use in intimate relationships than their male counterparts (Salina et al., 2000). Women who insist that their partners use condoms may risk rejection and accusations of infidelity (Cash, 1996; Salina et al., 2000).

In addition, males are often held responsible for purchasing, carrying, putting on, and removing condoms (Jemmott & Jemmott, 2000). Many intervention programs, to date, focus on the promotion of male latex condoms to prevent sexually transmitted diseases (Cabra et al., 2001). As a result, men are given more power and control over women's safety.

The concept of "serial monogamy strategy" is an additional explanation for why women, including female adolescents, have difficulty negotiating condom use. Several studies have found that women employ this strategy when they have a few long-term committed partners (Jemmott & Jemmott, 2000; Newman & Zimmerman, 2000; & Salina et al., 2000). Tschann et al. (2002) also found that adolescents are less likely to use condoms with close committed sexual partners than with casual partners. The concern for young women in long-term committed relationships is prevention of pregnancy (Roye & Seals, 2001), not STDs (Jemmott & Jemmott, 2000; Newman & Zimmerman, 2000). Therefore, they may not be motivated to use condoms, especially if they employ other means (e.g., oral contraception) to prevent pregnancy (Roye & Seals, 2001), thereby placing these youths at long-term cumulative risk for HIV infection (Jemmott & Jemmott, 2000; Newman & Zimmerman, 2000).

Biological and social factors, such as the case of transmission in certain sexes, as well as gender-related and power-related issues, have helped clarify the reasons that women are at greater risk of HIV infection than their male counterparts. These factors, combined with diminished overall control in a sexual context, highlight the complexity of risk factors involved. These same factors can be extended to other subpopulations—specifically African-American and Latina female adolescents—but are not entirely sufficient to explain the disproportionate rates of sexually transmitted infections among this population. Cultural factors, such as promotion of masculinity via child bearing, are risk factors that have been explored among the African-American and Latina female adolescents.

Race/Ethnicity: African-American and Latina Females

Many studies have focused on a wide spectrum of risk factors, including race/ethnicity (Jemmott & Jemmott, 2000), with the goal of determining who is at risk of HIV infection. Currently, minorities are disproportionately affected by HIV/AIDS. African-American and Hispanic women, together, represent less than one-fourth of all U.S. women, yet they account for more than three-fourths of the cumulative AIDS cases among women (Koenig & Clark, 2004). Specifically, among young women aged 13 to 24, African-American and Latina women represent three-fourths of the new HIV infections through June of 2000 (CDC, 2000). Furthermore, the AIDS incidence among Latino people in the year 2000 was 22.5 out of 100,000 people, a figure that is approximately three times as high as their Caucasian counterparts (e.g., 6.6/100,000) (Dudley, O'Sullivan, & Morceau, 2002). The U.S. Surgeon General projects that 80% of women newly infected with HIV will be African-American or Latina (AIDS Action, 2005). In another study, Latinos have been estimated to comprise 13% of the U.S. adolescent population and 19% of adolescents with AIDS (Jemmott & Jemmott, 2000). More specifically, the Latina female adolescent subpopulation is not only reported to have the highest rate of sexual activity in the past month at the time of the study (Faryna & Morales, 2000), they are also less likely to engage in self-protective sexual practices (Romo, Lefkowtiz, Sigman, & Terry, 2002). Essentially, African-American and Latina female adolescents with ages between 16 and 21 were seven and eight times, respectively, more likely as their Caucasian cohorts to be HIV-positive.

The importance of directly studying this particular population is that cultural values and norms are often vastly different from the dominant group (Caucasian). A

significant amount of data, thus far, indicated that childbearing females often employ oral contraceptives, rather than condoms, to prevent pregnancy. This behavioral norm, however, is quite contrary to the values of Latina female adolescents. This population of Latinas embraces the notion of motherhood, even at a young age, which can be explained by their general pessimistic outlook regarding their academic achievement and success in school (Romo et al., 2002). Consequently, they are less likely to use condoms, which place them at risk of HIV infection. Other factors, that include increased domestic violence, traditional gender roles, immigration status, limited English skills, lower socio-economic status, and religion, need to be considered when understanding the extent to which the Latino community is exposed to HIV infection (Marin, Tschann, Gomez, & Kegeles, 1993; Torres, 1991).

African-American adolescents are also at a vastly disproportionate risk, as they currently account for 37% of those between the ages of 13 and 29 years that are diagnosed with AIDS (Jemmott & Jemmott, 2000; Newman & Zimmerman, 2000). While African-American women represent 14% of the U.S. female population, they account for 58% of cumulative AIDS cases (CDC, 1998). Similar to Latina female adolescents, African-American females are also more at risk than their Caucasian female counterparts. African-American women tend to have a higher mean number of sexual partners and typically are sexually active at an earlier age than are Caucasian women (Braithwaite et al., 1998). In addition, results from a large national study showed African-American high-school students (35.6%) were significantly more likely than Caucasian (14.2%) to have had four or more sex partners (Valois et al., 1999).

In addition, the high rates of multiple sex partners, African-American and Latina females also tend to use condoms less frequently than their Caucasian counterparts. For example, Jemmott and Jemmott (1990) found that consistent condom use was reported by only one-fifth of sexually active urban African-American male adolescents, implying that their female sexual counterparts are equally vulnerable to STDs. Furthermore, African-American and Latina female adolescents were less likely to use condoms during their last intercourse than Caucasian females (29% vs. 44%) and they were less likely to use a condom overall compared to Caucasian females (37% vs. 56%) (Miller, Clark, & Moore, 1997). Finally, female minority adolescents (other than Asians) were more than three times as likely to be diagnosed with an STD than were Caucasian female adolescents (Crosby et al., 2000). These statistics can be partially explained by the increased use of hormonal contraceptives, where young women who use this method are a subgroup of minority adolescents that is at an elevated risk for HIV (Roye & Seals, 2001). In addition, these authors asserted that these adolescents may lack the cognitive and communication skills to negotiate effectively for safer sex behaviors or use condoms only for the purpose of preventing pregnancies.

Cabral et al. (2001) believed that identifying and addressing the intersection of cultural factors, specifically issues of masculinity/femininity and bearing children, may account for the inconsistent condom use among African-American teens. Young men who hold traditional attitudes toward masculinity tend to have greater numbers of sexual partners and believe that pregnancy validates their masculinity (Forste & Morgan, 1998). The pressure to abide by the traditional masculine role is particularly evident in African-American and Hispanic/Latino cultures. In a sample of African-American inner-city

adolescents, three times as many girls believed that their partners wanted them to conceive as reported wanting to conceive themselves (Zabin, Astone, & Emerson, 1993). Consequently, male partners may be putting women at greater risk of HIV/STDs by encouraging or pressuring their partners to bear children. This is one more factor that may explain the inconsistent condom use among this population.

The laundry list of risk factors has been empirically researched to determine who is vulnerable to STIs. Though each risk factor is intricate in its own right, much of the research into adolescent high-risk behaviors has focused on the prevalence and significance of single factors (Pivnick & Villegas, 2000). The studies struggled to disentangle the complexity of the interaction among the risk factors involved (e.g., gender, ethnicity, age, and SES), consequently affecting the prevalence of AIDS (Jemmott & Jemmott, 2000). Researchers must recognize however that these factors do intersect in a way that places specific populations at a greater risk—in this case, African-American and Latina female adolescents. A comprehensive understanding of the complicated cultural, economic, biological, and political factors that shape these young women's experiences is necessary to stem the rising tide of infections, especially women of color (AIDS Action, 2005). In order to design effective prevention programs that speak appropriately to African-American and Latina female adolescents, models of behaviors will be examined in order to evaluate its effectiveness as well as to explain, to predict, and ultimately to prevent initial risky behaviors.

Existing Models and Their Limitations

Systematically identifying and understanding the predictors of risky HIV-related behaviors is necessary to formulate effective interventions for at-risk populations who are

particularly marginalized by society. These predictors are often conceptualized into theoretical models to gain a more comprehensive approach to decreasing sexually risky behaviors and bringing about permanent change. Several theoretical models of HIV/AIDS intervention have been borrowed from other schools of thought, specifically from cognitive-behavioral psychology (Jemmott & Jemmott, 2000). For the purposes of this study, the Theory of Planned Behavior and the Information-Motivation-Behavioral Skills Model are discussed briefly in order to illustrate that, while they are fully embraced by the HIV/AIDS research community, these and other theories of behavioral change have visible limitations (AIDS Action, 2005).

The Theory of Planned Behavior (Jemmott & Jemmott, 20000) proposed that external variables (behavioral intervention and other external variables) directly influence the three different types of belief systems (behavioral, normative, and self-efficacy), which, in turn, influence behavioral intentions, including the intention to engage in sexual activity or to use condoms. Intention is the sole determinant of behavioral change for reduction in HIV risk-associated behaviors. External variables include variables that were not part of the original theory of planned behavior, but the revised version of the theory include external variables, such as socioeconomic status, gender, race/ethnicity, duration of relationship, alcohol and drugs, and HIV knowledge, all of which have a direct bearing on the individual's three categorical belief systems: self-efficacy, behavioral, and normative. Self-efficacy belief is the confidence in the ability to perform a certain behavior (Bandura, 1986), such as purchasing and using condoms. Behavioral belief focuses on the individual's perceptions of the consequences of engaging in a specific behavior. Those who are able to weigh the costs and benefits of engaging in

unprotected versus protected sexual intercourse are more likely to have stronger intentions to engage in safer sex practices than those who do not have the forethought to weigh such consequences. Finally, normative beliefs are the individual's perception whether his or her social support system (friends, family, sex partner, or peers) would approve or disapprove of his or her behavior. For example, the individual's friends encourage him not to use condoms because of the perception condoms are not "cool." These three belief systems then impact his/her intentions, which directly impact his/her behavior.

*The Information-Motivation-Behavioral Skills Model (*Fisher, Williams, Fisher, & Malloy, 1999) proposed that information and motivation are two basic determinants that influence AIDS preventive behavior, specifically practicing abstinence or consistently using condoms. Information refers to the personal practice of prevention, while motivation is based on attitudes toward preventative acts, social norms concerning preventive acts, and perceived vulnerability to infection. This theory proposes that behavioral changes occur through the application of behavioral skills, which refers to objective skills for performing acts such as condom use, perceptions of self-efficacy, and response-efficacy for doing so. The Information-Motivation-Behavioral Skills Model (IMB) suggests that the amount of information, motivation, and skills the individual possesses will determine the extent to which he/she will engage in AIDS- preventive behavior. For example, this model predicts that those who have a great deal of information regarding HIV/AIDS (transmission and prevention of STDs/HIV): (1) are motivated to practice safer sex, (2) are around others who support their decision to practice safer sex, (3) have the skills to use condoms properly, (4) can communicate

effectively with one's sexual partner about safer sex, and (5) will engage in higher levels of AIDS preventive behavior, such as using condoms on a consistent basis (Boyer et al., 2000).

Though there are many theories, Jemmott & Jemmott (2000) argued that there is considerable overlap in the constructs used, in that though the terminology may vary, the meanings underlying them are the same. With respect to the Theory of Planned Behavior and the Information-Motivation-Behavioral Skills Model, the term and conceptual meaning of self-efficacy did not vary and is integral in both theories. Self-efficacy, first originated by Albert Bandura (Bandura, 1994), is a fundamental concept across the majority of these cognitive-behavioral focused theories. Efficacy expectations are an individual's beliefs that they can successfully carry out the behavior required to produce desired outcomes. According to Bandura (1994), differences in motivation, behavior, and persistence in efforts to change behaviors are a function of individual beliefs about the connection between their efforts and their results. Cognitive processes play a central role in the acquisition and retention of new behavioral patterns. In the case of a female adolescent, these models assume she possesses the belief that she has the ability to influence her sex partner to practice safer sex consistently in order to produce the desired outcome of her sex partner wearing a latex condom. The principle of self-efficacy is that the individual's perception of self-efficacy can influence his/her choice of activities and can determine how much effort they will put forth in the face of obstacles.

While self-efficacy provides insights into human motivation and behavior, there are two inherent limitations. First, self-efficacy primarily operates within a cognitive-behavioral framework (Center for the Study and Prevention of Violence, 1998). Self-

efficacy indirectly attends to the young adult female's emotions, the impact of her core family, and her immediate community only through the examination of her behavior, which in large part is a function of her beliefs and expectations. Yet these young adult females have rich, complex, and varied upbringings that have a direct impact on their self-esteem and behaviors. Self-efficacy inadequately addresses these features of her personal history or the impact of those early experiences on her current sexual behavioral practices.

The second limitation is that self-efficacy attends to environmental influences in a cursory fashion. Female adolescents, for example, may not have the belief that they can influence their sex partner to use a condom in fear that their expectations and efforts would be met with punitiveness, resistance, or rejection. These models assume that young women have complete control over their own behavior, but they fail to acknowledge that the desired outcome of practicing safer sex is dependent upon the beliefs of the other sex partner involved (Amaro, 1995; Tschann et al., 2002). In the case of a young women being raped and the perpetrator not using a condom, the concept of self-efficacy is a mute point in that the environmental factor, that being the perpetrator is the sole determinant of the unexpected and unwelcome outcome. These cognitive-behavioral and individualistic-centered models (AIDS Action, 2005) inadequately account for the broader contextual factors. These include social aspects (e.g., effects of poverty or family structure), cultural influences (e.g., meanings associated with sexual experience and substance use in specific subcultures) (Pivnick & Villegas, 2000), and the context of women's lives (Wingood & DiClemente, 2000), in particular issues of power

and control that place certain, and often marginalized, groups at risk of HIV infection (Amaro, 1995).

The significance of securing a more comprehensive theoretical framework is to provide a clearer direction in creating a more relevant and more practical prevention campaign for women who are at risk for HIV infection. Women do not respond uniformly to gender-based prevention messages, as there exists additional entangled, and equally-relevant, variables including social, cultural, or economic factors (AIDS Action, 2005) that need to be addressed. Wingood and DiClemente (2000) further asserted that interventions for women are less than optimally effective if the existing models fail to account for the social and environmental factors that impact the lives and the safety of these young women.

Newly Emerging Theory: Theory of Gender and Power

The Theory of Gender and Power, at its very core, illustrates that sexual inequality and power imbalances increase a women's vulnerability to acquire HIV by addressing the larger contextual issues relating to women's lives. The theory neither places sole responsibility on women to alter her intentions as a means to influence her behaviors nor expects that she has the necessary control to produce the desired outcome. The theory, instead, recognizes that societal and institutional barriers first need to be scrutinized in order for behavioral changes to occur at the individual level.

The Theory of Gender and Power, first developed by Robert Connell in the 1980s, has been extended and elaborated by Wingood and DiClemente (2000) to identify exposures and risk factors that increase women's vulnerability to HIV. This theory posits

that there are three social structures (i.e., sexual division of labor, sexual division of power, and the structure of cathexis) that operate at the societal and institutional levels.

At the societal level, the *sexual division of labor* refers to the allocation of women and men in "gender-appropriate" occupations that are often divided in a way that men typically hold positions of power, such as being administrators or being chief executive officers, while women typically hold more subservient and service-oriented positions, such as a teacher or a sex worker. At the institutional level, this division of labor is maintained by social mechanisms, such that women receive uncompensated time for child care while attempting to have a career or being severely criticized for being career-driven. This division directly limits women's economic potential, confines their career paths, and creates economic imbalance. Consequently, the sexual division of labor creates inequities in gender and status, as well as in education, employment, job control, and access to health care. The women, for example, typically shoulder the majority of financial responsibility, including health care, food, shelter, and child care, in caring for their child or children, while receiving 21.4 % less than their male counterparts in the private sector for the very same position (Mano-Negrin, 2004). Being economically disadvantaged places women at greater risk of HIV infection and decreases their opportunities to seek appropriate and necessary medical care.

The *sexual division of power* refers to having the power to act or change or having power over others, at the social level. This division is maintained at the institutional level by social mechanisms via the abuse of authority and control in relationships. This sexual division of power stems from the effects of abuse of power, including a partner's power in a relationship, such as purchasing and wearing a condom, a partner's ability to have

affairs and to abuse intravenous drugs, and lacking the ability to negotiate the use of condoms. Wingwood and DiClemente (1997a) found African-American women who were sexually abused as children were 1.4 times more likely to have a sexually transmitted disease, 2.4 times more likely to have more than one STD, 5.1 times as likely to have a partner who had been physically abusive in the past month, and 2.6 times as likely to have a partner who was physically abusive when asked to use a condom.

The *structure of cathexis* is characterized by the emotional and sexual attachments that women have with men, and also refers to dictating appropriate sexual behavior for women at the societal level. The social mechanisms that maintain the structure of cathexis at the institutional level include social misconceptions and biases of socially-defined gender roles in the expression of human sexuality. Inequities arise from having older partners, desiring to conceive, being influenced by family mores, or addressing culturally conservative gender roles. This is particularly relevant for young women who believe they are in a monogamous relationship where asking to use a condom physically and psychologically threatens the integrity of their relationship (Cash, 1996).

The *sexual division of labor*, *sexual division of power*, and the *structure of cathexis* are rooted in society through numerous forces that segregate power and ascribe social norms. The social institutions include, but are not limited to, school, work, medical, religious, and family settings, as well as the media. The social mechanisms, such as unequal pay for comparable work, discriminatory practices, and imbalance of power within interpersonal relationships, produce gender-based inequities and disparities (e.g., unequal access to health care, gender-based expectations of women's role in society). Essentially these inequities and disparities are apparent in the public health, the

social and behavioral sciences, and medical fields as exposures, risk factors, and biological properties, all of which interact ultimately to increase women's vulnerability to diseases, including HIV.

In reviewing the Theory of Gender and Power, HIV prevention campaigns must account for two insidious cultural factors: (1) HIV risk reduction behavioral practices may be secondary to basic, and often urgent, survival priorities, such as food, clothing, housing, and childcare; (2) There is an imbalance in power specifically in a sexual relationship, where women seeking to employ safer sex practices must negotiate with the sex partner to wear condoms, whereas men choosing to use condoms is a personal choice. The underlying implication for asking the male sexual partner to use condoms are rejection and questions about the partner's infidelity and character. The theories must look beyond cognitive-oriented, individually-driven, and intrapsychic influences, such as the concept of self-efficacy, if the HIV epidemic is to be arrested. Theories must also incorporate the influences of the broader contextual obstacles unique to women, especially those that young women of color face. Therefore, HIV prevention strategies designed for women must continually evaluate the most appropriate point of reference for interventions for women of varying cultural backgrounds and socio-economic status (AIDS Action, 2005).

Quality of Existing Prevention Campaigns

Though there have been major strides in shaping prevention programs to reflect the current attitudes, norms, and acknowledgment of safer sex practices, some programs continue to be ineffective in preventing the spread of STIs and HIV/AIDS among young adults. Even though there are current conceptual models to create prevention campaigns,

many communities are still torn between their moral values and the reality of teen sexual behavior. Adults/parents are uncomfortable with explicit sex education and recommendations to youth regarding the correct and consistent use of condoms (Alstead et al., 1999). They focus almost entirely on educating adolescents about the consequences of HIV infection and types of behaviors that will reduce the risk of infection. In fact, a study cited that the second generation of communication programs in the 1980s and 1990s focused specifically on behavioral change related to abstinence and limiting one's number of sexual partners (Bertrand, O'Reilly, Denison, Anhang, & Sweat, 2006).

Focusing on the consequences of HIV infection is designed to instill fear as a method to reduce risky sexual behavior. However, fear alone does not drive most sexually active adolescents to use condoms (Rickert, Jay, Gottlieb, & Bridges, 1989). In addition, studies show that increased HIV knowledge does not appear to be significantly related to behavior change (Jemmott & Jemmott, 2000; Langer & Girard, 1999; Braithwaite et al., 1998; Rotheram-Borus, Mahler, & Rosario, 1995). The promotion of fear as a means to divert attention from alternative forms of contraceptive methods is still evident in school settings.

Haignere et al. (1999) stated that school districts often limit curricula choices to teaching abstinence only, with little discussion of condom use. They found that enthusiasm for abstinence-only education has actually increased at the local, state, and federal levels. Despite the lack of evidence supporting the efficacy of abstinence-only education and strong evidence supporting the efficacy of teaching condom safety, some abstinence educators continue to teach that condoms are inherently flawed at preventing

HIV transmission (Haignere et al., 1999). For example, *The Pro-Life Activist's Encyclopedia* reports that condoms allow HIV to pass through because condom pores are five microns in size, while HIV is .one micron (Clowes, 1994). Irrespective of this claim, the fact remains that proper consistent use of condoms is the most effective prevention method for sexually active persons. In essence, although most teenagers in the United States receive HIV education by the time they are in middle and high school (Alstead et al., 1999), the content, quality, and emotional relevance of sex education is rendered ineffective in significantly decreasing the rate of HIV infection.

Even mass media struggles to disseminate important information on condom use. Most of the mass media campaigns to date have focused on members of the general public, but not on other high-risk populations (Bertrand et al., 2006). Mass media campaigns that promote condom use for adolescents have rarely been used in the United States, largely because it has been feared that talk of condom use would lead to increased sexual activity among youths (Alstead, et al., 1999), even though other studies found that talking about condom use has not lead to increased sexual intercourse (Haignere et al., 1999). Furthermore, in a culture that produces vast quantities of hyper-sexualized images in all arenas of the media, L'Engle, Brown, & Kennavy (2006) reported that not only the majority of sexual content in the media depicts risk-free, recreational sexual behavior, but it also rarely depicts negative consequences from sexual behavior, and depictions of condom and contraception use are extremely rare.

Overall, earlier programs and even current mass media campaigns have been ineffective at decreasing the rate of infection. A meta-analysis of intervention evaluations suggested that current prevention programs often are ineffective in

encouraging adolescents to delay intercourse (Fasula & Miller, 2006). A similar sentiment is echoed by Koenig and Clark (2004) who asserted that the fact that many people do not respond to prevention messages is well-known (Koenig & Clark, 2004). They further contended that standard communication and condom skills-building interventions are particularly less effective for women with a history of sexual abuse (Koenig & Clark, 2004).

Contemporary models, like the Theory of Gender and Power, are better able to explain the psychological determinants of AIDS risk behavior, as well as to describe aspects of AIDS risk behavior that are unique to a diverse population of minority adolescents. Such models have also directed the type of research that is conducted. It no longer focuses on abstinence-based curricula, but emphasizes, in particular, communication patterns regarding condom negotiations, which is the cornerstone for women-focused interventions (Williams, Gardos, Ortiz-Torres, Tross, & Ehrhardt, 2001).

Sexual activity is complex and interpersonal in nature. Tschann et al. (2002) stressed the importance of addressing issues surrounding an interpersonal relationship that includes sexual activity, particularly the style, content, and process of communication patterns between the sexual partners involved. Individuals who communicate about safer sex in general, or condom use in particular, are more likely to use condoms (Tschann et al., 2002; Williams et al., 2001). Crosby et al. (2002) also emphasized the need to address partner communication, while taking into account the relationship among the "risk factors" (e.g., race, gender, and age). Specific topics, such as discussing safer sex prior to and during sexual contact and techniques to exit unsafe situations, (Fisher et al., 1999) are a few essential skills that need to be promoted more

often in prevention campaigns among this population. Crosby et al. (2002) found that greater perceived partner approval for condom use was associated with more frequent condom use among young-adult African-American women (Crosby et al., 2002). Furthermore, communication between parents and adolescents regarding practicing safe sex is another factor to consider when creating a comprehensive campaign to impede the spread of HIV (Crosby et al., 2002; Romo et al., 2002; and Werner-Wilson & Fitzharris, 2001). According to Bertrand et al. (2006) communication programs in recent years have expanded to address the full continuum from prevention to treatment to care and support.

Hence, contemporary HIV/AIDS interventions that are based on models, like that of Theory of Gender and Power model, take into account risk factors for disease transmission, condom negotiation skills, and techniques for overcoming barriers to condom use (Crosby et al., 2002; Cabral et al., 2001). There is no doubt that comprehensive education on human sexuality that includes contraceptive methods, abstinence, and skill-building information not only requires further study (Belzer, Rodgers, Camarca, Fuchs, Peralta, Tucker, &, 2001), but also has been found to yield more positive results than abstinence-only programs (Haignere et al., 1999). Such curriculum also focuses on increasing a wider range of skills, such as teaching peer-pressure resistance (DiClemente & Wingwood, 1997).

Role of Quantitative Research Design

Research studies in HIV/AIDS have concluded that specific variables uniquely place African-American and Latina late-adolescent females at high risk for HIV infection. The significant increase in HIV infection among this population is largely attributed to inconsistent condom use, as studies revealed. Although there is considerable

evidence supporting the use of condoms to prevent HIV infection, and additional research has directed its focus on understanding the variables involved for this inconsistent use of latex condoms, African-American and Latina female adolescents continue to be at risk for HIV infection. HIV/AIDS studies that have been grounded in conventional research design may explain the failure in addressing the crux of this social epidemic and in obtaining answers to questions such as why prevention programs have not been effective in motivating African-American and Latina female adolescents to engage in safer sex practices.

CHAPTER 2: METHOD

A Different Kind of Knowing

This chapter serves several purposes: first, it describes the origin of the traditional scientific inquiry, proposes an alternative paradigm, and outlines the methodology of this study. Next, it discusses the origin of dominant research practices in the field of psychology in which it has permeated HIV/AIDS research. The assumptions on which the scientific method rests are not only pervasive, it has also become the sole criteria for what knowledge is deemed legitimate in the field of psychology, thereby allowing the way in which data are gathered and examined go unquestioned. Critiquing this issue more in-depth is necessary as it illuminates the limitation of the underpinning of scientific inquiry.

This chapter's other function is to critically examine the conventional methodologies. Objectivity and context-stripping are key characteristics of traditional paradigms that have been the standard and the method for legitimatizing scientific knowledge in the field of psychology. These two particular assumptions underscore the limitation of the type of data collected to advance HIV prevention campaigns. Recognizing that all knowledge is not equal, it is imperative that HIV/AIDS prevention be understood from the perspective of those most affected by it. This implies the need for qualitative inquiry whose underlying philosophy realizes that knowledge is based on antifoundationalism and refuses to adopt any permanent, unvarying standards by which truth can be universally known (Lincoln & Guba, 2000).

The third, and equally important, purpose of this chapter rationalizes the need to implement a qualitative-based research design that is grounded in a different kind of

paradigm—constructivism (Lincoln & Guba, 2000). Qualitative methods, after experiencing a period of ascendancy from an earlier era of skepticism, is now again being called into question, under the notion of "scientifically-based research". Much of the research training in the fields of clinical and counseling psychology continue to refer to qualitative methods as an "alternative" approach (Heppner, Kivlighan, & Wampold, 1992), thereby deeming the knowledge gathered from this framework as less credible. It is, nevertheless, important to realize that the need to discuss the rationale for conducting qualitative research design is not a requirement, but a necessity, in order to deem the knowledge collected from this kind of study as being equally valid. Finally, this chapter concludes with the methodology of this study. It explains the recruitment of subjects, the measurements, the interviewing protocol, and the analysis of the data.

Current Epistemological and Methodological Research in Social Sciences

To understand the aim, practice, and prevalence of quantitative research is to learn first about the epistemological and methodological assumptions in which it is grounded (Guba & Lincoln, 1994). These assumptions have been rooted in positivism, the dominant paradigm in the physical and social sciences for the past 400 years (Guba & Lincoln, 1994). Traditional scientific inquiry has borrowed many of the fundamental principles of positivism (Guba & Lincoln, 1994), one of which is the assumption that nature of reality consists of a single and apprehendable reality that operates according to immutable natural laws (Derry, 1999; Guba & Lincoln, 1989). The researcher has the capacity to discover that reality and its laws, without undue influence: that the researcher and subject under investigation are independent of each other (Guba & Lincoln, 1994). Objectivity is a prominent feature of traditional scientific inquiry because of the

perception that it prevents biases from influencing the outcome of the study (Philips & Burbules, 2000; Heppner et al., 1999).

Rather than focusing on differentiating the terms such as positivism and the received view, the importance lies in critiquing the assumptions underlying the traditional scientific inquiry and the examination of how past and present practices in psychology research have been seamlessly interconnected in the goals and standards for studying a phenomenon. Over time, conventional research methodologies surreptitiously has led to the advent of the scientific method and statistical analyses in psychology, which are the most common and most accepted forms of studying scientific inquiry. The scientific method stems from the ontological assumption that there is one "reality," governed by immutable laws. This method, which is based on a priori hypothesis testing and controlling for confounding variables, (Williams & Monge, 2001; Lincoln & Guba, 1989) describes that reality and discovers the laws that determine it, which subsequently predicts and controls ensuing events (Guba & Lincoln, 1989). When employing the scientific method, the assumption is that the researcher is believed to have the capacity to remain objective. To increase objectivity, contemporary research methodologies heavily rely on quantifying the phenomenon (Guba & Lincoln, 1989). Statistical analysis is thereby the means for achieving that objectivity by determining numerical relationships with precision and accuracy among operationally defined variables (Philips & Burbules, 2000; Heppner, Kivlighan, & Wampold, 1999; and Neimeyer & Resnikoff, 1982). Objectivity, accuracy, and precision have, therefore, become the "gold" standards in psychology's contemporary research practices.

The epistemological and methodological assumptions and goals of conventional scientific-based research designs are equally prevalent in research literature on HIV/AIDS prevention and intervention. According to Seal, Bloom, and Somlai (2000), much of the new generation of sex research has involved quantitative surveys of sexual behavior, sexual risk predictor studies, and/or assessment of the efficacy of HIV-risk reduction programs. In fact, many studies have been empirical and quantitative in nature by identifying populations at risk. The current empirical studies reveal that women, adolescents, and minorities have been identified as "at-risk" populations for potentially becoming infected with the HIV/AIDS virus.

Further research has concentrated on prevention, or intervention, strategies that primarily focus on the quantification and statistics of inconsistent condom use and risk factors to explain this trend. Condom use continues to be the chief prevention method. Inconsistent condom use, which is the result of complex interplay of countless risk factors, is believed to be one important avenue to understand why and how African-American and Latina female adolescents continue to be vulnerable for HIV infection.

Critique of the Assumptions Underlying Traditional Scientific Inquiry

The assumptions underlying traditional scientific inquiry have been so influential in the social sciences (Polkinghorne, 1984) that rarely has it been challenged from an epistemological and methodological standpoint (Derry, 1999). While these assumptions retain its hegemony over research practices (Lather, 1991, p. 2), the received view has been under assault over the last several decades (Guba & Lincoln, 1994; Polkinghorne, 1984). Lather (1991) wrote that the reason for challenging these types of assumptions "...might be seen as an effort to break out of the limitations of increasingly inadequate

category systems and toward theory capable of grasping the complexities of people and the cultures they create," (p. xvi). These types of critiques have been the impetus behind the need for fundamental adjustments to the received view (Guba & Lincoln, 1994). Striving for objectivity and the promotion of context-stripping in hope of "predicting" and "explaining" the subject matter under investigation are the two fundamental assumptions of traditional scientific inquiry that will be critically evaluated in terms of how they have limited the advancement of HIV/AIDS prevention.

The first fundamental claim of the traditional scientific inquiry is the assumption that objectivity must be attained in order for the knowledge to be deemed "legitimate." Objectivity is typically paramount during the concrete stages of conducting a study. Controlling for confounding variables is one example of precluding biases from affecting the outcome.

Researchers' biases, however, can have an equally aversive impact at different points in a study, beginning with the scientific community to which researchers belong. Researchers are part of a social community, who share a set of assumptions, techniques, methodologies, and worldviews (Derry, 1999). This community has been historically comprised of white, Anglo-Saxon males, who generally came from privileged backgrounds of wealth and education. Often, they have had the power and privilege to determine the overall nature of scientific inquiry (e.g., what topics are worthy of further investigation) and even the criteria used to determine the credibility of "scientific knowledge." Bakhtin (1984) echoed this point more than 50 years ago by arguing that "positionality" weighs heavily in what knowledge comes to count as scientifically acceptable in historically specific times and places. Examining legitimacy of scientific

knowledge is crucial when inquiry focuses on marginalized and oppressed social groups because their life experiences are often vastly different from those of the researchers. Consequently, scientific knowledge, itself, can direct the way in which questions are shaped and variables are selected.

In the area of HIV/AIDS prevention studies, current research designs, which largely rest on the ontological, epistemological, and methodological assumptions of traditional scientific inquiry, fail to capture the exceedingly complex psychosocial phenomenon of human sexual interaction. Quantitative research designs struggle further with understanding the nuances and complexity of the way in which African-American and Latina late-adolescent females inconsistently use condoms and, in general, ways to stop the spread of the virus. The limitations of the traditional scientific method that is predominately used in HIV/AIDS prevention studies may explain for such failures. More specifically, the influence of a researcher's experiences and biases may have a larger role in "contaminating" the quality and outcome of these studies.

Studies that are based on hypothetico-deductive reasoning, for example, whereby the researcher's role is to preselect a risk factor (e.g., child bearing) that the researcher believes places a population at risk can lead to potential problems. Many of the HIV/AIDS studies and existing models struggle to recognize and research other equally relevant risk factors, which may directly relate to the fact that the researcher's life experiences are naturally different from the participants, which he/she is studying. A researcher's biases and values unwittingly factor into determining *which* risk factors may or may not be investigated. For example, a study by Salina et al. (2000) acknowledged

that HIV prevention programs have largely ignored important factors that may impact the use of condoms during sexual relations, such as sex role expectations.

The procedure to verify risk factors through hypothesis testing may be objective, but selecting a variable (e.g., risk factor) can be more appropriately characterized as a subjective process. Consequently, the community of social scientists has, and will continue to unduly influence, one another and the overall discourse of scientific inquiry. Even if researchers were consciously to refrain from employing dominant disciplinary concepts and frameworks in the analysis, it is impossible to prevent intrusion of the researcher's own taken-for-granted, everyday concepts into the inquiry.

The second fundamental assumption that operates within conventional methodologies is the practice of context-stripping (Guba & Lincoln, 1994). According to the principles associated with the scientific method, if the "one reality" is to be studied and the immutable natural laws that determine it be explained, the variables specific to the study must then need to be examined, while controlling for all other variables. In other words, the context of the phenomenon is observed within a vacuum, which "effectively strips away the context and yields results that are valid only in other contextless situations," (Guba & Lincoln, 1989, p. 60). Contextual factors are deemed appropriate only to the extent to when they can be physically and/or statistically controlled (Guba and Lincoln, 1989). The results of a study should ideally explain the variables in a predictable manner and in a variety of situations. However, if context-stripping is being practiced, Guba and Lincoln (1994) illustrated that the "outcomes can be properly applied only in other similarly truncated or contextually-stripped situations" (p. 106).

With respect to African-American and Latina late-adolescent females' sexual practices, examining their inconsistent condom use during sexual activity in contextless environments is of no assistance in stopping the epidemic. Instead, the contextual factors are necessary components in creating an effective HIV/AIDS prevention campaign. This social epidemic is becoming increasingly complex because of the multitude of possible variables, and more importantly, the interaction of these variables. Socioeconomic status, gender, race/ethnicity, age, education, reproductive motivation, infrequent communication with sex partners, type of sexual activity, limited access to health care, duration of relationship, use of other contraceptive methods, and illegal substances are just a few contextual factors that are currently under investigation.

One combination of such factors could explain why one female adolescent would engage in unprotected sex, while simultaneously failing to explain identical actions of another adolescent in similar circumstances. The degree to which one wants to bear children, for example, has been identified as a contributing factor to inconsistent condom use. Studies show that the promotion of child bearing in the Latino culture is one reason why Latina females may not use condoms, while Caucasian female adolescents may have increased frequency of condom use in order to prevent pregnancies. Numerical relationships regarding the promotion of child bearing as an identified risk factor were derived from the implementation of the scientific method and statistical analysis; the explanation, however, behind the promotion of child bearing from one culture to another culture are based on cultural underpinnings and the researcher's own assumptions.

This epidemic could be better understood, however, if the assumptions of the traditional scientific inquiry are explicitly challenged, specifically in the failure of the

"gold standard" of striving for objectivity through context-stripping (Guba & Lincoln, 1989). The practice of value-free science and context stripping are counterproductive and are no longer applicable to the different types of data that are being studied. The new zeitgeist—diversity among members in the social scientist community and in the topics of interest—has forced social scientists not only to negate values, but also to accept that value-neutrality and objectivity are no longer the "ideal" standards in research practices. The need to examine subjects within their natural settings is essential to clarifying broader areas of HIV/AIDS studies. In addition, multiethnic and multicultural voices bring different types of epistemological and methodological approaches to examining data. Guba and Lincoln (1989) were well aware of the changing times and described this change as stemming from a *failure to accommodate value-pluralism*, in that "the question of whose values would dominate in an evaluation, or alternatively, how value differences might be negotiated, has now emerged as the major problem," (p. 34).

Current quantitative research designs have largely been grounded in the received view of social sciences and heavily practiced in HIV/AIDS prevention studies. They have been, at best, sufficient in identifying populations that are at risk and, to some extent, the factors that contribute to these populations engaging in risky sexual behaviors. This methodological practice has been able to identify that African-American and Latina late-adolescent females are disproportionately at risk for sexually transmitted diseases compared to their Caucasian counterparts and that there are a number of risk factors that explain for their inconsistent condom use during sexual activity.

These research designs not only neglect to address the more pervasive and latent reasons regarding inconsistent condom use, it also has yet to comprehend fully the more

elusive areas of this phenomenon: Why is it that African-American and Latina late-adolescent females continue to be susceptible to HIV-infection, despite identifying a plethora of antecedent factors? What are the deciding factors to engage in sexual relations? What do these females really know about HIV/AIDS? What types of prevention campaigns will effectively encourage these adolescents to implement consistently safer sex practices? These types of research inquiries strike at the heart of the HIV/AIDS epidemic among African-American and Latina adolescent females. Belzer et al. (2001) asserted that the next critical step in conducting research is to examine how youth view and use contraception as a means to reduce unplanned pregnancies and the transmission of HIV.

Conventional methodologies have limited the advancement in HIV/AIDS prevention, specifically in the areas of describing and implementing culturally-appropriate and gender-specific HIV prevention campaigns. Because a selected research method must fit both the phenomenon under investigation and the type of information sought (Silverman, 2001; Heppner et al., 1999), a different type of research design grounded in a different type of ontological, epistemological, and methodological assumptions might be more appropriate in examining why HIV remains an epidemic among African-American and Latina late-adolescent females.

Why Employ a Qualitative Research Design?

A qualitative research design that is situated in constructivist paradigm is a complimentary methodology (Guba & Lincoln, 1989) to examine African-American and Latina late-adolescent females' perspectives and experiences regarding their sexual practices, barriers to employing condoms on a consistent basis, communications with

their sex partners, and HIV/AIDS prevention messages. The main objective for employing a qualitative research is to capture the narrative perspective of the event that is being studied in order to extract the meaning and process of the complex phenomenon (Bogdan & Biklen, 1998).

Constructivist paradigm, though it has been in existence for several hundred years, is newly emerging as a major contender to the positivist paradigm, and is appropriate for the purposes of this study. Much of the discussion on paradigm shift comes from the works of Yvonne Lincoln and Egon Guba (Lincoln & Guba, 2000; Guba & Lincoln, 1994 &1989). The ontological stance of constructivism denies the existence of one objective reality, asserting, instead, that realities are social constructions of the mind, which are socially and experientially based. Agreements about truth may be the subject of community negotiations regarding what will be accepted as truth (Lincoln & Guba, 2000). In other words, "findings" are literally created as the investigation proceeds to the need to strive for "objectivity" and is irrelevant within this framework. Within the constructivist paradigm, it is understood that values are inevitable and, therefore, are embraced as an integral part of this inquiry. One cagveat, however, is that because the paradigm is still in the formative stages, the ideas and discussion on it should be considered tentative.

Guba & Lincoln (1989) defined four "entry conditions" that must be met so that the methodology is grounded in the constructivist paradigm. The first is that the study must be pursued in a natural setting because "contexts give life to and are given life by the constructions that are held by the people in them"(p. 175). The second is that constructivists do not assume that they know enough about the context frame a priori to

know what questions to ask. The third condition is that the use of a human instrument suggests that the methods employed should be primarily those that are congenial to humans—qualitative methods. "Humans collect information best, and most easily, through direct employment of their senses: talking to people, observing their activities, reading their documents, assessing the obtrusive signs they leave behind, responding to their nonverbal cues, and the like. It is for this reason that qualitative methods are preferred..." (p. 176). The fourth condition is that the researcher has the privilege of drawing on his or her *tacit knowledge*, which can be defined as all what we, the researchers, know minus all we can say (the latter is prepositional knowledge.) "It is precisely this same tacit understanding of a situation that serves the constructivist in the beginning stages of an inquiry," (p. 177). Aucherbach and Silverstein (2003) also share similar views on the role of qualitative research, which is to ascertain subjective experiences of the participants. The subject experience is based on the epistemological assumption of understanding human behavior and that human behavior is incomplete without insight into the framework within which individuals interpret their own behaviors, thoughts, and feelings (Neimeyer & Resnikoff, 1982).

Qualitative methods are highly advantageous in exploratory research. When studying a group that is socially marginalized (i.e., African-American and Latina female adolescents), employing a methodological approach that is based on qualitative premise to obtain subjects' intricate and private experiences is not an option, but a necessity. The kinds of subjects and the type of topics being studied determine the methodology. With respect to adolescent sexual behaviors, Tschann et al. (2002) stated that there is a paucity

of literature in the ways in which other aspects of the dynamics between sexual partners might affect sexual behavior, including condom use.

This topic lends itself for qualitative-based research designs that allow the participants to share their stories regarding their sexual experiences, rather than imposing cognitive-focused models onto this very complex phenomenon. Seal et al. (2000) asserted that qualitative research methods designed to understand human behavior, its meanings, and the impact of the sociocultural context in which the behavior occurs is necessary. Lichtenstein (2000) echoed a similar point of view with an emphasis on the subjects' views and behaviors in a narrative format and in culturally sensitive modalities. McCracken (1988) also emphasized that the qualitative approach has the capacity to sift through the data to uncover the cultural assumptions that mediate human behavior.

This approach can help researchers look beyond the dominant disciplinary and cultural ideologies pertaining to such groups when examining subject matter that is sensitive, personal, and socially taboo in nature. The goal of this study is to explore the African-American and Latina female late-adolescents' perspectives regarding their knowledge of HIV/AIDS, their definition of sex, their own sexual practices, their perceptions of practicing safer sex, the barriers that they may encounter to practicing safer sex, the communication patterns between sex partners, and their assessment of the utility of existing HIV/AIDS prevention messages. Having a thicker and richer understanding of the participants' belief systems and worldviews in these areas will create more appropriate prevention programs that directly address the complex and intersecting risk factors.

Overview of the Research Design

Semi-Structured Interviews

This study utilized a method that is qualitative in nature, and has been grounded in constructivist paradigm. The use of semi-structured interview in the form of face-to-face, one-on-one, verbal interchange is the specific means in which the data have been gathered for several reasons. The first and, more general reason, is that interviews are no longer viewed as neutral tools of data gathering, whereby the participant passively answers a set of research questions. It is, instead, seen as an active interaction between two people leading to negotiated, contextually-based results (Fontana & Frey, 2000). The interview, according to McCracken (1988), will uncover the silent assumptions that operate in the everyday, social situations. Conducting one-on-one, face-to-face interviews is appropriate and necessary when the topic of interest is complex, controversial (e.g., HIV/AIDS), or personal in nature (Smith, 1995) and is the most common form of interviewing (Fontana & Frey, 2000). Given the topic and nature of this research project, interviews are not only an appropriate method of data gathering, but they are also consistent with the aim of this study in that "interviews are moving to encompass the how of people's lives (constructive work involved in producing order in everyday life), as well as the traditional activities of everyday life," (Fontana & Frey, 2000, p. 646). Finally, one characteristic of an interview is the degree of structure, ranging from structured to semi-structured to unstructured. The semi-structured interview format was selected for the purposes of this investigation, as it allowed the researcher to ensure specific content areas were addressed, while allowing participants to have the flexibility, depth, and breadth to respond to these areas (Bogden & Bilken,

1998). According to Ladany et al., (2000), structuring the questions in an open-ended, semi-structured format also allows for the researcher to follow up on topics that can be of particular interest to the research study (Smith, 1995).

Participants

The purpose of this investigation is to obtain the subject's perceptions on a wide-range of topics related to HIV/AIDS (e.g., her sexual activity, communication with sexual partner, and barriers that she found in practicing safer sex). Unlike quantitative research methodologies where greater randomization and higher frequency of sample size are the core standards of data collection, qualitative research is less concerned with obtaining a large sample size. The process selection, instead, involved creating a list of participant characteristics and subsequently locating those who meet these characteristics (Lecompte & Preissle, 1993). Smith (1995) echoed a similar viewpoint when stating that the sample that is selected should be as closely representative of the population of interest as possible.

The participants for this study were recruited from a large Midwestern University, and comprised of 10 African-American and nine Latina female student volunteers, who range in ages from 18 to 22, are heterosexual, and who have engaged in heterosexual sexual activities. The importance of the participants having engaged in sexual activity at some point in their lives was necessary in order that the participants had exposure and experiences from which they could speak.

The rationale for selecting 19 participants is based on several studies that employed similar qualitative design (i.e., using semi-structured interviews). Hill, Thompson, and Williams (1997) recommended to sample between eight and fifteen

participants, as this sample size allows for determining whether findings apply to several people or are representative of only one or two people. A small sample size, according to McCracken (1988), is based on the principle that "less is more," as the function of *n* is not to represent the population, but to offer, instead, a chance to examine the "complicated character, organization, and logic of culture," (p. 17). Rich data can easily be lost if the sample size is too large. Other studies reported similar sample sizes. In Willig's (1997) study on construction of sexual practices, she recruited 16 subjects, while another study using consensual qualitative research (CQR) recruited 11 participants (Ladany, Miller, Constantine, Erickson, & Muse-Burke, 2000). Given the wide variation of sample sizes among established researchers, guidelines for deciding appropriate sample size seemed flexible and, in general, had a proclivity to smaller, rather than larger, sample sizes. For the purposes of this dissertation study—an exploration of various meanings, experiences, and contexts of sexual active late-adolescent females' lives—qualitative research with a small and diverse sample is appropriate.

Although Hill et al. (1997) recommended that the process of selecting the sample should be random, other studies (Smith, 1995; Lecompte & Preissle, 1993) underscored that the demographic characteristics of the participants are paramount and reflective of the research study. This study employed a convenient and snowball sampling approaches. Participants were made aware of the study by flyers (see Appendix A) posted in both residence and academic halls, as well as distributed to ethnic-focused student groups. The content of the flyer consisted of the epidemiology of HIV/AIDS among minority female adolescents, the researcher's contact information, and the general nature of the study. Another form of sampling, the snowball approach, recruited a few

research participants in the beginning, and then asked the initial participants to recruit others to participate in the study (Auerbach & Silverstein, 2003).

Researcher

The primary researcher for this study is a Korean-adoptee, American-raised female doctoral candidate in counseling psychology, and is 31 years of age. She has approximately seven years of counseling and clinical experience. Prior to data collection, expectations and biases of the researcher pertaining to the beliefs about the participants' sexual experiences were recorded, a procedure known in qualitative research as bracketing (Rennie, Phillips, & Quartaro, 1988). These expectations and biases were addressed in order to inform the reader how the researcher's preconceived ideas were in part socially constructing the meanings derived from the participants' responses. In terms of the summary expectations, I believed that the participants would be well informed about the ways in which HIV is transmitted, that they would share in detail accurate information about HIV. This belief stemmed from the notion that they are college-educated. In regard to their sex knowledge and their sexual experiences, I surmised that the participants would provide evasive and less-than honest responses, especially when discussing their own explicit, sexual practices. This assertion is stemmed from the belief that talking about one's own sexual practices is a private and personal, thereby suggests that it is generally not openly discussed and certainly not with a stranger, the primary investigator. The section in the questionnaire that focuses on communication patterns with their sexual partners, I presumed that the participants and their male sexual partners, on average, would avoid discussing safe sex practices, STDS, and HIV. If these topics were to be addressed, I assumed that the responsibility would be

left to the female participant. This assumption was based on the general concepts of gender role and communication styles in that women generally are the ones initiating conversation, especially when the topic is taboo and sensitive in nature. The last section of the questionnaire, where it focuses on prevention messages and their effectiveness, I thought that the female participants would find that past and present prevention messages were ineffective, but would provide explicit and detailed steps in generating a more effective HIV/AIDS prevention campaign.

Procedure

Research conducted on socially sensitive topics, particularly with marginalized populations, is highly vulnerable to potential abuses of power on the part of the researcher. Because of this, it is imperative clear protocols were implemented in order to prevent abuses and to make potential research participants aware of the certain risks and rights vis-à-vis their study participation. The protocols for this study were reviewed and approved by the University Committee on Research Involving Human Subjects. Potential participants who were interested in the study were directed to contact the researcher either by telephone or e-mail. The researcher would then call each prospective participant to assess the degree of interest she may have in participating in the study, adhering to a prescribed screening script (see Appendix B), which summarized the purpose of the study, the protocol of the study (e.g., the length of the interview), and assessment of her eligibility to participate. If she identified herself as being either an African-American/Black or Hispanic/Latina/Chicana female between the ages of 18 and 22 and having been engaged in heterosexual sexual behaviors, she was permitted to participate in the study. Once she expressed direct interest in participating, a date, time,

and a secured location to conduct the interview, based on the participant's convenience, was determined. The location for conducting the interview varied, ranged from dorm rooms, to isolated library rooms, to conference rooms in the multicultural center located in the student union, and to study halls. Regardless of the location, each interview took place in a secured facility where confidentially and privacy were intact.

At the outset of the interview, the first step involved reading a prescribed script (see Appendix B) to each participant, addressing several aspects of the interview, including the purpose of the study. Being mindful of the power differential between the researcher and the participant and of the sensitive nature of the topic, the script contextualized the purpose and protocol of the study in a collaborative manner. Furthermore, because the participants perceived the study to be Socratic dialogue, her opinions, thoughts, and concerns were elicited throughout the entire duration of the interview process by asking her, "Do you have questions?" throughout the screening script, the interview script, and the semi-structured interview questionnaire. The participants were also informed that the interview was semi-structured (in that they would be asked a series of open-ended questions) and were asked to read the consent form (see Appendix C) in which they were asked to sign one copy and keep the other copy for themselves.

To ensure comprehension of the consent form, the consent process involved oral administration of the consent form by reviewing the voluntary and anonymous nature of the study, the purpose of the study, the kinds of questions being asked, the fact that the interview would be audio-taped, the length of the interview, the risks and benefits of participating in the study, and the precautions in protecting the data. In regard to

confidentiality, the participant was reminded that the confidentiality of her responses during the interview would be protected to the maximum extent permissible under the law. The following precautions were taken to protect her confidentiality. No individual names would be used in any reports or publications that may result from this study, and the participant's name would not be on any of the surveys or tapes. Instead, any responses provided would only be associated with an identification number. The identification number would be associated with the consent form. Furthermore, once the data had been collected and transcribed, the audiotapes would be destroyed, and the transcription would be saved on a CD in a lockbox for seven years, as this time period adheres to the American Psychological Association ethical guidelines. After seven years, all data, including the transcriptions and CD, would be destroyed. Lastly, the participant was informed that if she decided to participate, she could withdraw from the study at any time without penalty and loss of benefits to which she was otherwise entitled. If she withdrew from the study before the data collection were completed, her data would be destroyed.

Each participant signed the consent form and the interview ensued. Each interview began with participants answering an orally-administered demographic survey, which lasted approximately 5 to 10 minutes (see Appendix D for a copy of the instrument). All interviews were tape-recorded and transcribed. Interviews lasted approximately 60 to 120 minutes. During the interviews, broad and lead-in questions were used to encourage narratives on the following four areas of the participant's life: HIV/AIDS: knowledge, needs, and perceptions; sex: definition, safer sex and barriers;

communication with sex partner; HIV/AIDS messages (see Appendix D). Participants were given $15 as a form of gratitude at the end of the survey.

The audiotapes have been saved in a lockbox and have been transcribed in a word processing program. The audiotape and the transcription have been compared to determine accuracy of the respondents' interview, and the audiotapes have been erased and destroyed. The transcribed data have been saved electronically on a CD-ROM and as a hard copy, all of which have been stored in the lockbox.

Measure

Prior to implementation, a pilot test of the questionnaire was conducted on two Latina and African-American late-adolescent females, who provided extensive feedback on the readability, language, and cultural relevance. The questionnaire was administered at a secured location to protect the confidentiality of the participants. Changes, based on the responses provided during field-testing, were incorporated into the instrument. Much of the revision consisted of adding brief scripts throughout the interview questionnaire to remind the participants that their responses were deemed important, that their responses remained confidential, and that the overall appreciation of their time and effort were made known, all of which were to increase trustworthiness (Lincoln & Guba, 1985). An excerpt of the script is provided:

> "Those were tough questions, and we really appreciate your honest responses. I know this study and your responses will help the women in your community from getting hurt."

The revised protocol was re-administered to the same two Latina and African-American late-adolescent females to determine face validity.

The semi-structured interview was comprised of two sections: *demographic questionnaire* and interview questionnaire. The *demographic question* included a 15-item closed-ended survey that was given to each participant prior to the open-ended, semi-structured interview. The data were gathered by asking respondents directly to enter requested information on the following areas: gender; race/ethnicity; date of birth; current age; highest level of education earned; number of sexual partners; number of times of engaging in vaginal, oral, and anal sex in the past 12 months; the number of times condoms were used during vaginal, oral, and anal sex in the past 12 months; the number of times tested for HIV; the date on which the last HIV test was administered; determination of receiving the results or not, and, if applicable, reason for not receiving the results.

The interview questionnaire included an 18-item open-ended questionnaire (see Appendix D) that explored several topics related to HIV/AIDS. The first open-ended question inquired about the participants' perceptions on their general knowledge on HIV transmission. Questions included: "Tell me what you know about how HIV is passed on from one person to the next person." The next broad category consisted of 11 items that explored participants' understanding on the types of sexual activities and definitions of "safer sex." Two additional questions focused on communication patterns with sex partners. The last section consisted of four items that concentrated on the participants' perceptions of the sources and types of HIV/AIDS messages that they have encountered and effectiveness of these messages.

Data Analysis

In looking through several references on qualitative research, there is a paucity of sources that discuss the steps to analyze in detail of the data (Auerbach & Silverstein, 2003; McCracken, 1988) in a systematic fashion. Despite McCracken's confirmation that the data analysis were the least examined area of the qualitative research process (McCracken, 1988, p. 41), Becker (1998) reminded the qualitative-oriented research community that the development of concepts should be a "continuous dialogue with the empirical data," (p. 109), rather from a hypothetico-deductive process. McCracken's five-stage analysis adheres to Becker's recommendations. The process of analyzing the current data set was borrowed from McCracken's five-stage analysis, where each step represents a higher level of generality. The first two stages involve examining and intra-comparisons of observations within the interview and for each interview. The last three stages focus on inter-comparisons of observations and themes across all interviews.

The first stage involved using the broad research questions as a guiding tool to decipher between relevant and irrelevant data. The relevant material in which McCracken referred to as "utterances" is examined only in relation to the meanings contained within its range of implications. In other words, McCracken wanted the investigator to avoid making assertions from these utterances and prematurely connecting themes with other utterances. The data were demarcated into three major sections for the purpose of managing the abundant number of text that was collected. The three sections are as follows: (1) *Knowledge of HIV transmission and relation to HIV infection;* (2) *Thoughts and behaviors about sex, safe sex, participants' past and present sexual experiences, and communication patterns with sex partners,* which was further divided

into four subsections: Definition of sex, Definition of safe sex, Personal account of past and present sexual experiences, and Communication patterns with sex partner; and (3) *Effectiveness of past and present HIV/AIDS messages and Suggestions to increase consistent condom use and HIV awareness*. Each transcript was carefully previewed and the data were categorized accordingly. For each transcript, main points, also known as "utterances," were then reviewed and extracted within each category. "Vaginal intercourse between a male and a female," for example, is an utterance that was extracted under the category, *Description and meanings associated with sexual behaviors*.

The second stage consisted of contextualizing these utterances in relation to other utterances within the transcript, with the cultural review, and with previous literature. These observations and assertions were then supported by the excerpts from the transcripts. This stage essentially examined patterns, relationships, similarities, and dissimilarities of the main points (also known as "observations") within each category for each transcript. An example of an observation made from one of the participants is how past sexual abuse had a direct bearing on her current cognitive processes regarding her sexual behaviors. This participant admitted that her childhood sexual trauma influenced her present outlook, stating "So I turned very rebellious, I turned to drugs, alcohol, and sex." Furthermore, she not only viewed sex as, "I don't see sex as a very special thing," but uses sex as a means to gain personal power. As she stated, "It [sex] was just taken from me when somebody wanted it so now when I want it, I get it."

The third stage expanded the analysis by comparing the observations with other transcripts. In other words, McCracken referred to this stage as the "interconnection of the second-level observations." Broader themes and patterns emerged by inter-

comparing between observations from one transcript and observations from another transcript. Again, these broader observations, now referred to as themes and patterns, are further contextualized within the cultural review, with previous literature, and in relation to the actual data from the transcripts. For this study, the data from all the participants were compiled into a table where the headings represented one of the six categories and all the observations were categorized accordingly. Below is Table 1 of the category, *Communication patterns with sex partners*, with a sample of participants' "observations." A broad theme resulted from this sample of participants and suggested that HIV messages are most pronounced in the media which then act as a springboard for the participants to initiate conversations about safe sex practices. This visual aid eased the process of comparing the responses across all transcripts and ensured greater accuracy in that no data were inadvertently discarded.

The fourth stage is the development of themes that were a result from all the observations. The themes are then under "collective scrutiny" in order to determine the patterns of intertheme consistency and contradictions.

Table 1

A Sample of the Third Stage of the Five-Stage Analysis of Qualitative Research

(McCracken, 1988)

ID #	Communication patterns with sex partners	Motivational Factors to increase communication with partner
12212	▪ Communication changed over time o Early on, did not discuss it o Changing factor→heard HIV is a real issue, hearing about STATS via media o Changing factor→being more mature and being more career-oriented (futuristic oriented) ▪ Use stats and articles to springboard conversations ▪ Past two SP talks about HIV	▪ Won't have unprotected sex, unless in a long-term committed relationship and trust has been established
12006	▪ Condom vs. No Condom is always discussed ▪ Media (e.g., Montel Williams) springboard discussion of HIV, sometimes ▪ Sex partner typically initiates topic regarding safe sex practices→ they ask if condoms are available or if she is on Birth Control→she still insists they use condoms ▪ Timing o Condom talk usually occurs when foreplay (kissing) becomes sexually intimate ▪ Actions are consistent with Thoughts→ when condoms are not available she does not have sex	▪ Pregnancy scare ▪ Condom scare "Um, a scare. Like, any type of pregnancy scare, or um, condom scare, or actually with the guy who I said earlier we just um, didn't have a condom and we stopped, when we went out?"
11914	▪ HIV is discussed in the form of Testing ▪ Discussion occurred with those she had unprotected sex with ▪ She always initiates it	▪ To be more comfortable ▪ To not be afraid ▪ TV shows, PBS address AA girl who was HIV positive and gave birth to a HIV + kid→ it hit home

For the purposes of this study, the emerging interrelationship patterns among the themes and observations were examined across all transcripts, but within their respective categories and within their respective ethno-cultural groups between the Latina adolescent females and the African-American adolescents. The themes were also examined across both ethno-cultural groups as given in Table 2.

The fifth, and final, stage is generating a conceptual framework from the collected themes and patterns across all interviews, all categories, and both ethno-cultural groups. This conceptual framework emerged in the midst of going through the data, which gave way to the utility of this research project, thereby providing age-specific, gender-appropriate, culturally-relevant HIV/AIDS messages. The female participants' responses regarding their thoughts on solutions and recommendations in increasing HIV awareness were compared to the principle investigator's own impressions from the participants' experiences, thoughts, and behaviors.

Quality Control

A common mistake is to impose quantitative standards when evaluating qualitative research (McCracken, 1988). McCracken recommended borrowing Bunge's "symptoms of truth" in order to evaluate the results of qualitative data and view the data as legitimate knowledge. During the analysis process, quality control was maintained through the adherence of the following standards: (1) It be must be exact so that no unnecessary ambiguity exists; (2) It must be economical so that it forces one to make a minimum number of assumptions and still explain the data; (3) It must be mutually consistent so that no assertion contradicts another;

Table 2

A Sample of the Fourth Stage of the Five-Stage Analysis of Qualitative Research (McCracken, 1988)

SubGroups	Description and Meanings Associated with Safe Sex
Latina Females	▪ 6 Latinas stated Safe sex is defined in terms of Protection o Protection frequently referred to birth control (5) o Not all said protection, but all nine Latinas referred to condom as a means of safe sex ▪ 2 Latinas Safe sex is Tested o La Chingona "then I guess now like my thing is like ok I'm going to use condoms at the beginning but try to go get tested right away because I'm not really into this, into using condoms. So, as long as you get tested, it would be ok." o O'Connor "If you've both been tested and you know that you are both all well and good and you are in a committed relationship with that person and you do not plan to sleep with anybody during that relationship either than the two of you"
African-American Females	▪ 10 African-Americans defined Safe sex in terms of Condom ▪ 3 African-Americans defined Safe sex in terms of Birth Control ▪ 3 African-Americans defined Safe sex in terms of Knowing Sex Partner's Sex History
Latina and African-American Females	▪ All participants said that Condoms are a form of safe sex ▪ Seems that more Latinas believe Birth Control is a form of safe sex, where only three AA said it was form of safe sex ▪ Equal number of Latinas and AA (3 each) said knowing sex partner's history is a form of safe sex ▪ 2 Latina and 1 African-Americans believe Getting Tested is a form of safe sex

(4) It must be externally consistent so that it conforms to what we independently know about the subject matter; (5) It must be unified so that assertions are organized in a manner that subsumes the specific within the general, unifying where possible, discriminating when necessary; (6) It must be powerful so that it explains as much of the data as possible without sacrificing accuracy; and (7) It must be fertile so that it suggests new ideas that are opportunities for insights.

Summary

Objectivity, accuracy, and precision are the "gold" standards in psychology's contemporary research practices and in the HIV/AIDS prevention studies that the assumptions often go unchallenged (Derry, 1999). However, traditional methodological designs have been, at best, sufficient in identifying populations that are at risk and, to some extent, the factors that contribute to these populations engaging in risky sexual behaviors; yet, this social epidemic is going amok because of the multitude of variables and the complex nature of the interaction of these variables.

The purpose of examining the current methodological practices is not to negate the viability and utility of positivism, but to illustrate simply that it, too, has its imperfections. According to the bubble hypothesis, coined by Gelso in 1979 (Gelso & Fretz, 2001), "each attempted solution causes a problem to appear elsewhere," (p. 79) similar to a sticker on a windshield. When pressing the bubble in one area, it causes a new bubble to appear in a different location. Gelso and Fretz (2001) reminded the community of researchers in the field of psychology that "each and every study is highly imperfect and that each contains some inevitable flaws," (p. 79), in that each research design has its strengths and weaknesses. They proposed convergent of findings that resulted under conditions of methodological diversity will combat most effectively the bubble effect of any given methodological design that is inherently flawed. The application of a semi-structured interview to elicit uninterrupted discussion on female adolescents' perceptions, beliefs, thoughts and behaviors regarding critical topics on HIV-related issues is appropriate for this study, and such a study is necessary for the area of HIV/AIDS prevention.

CHAPTER 3: RESULTS

This chapter is divided in three parts. The first focuses on the results from the survey segment of the interview. The second reveals a snapshot of each participant's background, which includes their career aspirations, family upbringing, and sexual history. The third details the findings for each of the major sections from the open-ended, semi-structured questionnaire.

Survey

The survey portion of the semi-structured interview extracted information in several areas: 1) the frequency and types of sexual activity experienced by these participants, 2) the frequency and consistency of using condoms when engaging in vaginal intercourse as well as anal and oral sex, and 3) the total number of times they reported getting HIV tests, and whether or not they obtained their results. The following data are congruent with literature that has shown that late-adolescent females are sexually-active and do not take safety precautions to decrease their risk of infection from a multitude of sexually transmitted diseases. Table 3 summarizes the results of the survey.

Of the 19 participants who were involved in this study, nine identified themselves as being Latina and the other 10 identified themselves as being African-American. For the participants in the Latina category, the mean age was 19.78, while the age range was between 18 and 21. For participants in the African-American group, the mean age was 20.8, and the age range was between 19 and 22. The Latina group reported a mean of seven, and a range between one and 23 for the number of partners with whom they have been sexually active.

Table 3

Demographic Variables, Number of Sex Partners, Condoms Use, and HIV Test

	Mean: Age	Class Level 1 = Freshman 2 = Sophomore 3 = Junior 4 = Senior	Mean: Number of Sex Partners	Range: Number of Sex Partners	Mean: Number of Sex Partners without condom use	Range: Number of Sex Partners without condom use	HIV Test	Obtain results of HIV Test
African-American (n = 10)	20.8	3.5	13.89	1-50	2.4	1-5	8	6
Latina (n = 9)	19.78	2.2	7	1-23	3.75	1-15	2	2
Total (n = 19)	20.31	2.89	10.44	1-50	3	1-15	10	8

The African-American group indicated a mean of 13 and a range between one and 50 for the number of partners with whom they have been sexually active. Two participants from the African-American group reported being sexually involved with more than 30 and more than 50 sexual partners, which increased the mean for their respective group norms. Though the average number of sexual partners among Latina females were lower than their African-American female counterparts, the mean number of sex partners with whom Latinas did not use condoms (n = 3.75) was higher than their African-American counterparts (n = 2.4).

The survey assessed the participants' types of sexual activity, including oral and anal sex as well as the extent to which they took safety precautions. Among the Latina females, three of the nine respondents who reported engaging in anal sex, also reported not using condoms. Among the African-American females, six out of ten indicated having anal sex, but only three indicated using condoms at that time. All 19 of the female participants reported having had oral sex. Sixteen respondents admitted to not using condoms when engaging in oral sex, one respondent did not provide a response, one respondent indicated using a condom, and one participant stated that she used a condom when giving fellatio, but not (a female condom) when engaging in cunninlingus. Within this sample, participants reported an equal occurrence for oral sex and vaginal intercourse. However, the results from their responses indicated that condoms were used significantly less often when oral sex was involved. When asked how they would protect themselves when performing oral sex, one respondent stated, "Don't swallow," and another admitted, "I wouldn't know how you would protect yourself from oral sex." These quotes from two participants not only revealed that they lacked the knowledge in

protecting themselves, but it also revealed how certain methods give them an illusion that they are free from infection when practicing oral sex. Though their thought patterns were disconcerting, they were, nonetheless, candid.

The survey also examined the number of "one-night stands" for each participant. For the purpose of this study, a "one-night stand" is defined by engaging in sexual intercourse on the same day as first meeting that sexual partner. A total of 11 participants reported engaging in one-night stands. Two participants reported having one-night stands, but both stated they could not recall the number of times they had one-night stands. Of the nine other participants who had one-night stands, the mean was two with a range between one and four. Five participants admitted to having sex within a week of meeting their sex partner. Of these encounters, the average number was five and the range was between one and 19 partners. Three female participants reported both having one-night stands and engaging in sex with a person whom they met within a week. Eight participants reported they had not engaged in either a one-night stand or having sex with a person they met within a week's time of meeting. Finally, of the ten participants who sought an HIV test, six of the eight African American and two of the two Latina females obtained the results of their HIV tests.

Biography

The purpose of providing a brief description of each participant is to capture the essence of her individuality, which will, in turn, contextualize the results and the generalized themes derived from their semi-structured, open-ended interviews. Each of the late-adolescent females was given the opportunity to assign a pseudo-name in order to protect the confidentiality of her identity and to promote candidness when responding to

emotionally-charged, taboo-oriented questions. In addition, the terms *protection* and *condom* are used interchangeably. Lastly, the information is presented in chronological order as collected from April 2004 through May 2004.

African-American Females

Angel is a 21 year old African-American senior who is majoring in marketing. She stated that her passion is in entertainment, and she would eventually like to become a model and a dancer. Her parents had five children; Angel is the middle child and has two older brothers and two younger sisters. Her parents were married for 24 years prior to her father's death from a motor vehicle accident. The father was diagnosed with schizophrenia when she was 5 years old, and was frequently institutionalized for his psychiatric problems. She described her relationship with her mother as being "really close." Angel reported that her fiancé of a year and a half is currently attending college in another state. She has been sexually active with five partners, with two of whom she did not use protection. She engaged in vaginal intercourse and oral sex approximately 12 times in the past 12 months, and did not use a condom in any of these incidences. She stated she has not engaged in anal sex. Her most recent HIV test was in April 2004, but she did not obtain the results of her test.

Chi-Chi is a 22 year old African-American 5th year senior, majoring in the food industry. Her ideal career is to become a talent agent, and a film director in the hope of using the media as a forum to create public service announcements for young women. She stated that she would like to use the media as a teaching tool. She has no contact with her father, as her mother never married. She stated that she is close to her mom. She has had unprotected sex with one of eight sexual partners. In the past 12 months, she

used condoms each of the six times she engaged in vaginal intercourse. She reported that she has not engaged in anal or oral sex in the past 12 months. She also reported that she has been tested for HIV on two different occasions.

Chocolate Princess is a 19 year old African-American sophomore who is majoring in human resources. She eventually would like to advance her education by attending graduate school in the same field and work in an office. She stated that she likes to be in control. She was born and raised in a large inner city in the Midwest. Her parents divorced when she was a year old, but her mother re-married approximately four years later. She described her relationship with her mother as "getting better," but alluded to past interpersonal conflict. The most recent was Thanksgiving, the first time in 5 years that she visited her father, even though he lives within 15-miles of her. She never viewed her stepfather as a father figure, and instead, felt out of place at home. Of the 13 sexual partners she has had thus far, she reported having unprotected sex with 5 of them. Though she is not currently in a monogamous relationship, she reported engaging in vaginal intercourse approximately 50 times in the past 12 months, but only used condoms half of that time. She also reported not using condoms in the past 12 months either when engaging in anal sex on one occasion or when having oral sex approximately 20 times. She sought an HIV test, but did not obtain the results of her test.

Josephine is a 22 year old African-American 5th-year senior majoring in psychology. Her goals include earning a master's degree in counseling and owning a private practice. She would like to use cosmetics as a means to increase self-esteem for women who have been domestically assaulted. She stated that she was born in the South but was raised in the Midwest. Her father, who is a pastor, and her mother, who is a full-

time homemaker, are still married and have three children. She reported that of the 5 partners with whom she has been sexually active, she had unprotected sex with one of them. She approximated engaging in vaginal intercourse, on average, three times a week for the last 12 months, and she approximated her use of condoms as 10 times in the same time period. In the past 12 months, she also engaged in anal sex approximately four to 10 times, but did use condoms each time. She did not protect herself when practicing oral sex. In 2002, she was tested for HIV and obtained her results.

Ladybug is a 19 year old African-American sophomore majoring in human biology, as well as in marketing and management. Her goal is to become and emergency room physician, and perhaps specialize in pediatrics. She was born in the South but was raised in the Midwest. Her parents had one child and were married for 6 years. Her father remarried approximately 12 years ago and had 5 additional children. Her mother was remarried approximately 17 years earlier and had one additional child. She described her relationship with her parents and step-parents as being her "best friends." She reported being sexually active with six partners and was unprotected with two of them. She is presently in a monogamous relationship and has practiced safe sex half the time she engaged in vaginal intercourse. She has not engaged in anal sex for the past 12 months and used both a female and male condom each of the 20 times she had oral sex in the past 12 months. She reported that she obtained the results from her most recent HIV test in January 2003.

Mary is a 22 year old Kenyan-American female earning a master's degree in Social Work. Her goal is to become the first African-American female Mayor of her hometown. She stated, "It was my calling." Her father, who is Kenyan-American and a

professor in economics, and her mother, who is a finance manager, have been married for approximately 26 years and have three children with Mary being the oldest. She currently interns at a local nonprofit AIDS agency. She stated that of the 30 partners with whom she has been sexually active, she was unprotected with 5 of them. In the past 12 months, she stated that she engaged in vaginal, oral, and anal sex, and only used condoms during vaginal intercourse, albeit inconsistently. She reported that she was tested for HIV and received the results of her test in 2002.

Osa is a 21 year old Nigerian-American junior majoring in journalism. She hopes to work in public relations as a special-events coordinator. She was born in the United States, whereas her parents, who divorced when she was 13 years old, were Nigerian born. Her father is a professor (journalism) at a large university and her mother is a nurse. She described her relationship with her father and mother as being "very good." She revealed that she struggled to feel accepted by the African-American community in high school, and was frequently told that she was "not black enough." She felt accepted by her Caucasian peers both in the high school and college settings. She has been sexually active with one partner who is her current boyfriend. In the past 12 months, condoms were used approximately 10 of the 20 times she reported engaging in vaginal intercourse, and none of the times when practicing oral sex. Her primary concern is prevention of pregnancy, rather than sexually transmitted diseases. She has yet to get an HIV test.

Poet is a 22 year old African-American senior majoring in advertisement. She attributes her career goal of wanting to write commercials as being influenced by her mother's work in the radio industry. She was born and raised in a large inner city in the

Midwest. She reported that her parents are on the verge of separating because of her parents being "unfaithful" to each other. She also revealed that she has become more spiritual and more of an advocate for young African-American women. Poet admitted to being sexually active with more than 50 partners, with four of whom she intentionally did not use condoms. In the past 12 months, she consistently protected herself each time she engaged in vaginal intercourse and oral sex. She reported that she did not engage in anal sex in the past 12 months. She did get an HIV test approximately a year earlier and received the results of her test.

Spirit is a 20 year old African-American junior majoring in advertising. She revealed that she would like to one day own a dance studio and create public service announcements. She grew up in an inner city of the Midwest. Her father died from Lou Gehrig's disease at the age of 36. Her mom currently sells real estate. She emphasized the importance of an education as a means to practicing safer sex and stated that the average African-American woman does not seek a college education. She reported that she has been sexually active with five partners, with two of whom she did not use condoms. She reported that she has not engaged in anal or oral sex in the past 12 months. She did get an HIV test approximately two years ago.

Tinay is a 19 year old African-American female who is a freshman majoring in Pre-Nursing. She was born in the Northwest, but was raised in the Midwest by her biological father whom she described as being strict. In 2004, her mother was incarcerated for credit fraud. Her long-term goals include becoming a nurse, owning a home, being married, and having a dog. She reported not using protection with one of the 5 partners with whom she has been sexually active. In addition, she reported using

condoms approximately eight of the 20 times she engaged in vaginal intercourse in the past 12 months. She stated that she did not engage in anal sex and did not use condoms in the 30 times she had engaged in oral sex in the past 12 months. Lastly, she reported that she has not, to date, sought an HIV test.

Latina Females

Butterfly is a 20 year old Latina sophomore majoring in interior design. Her long-term goal is to become a community activist. She was born and raised in the Southwest, and described her family dynamics as being "traditional." Her father is employed full-time in the service industry, while her mother works part-time. She reported being sexually active with two partners thus far and was unprotected with one of them. In the last 12 months, she reported engaging in vaginal intercourse five times and being protected each time, but did not use condoms at all when participating in oral sex. She reported that she, to date, has not been tested for HIV.

Goddess is an 18 year old Latina freshman who is majoring in packaging. She has been sexually active with seven partners and was unprotected with one of them. She reported that she has, on average, engaged in vaginal intercourse 24 times in the past 12 months, but did not use condoms on four of those occasions. In the past 12 months, she reported that she did not engage in anal sex, but practiced oral sex 12 different times, and did not use a condom during those times. She admitted that she has yet to get an HIV test.

La Chingona is a 20 year old Latina sophomore who has yet to declare a major. She stated that "La Chingona" means tough and strong. She hopes to become an advocate for the Latina community as an events coordinator. She was born in Mexico, but was raised in the United States. Her parents never married each other. Her mother married and had two additional children. She revealed that of the four sexual partners, she failed

to protect herself with three of them. She averaged engaging in unprotected vaginal intercourse and oral sex, a total of both three times a week for the past 12 months. Her most recent HIV test was in January of 2004, but she did receive the results of her test.

Leslie is an 18 year old Latina freshman majoring in child development. Her long-term goals include returning to the Southwest area, getting married, having children, owning a home, and opening a daycare center. She was born in Mexico, but was raised in the Southwest region of the United States. Her parents had seven children and were married for 12 years until her father's suicide when she was 5 years old. She described her relationship with her mother, who re-married approximately a year earlier, as being "very good." For the previous 12 moths, she reported having both vaginal intercourse and oral sex, with one person to whom she is currently engaged. She stated that she did not use condoms at that time, and has not sought an HIV test.

Morning Star is a 20 year old Latina sophomore who is majoring in human biology and in Spanish. She would like to become an emergency room physician and work in Africa. Technically, she is bi-racial, being both German and Puerto Rican, but when she is asked to identify her ethnic/cultural heritage, she predominately identifies with being a Latina. She reported being involved with 12 sexual partners and using protection with all but one partner. In the past 12 months, she estimated that she has had vaginal intercourse 10 times and used condoms each time, but did not use condoms when engaging in oral sex on approximately four occasions. She stated that she did not have anal sex. Her most recent HIV test was in the summer of 2002, and she did obtain her results.

O'Connor is a 21 year old, Latina senior majoring in political science. Her career goals include earning a master's degree in education, as well as a law degree. She revealed that her father, who was Mexican, died of a heart attack when she was 14 years old. Her mother, who is Puerto Rican, was a teacher and had three additional children from previous relationships. O'Connor was born in Mexico, and has dual citizenship. Of the 23 partners with whom she has been sexually active, she estimated that she used condoms with approximately one third of her sex partners. She has been sexually active on a consistent basis for the past 12 months, and reported not using condoms during vaginal intercourse and oral sex. She also admitted that her fears have prevented her from getting tested to determine her HIV status.

Princess is a 21 year old Latina senior who is majoring in psychology and she hopes to become a marriage and family therapist. She stated that her parents, who are both Hispanic, are still married, and have 4 children. She reported that she has had, to date, three sexual partners, and had had unprotected sex with one sexual partner. She approximated engaging in vaginal intercourse twice a week for the past 12 months and during that time, reported not using condoms on two occasions. However, she appeared to misunderstand the question, and I believe her response is not accurate to the question being asked as she stated, "Um, twice and that was just with the last first two before my boyfriend now." This response leads me to believe that she has not used condoms with her most current sexual partner who she identified as her boyfriend. She stated she has not engaged in anal sex, but had oral sex on average once a week for the past 12 months, and did not use condoms. She has yet to get an HIV test.

Sam is a 19 year old Latina freshman who is majoring in advertising. Her long-term goals include being financially stable and being content with her job. Her mother and father, who speak fluent Spanish, are still married. She revealed that she is not actively involved in the Latina community, and that her friends view her as being "White," even though she has expressed interest in the Latina community. She reported that she has been sexually active with one person, who is presently her boyfriend, and has consistently used condoms when engaging in vaginal intercourse, but not during oral sex. She also reported that she has yet to get tested for HIV.

Vixen is a 21 year old Latina attending her fourth year at a local community college, and is majoring in photography. Her mother and father, who are Mexican and Puerto Rican, respectively, never married each other. Her mother is married to her stepfather, who is African-American. She views him as a role model. She described her overall childhood experience as being "very good." Her career goals include being a photographer and eventually becoming a trainer at SeaWorld. Of the 10 partners with whom she has been sexually active, she reported failing to protect herself with seven of them. She estimated that she used protection 20% of the 208 times she had vaginal intercourse in the past 12 months. She also revealed that she engaged in both oral and anal sex in the past 12 months, but admitted she failed to protect herself in each of those instances. In addition, she admitted that she has yet to get an HIV test.

Findings

The type of data analysis for most qualitative research is theme-driven; however, the themes derived from this study are contextualized within their respective sections and within the questions that were asked. The results of the data analysis are clearly outlined.

The first major section, HIV Knowledge, encompasses two questions: (1) What are the respondents' understanding of how HIV is transmitted, and (2) How do the women think of themselves in relation to HIV? The second major section, which is titled Thoughts and Behaviors about Sex, Participants' Sexual Experiences, Safe Sex, and Communication Patterns with Sex Partners, is further divided into four subsections: Definition of Sex, Personal Accounts of Past and Present Sexual Experiences, Definition of Safe Sex, and Communication Patterns with Sex Partner. The third major section, Effectiveness of Past and Present HIV/AIDS Messages is divided into three sections, including Types of Past HIV/AIDS Messages, Types of Present HIV/AIDS Messages, and Suggestions to Increase Consistent Condom Use and HIV Awareness.

In addition, many, if not most of the participants, provided multiple responses for the open-ended questions. For example, when asked to discuss their knowledge of the transmission of HIV, many of them listed several examples within a given response. La Chingona's response serves as an example:

> La Chingona: "I know you get it through sex sexually, that's orally or anal sex, through blood, like semen or the same thing, sex, sharing of needles, blood, I'm trying to think how else I think that's it, I know you can't get it through kissing, unless there's a cut."

Multiple examples were then delineated into their own categories. The results were also outlined in a comparative framework between the Latina and African-American late-adolescent groups. Table 4 summarizes the participants' responses to the two content domains: knowledge of HIV transmission and the extent they identify with HIV/AIDS.

Summary of Knowledge Regarding HIV Transmission

Table 4

Themes on Knowledge Regarding HIV Transmission

Question	Themes	(*n* = 19)
Mode of Transmission		
	Sexual Contact	18 Total
	Vaginal Sex	7
	Oral Sex	7
	Anal Sex	5
	Intravenous Needles	12
	Exchange of Bodily Fluids	8
	Blood Transfusion	7
Relation to HIV/AIDS		
	No	9 Total
	African-American	3
	Latina	6
	Yes	10 Total
	African-American	6
	Latina	4

All of the participants, with the exception of one, responded to the question of identifying ways HIV can be transmitted and made some form of general reference to *sexual contact* as a means of transmitting the virus. Seven participants made mention of vaginal and oral sex as a route in which HIV can be transmitted. Osa's response is representative of a typical answer; she stated, "Through some type of sexual contact whether it's oral sex or vaginal sex." The five other participants stated that anal sex is a form of sex, and is thereby, a form of transmission. Twelve participants viewed *intravenous drug use*, a phrase denoting the use/exchange of contaminated needles, as another culprit for the spread of HIV. *Exchange of bodily fluids*, including blood, semen, and saliva, was also mentioned by eight respondents. Seven indicated *blood transfusion,*

while three indicated childbirth by an HIV-infected mother as a means of transmitting HIV.

Their responses to the next question—Have you ever thought about yourself in relation to HIV/AIDS—may clarify this matter. Their responses fell into two equally divided camps: *No* and *Yes*. Six Latina and three African-American females stated that they do not think of themselves in relation to HIV. Three participants reported a *No* without further explanation. For the six other participants who indicated a *No* response, the most common explanation given was a combination of being with a "few" partners and "knowing" their sex partners precluded them from thinking of themselves in relation to HIV.

> Goddess: "No. Like I, everyone who I've had sex with, I've known and so I trust them, and I pretty much know who they've been with so I feel really comfortable with them...I don't have many worries about getting HIV or AIDS."
>
> Leslie: "No. Because I have been with one person."
>
> Butterfly: "No. I've never believed that about myself. I guess because the people I have been with, you know sexually active with, they, it was either their first time, or to my understanding they hadn't had so many sex partners."

The aforementioned statements are indicative of a false belief of being safeguarded from the possibility of getting infected. Six African-American and four Latina females directly and indirectly indicated that they have thought of themselves in relation to HIV and the most common explanation provided was a combination of their own sex history, including "bad decisions they made," and the act of getting an HIV test. Poet's and Angel's responses illustrates this theme.

> Poet: "Yes, the first time I went and took my AIDS test, I was terrified. I think I was like 20, the first time I took it, 21 something like that. But

> um, I was really scared to take it because I thought about all the bad decisions that I made as far as sexual partners. I had a lot of one night stand and it was like even if I did have it, I wouldn't even know who to start calling to find out where I got it from and that was a scary thought."
>
> Angel: "Yeah, by me participating in unprotected sex, I think about it often and I get tested once a year. Yeah, before I didn't have unprotected sex so I didn't feel the need to get tested."

Television programs (n = 2), educational classes on sex (n = 2), and the need to protect themselves (n = 2) were other explanations given when these late-adolescent females think of themselves in relation to HIV.

A subtle pattern emerged regarding why these participants did, or did not, consider the potential impact of HIV and its bearing on their safety. Latina females demonstrated a greater incidence to being impervious to the belief that they can become infected. This is most attributable to false assumptions such as (1) having fewer partners is safe(r) and/or (2) knowledge of their partner's sexual history and behaviors. Alternatively, African-American females were able to conceptualize the relationship between their history of sexual practices, motivation to get an HIV test, and their thoughts and actions around the possibility of being HIV infected.

Thoughts and Behaviors about Sex, Participants' Sexual Experiences, Safe Sex, and Communication Patterns with Sex Partners

Definition of Sex

There is a paucity of research studies that has examined the relationship between condom use and oral sex (Boekloo & Howard, 2002), even though other studies revealed that adolescents are more likely to experience oral sex sooner than penile-vaginal intercourse (Newcomer & Udry, 1985). A general concern among the HIV/AIDS research is that when studying or conceptualizing "sex" and "safe sex," it is often

operationalized in terms of vaginal penetration because of an unconscious exclusion of oral and anal sex. This pervasive, yet silent, assumption has surfaced in the literature, and has been echoed by the participants being studied. The following results detail the participants' definition of sex, conceptualization of anal and oral sex, ages when they learned the meaning of sex, and sources from which they learned the information.

Among the African-American females eight of the ten respondents defined sex by providing specific examples of sexual behaviors, which included anal, vaginal, and oral sex, as well as the exchange of bodily fluids, which was then encompassed under the broader category of *Penetration*. Poet's and Chi-Chi's responses typify the way the female participants conceptualized the term *sex*.

> Poet: "Well, sex is, of course, there is intercourse, there's oral, anal, and vaginal sex."
>
> Chi-Chi: "Penetration. [Investigator: Tell me more about that.] If someone is penetrating the other, then I think that's when they really are starting to open themselves up to diseases."

Josephine and Ladybug further conceptualized sex as being an intimate experience and a means to express love and affection. Furthermore, sex is not merely a "past time" or "something just to do," according to Josephine, but it is to be viewed as an emotional and personal interaction between two people.

Among the Latina females, seven of the nine respondents also provided specific examples of sexual behaviors, including vaginal, oral, and anal sex, which was also subsumed under the category of *Penetration*. O'Connor's response, "Vaginally, orally, anally. There is penetration involved. Penetration into orifices," epitomized the *Penetration* category. Of the nine Latina participants, two referred to sex as heterosexual

sexual behavior, while two others viewed it as an emotional and intimate experience. Princess's and Leslie's excerpts typify both response sets.

> Princess: "Either through oral sex and or just regular heterosexual sex. I guess anal sex as well, I'd classify that under the category of having sex just less dirty."

> Leslie: "Yeah, okay, my definition of sex is a way of showing your primary love. I don't just want to do just for fun, but the person I do it with is because I love him."

When asked to define sex, the majority of the responses across both groups conceptualized it in regards to *Penetration*, which is in and of itself an equally broad and abstract term. Many provided specific examples of p*enetration*, including vaginal, anal, and oral sex, while others thought of sex in terms of exchange of bodily fluids, and other respondents qualified *penetration* or *sex* as a sexual act in a heterosexual context. Two participants from each group viewed it more than a mere behavior, but as an emotional, intimate connection between her and her sex partner, regardless of gender and sexual orientation. Sex and penetration were largely defined in terms of discrete behaviors (e.g., vaginal intercourse), as evidenced in this sample, but when the participants were asked whether specific sexual acts can be categorically and unequivocally defined as sex, the responses became less than clear and are evident in the following subsection.

Conceptualization of anal and oral sex. A total of 12 out of the 19 participants, eight African-Americans and four Latinas, definitively stated that anal and oral sex constituted sex, while 7 out of the 19 participants, two African-Americans and five Latinas, revealed a more varied and complex response set. Angel and Chi-Chi, who are both African-American females, viewed vaginal intercourse as distinctly different, and

conceptualized oral and anal sex either in terms of losing one's "virginity" or on a continuum of "penetration."

> Angel: "Oral, no. Anal, I would actually say, yes, but I don't know because to me, losing your virginity is vaginal; it's not anal and I think when virginity is first discussed with me, it was brought about as vaginal. I didn't learn about anal sex until later on in life. Actually didn't learn about it until several years later so I never thought of it as losing your virginity."

> Chi-Chi: "Yes." But then later states, "Oral sex is sex but not to the extent to which penetration is."

Morning Star and Vixen both indicated that oral sex is "foreplay," but had opposing views as to whether anal sex constituted "real" sexual behaviors. Sam also agreed with Vixen that anal sex is sex, but was uncertain as to how to conceptualize oral sex.

> Sam: "I think anal sex is, I feel like oral sex is sometimes... I don't know, I haven't decided whether it is or isn't...Anal sex is because it would be penetration whereas oral sex is not, because it's not necessarily, well it isn't...kind of... (Laughs nervously)."

Princess stated that both acts were forms of sex, but felt that anal sex was "just less dirty." Conversely, Leslie's response gave a strong implication that she viewed both oral and anal sex as being "dirtier" as she thinks of them as being "nontraditional" and "non-conservative" sexual behaviors. She believed that penile-vaginal intercourse is "normal" sex, and therefore is permissible, based on the premise that vaginal intercourse can be openly discussed among her peers. However, some topics, including oral and anal sex, are forbidden from peer-discussions and are considered taboo. Therefore, they are designated as "not normal" sex behaviors, according to Leslie's assertions. Consequently, anal and oral sex are not only perceived as "dirtier" forms of sexual

behaviors, but the character of the person who initiates these taboo topics is under attack as well.

Though the majority of respondents indicated that both oral and anal sex constitute sex, the five other respondents conceptualized these sexual behaviors within several frameworks: degree of sexual penetration, the cultural norms associated with "virginity," and culturally-defined taboos. The following subsections examine the age and source from which they acquired the meanings associated with sex.

Age and source from which they learned about sex. The most popular response for how the participants acquired their understanding of sex was through formal sex education (Latinas = 4 and African-Americans = 5). Six African-Americans compared to three Latina females indicated that family, especially their mothers, were involved in their understanding of sex. There was equal mention (n = 3) of various forms of media (e.g., MTV and BET) that assisted in their acquisition of the term sex. Friends and personal experiences were also mentioned, but the type of interactions they had with their family members differentiated the two groups. The Latina participants indirectly learned about sexual behaviors and social norms from their parents. Examples of imparting such beliefs and norms included covering the children's eyes to hide movie and television scenes that were sexual in nature, and making suggestive comments about waiting to have sex until marriage. The African-American participants acquired norms and beliefs about sex from their parents as well, but the messages were more explicit, and the conservations occurred with greater frequency. Examples of messages that they obtained from their parents included treating one's body with respect, revering one's body as a temple, and engaging in sexual acts when one is emotionally "ready." In other words,

both groups were encouraged to "wait" in having sexual relations, but the Latina females were told to wait until marriage, while the African-American females were told to wait for the right person or until the person is emotionally mature. Vixen and Leslie, who are both Latinas, and Tinay, who is African American, confirm these observations.

> Vixen: "[Investigator: Where did you get your description of sex from?] TV, you know, watched TV and saw the sexual acts and usually my parents would cover my eyes but I could still see it when they weren't around."
>
> Leslie: [Investigator: Where did you get your description of sex from?] I think that is the way I was raised. I was told that you are not supposed to have sex until you get married. I was raised in a way that the best thing you can offer your husband when you get married is your virginity."
>
> Tinay: Everything: Media, parents, friends. [Investigator: What about parents?] Trying to wait until I find the right person."

The majority of Latina (n = 6) and African-American (n = 7) females indicated that *Middle School*, which included 4th through 8th grades, was the timeframe in which they began thinking about the concept of *sex*, while three respondents thought about sex much sooner because of either having an early onset of their menstrual cycle, being sexually abused, or having early talks with their mothers. Chi-Chi, for example, had her first discussion with her mother when she was 8 years old; Poet recalled of her first menstrual period at the age of nine as the reason for having her first discussion with her mother. LaChingona was forced to conceptualize sex when she was sexually abused at the age of six.

The purpose of this subsection was to determine the participants' conceptualization of sex, the sources by which they acquired their understanding of sex, and the timeframe in which it was learned. Essentially, *formal sex education* classes in

school settings, *family*, and the *mass media* were identified as the primary sources for explaining the sources from which they learned about sex predominately during "*middle-school*" years. The goal of the following subsections is to examine the intimate details and personal accounts of these participants, the motivation to engage in past and present sexual experiences.

Personal Accounts of Past and Present Sexual Experiences

One approach to understanding better the HIV/AIDS epidemic among minority adolescent females is to examine the variables that motivate them to engage in sexual behaviors with each new sexual partner. Understanding the highly interwoven, multi-layered factors regarding their rationale, motives, and behaviors for engaging in sexual behaviors may be one key determinant in generating HIV prevention messages, as it will have significant relevance to the specific population being studied. Three categories emerged from the data analysis for both African-American and Latina females: low number of sexual partners (i.e., 1-4), moderate number of sexual partners (i.e., 5-10), and high number of sexual partners (i.e., > 11). Among the nine Latina late-adolescent females, five fell in the *low* number of sex partners, two were classified in the *moderate* number of sex partners, and two were grouped in the *high* number of sex partners. Among the 10 African-American late-adolescent females, one participant was assigned to the *low* number of sex partners, six were categorized in the *moderate* number of sex partners, and three were delegated to the *high* number of sex partners. This information is shown in Table 5.

The following subsections are further divided by racial/ethnic groups, where African-American will be described first, and then the Latina group, followed by a synopsis of the themes derived for each category.

Table 5

Categorization of Sexual Partners by Number and by Race/Ethnicity

	Low Number of Sex Partners (1-4 sex partners)	Moderate Number of Sex Partners (5-10 sex partners)	High Number of Sex Partners (> 11 sex partners)
African-American Females	1	6	3
Latina Females	5	2	2

Low number of sex partners among African-American females. Osa lost her virginity at the age of 20, and stated several reasons why she engaged in her first sexual experience. The "self-oriented" reasons focused on how she felt mentally and physically ready to explore sexual activities and that she was tired of being the "only virgin" within her circle of friends. The other reasons shifted the focus to her sexual partner and how she "felt a connection" with him, that he was disclosing of his past, and that she was able to see a potential long-term commitment with him as evidenced in the following excerpt:

> Osa: "I guess I felt more of a connection with him and I think I was just ready. I've heard conversations from my friends who have been having sex, and I just felt like I was almost alone, I never experienced it. At first I didn't' care, but then it started to get to me, and so I would say probably, the connection with a person and also the fact of being the only virgin within my circle of friends."

Ironically, though she delayed losing her virginity until the age of 20, she engaged in sexual intercourse within the first month of meeting her sexual partner and described her first sexual experience as being in the "heat of the moment."

> Osa: "I was still 20 and it was just kind of the heat of the moment type thing. Got wrapped up into whatever we were doing and it was, it just kind of happened, you know. It doesn't sound too good does it?"

It seems that Osa's primary motivations to engage in sexual relations with someone who she knew approximately a month were two-fold: she felt (1) alienated by her peers for being the "only virgin," and (2) the need to have an emotional connection with her sex partner. Osa appeared to gain awareness in how she had protected her sexual identity only to lose her virginity within a month's time of meeting her sex partner.

Low number of sex partners among Latina females. Butterfly lost her virginity at the age of 20 and had a total of two sexual partners. She was motivated to "take that step" and have her first sexual encounter with her long-term boyfriend because they "had a lot in common and stuff," even though she admitted that "I always thought about waiting until to get married." She described her other sexual encounter as being "in the moment."

> Butterfly: "I guess it was just in the moment or something? It wasn't like I thought about it. It was more of he was willing—he was more the one that wanted to do it—and I didn't really think about it; I just went along with it. Maybe it was not a good choice that I made."

Butterfly emphasized the importance of taking the time to get to know her sexual partner, as evidenced by this statement:

> Butterfly: "I would really have to know the person before I got into any kind of sexual relationship. I'm not the type of person that will see a guy, and will just get attracted to him, and like have one night stands, or something like that."

Butterfly then attempted to address the subtle, yet apparent, contradiction:

> Butterfly: "The first person, of course, because it was in time. We would spend every single day with each other because we went to the same high school and he took me home. But with the second person, it was more, even though we didn't know each other for that long of a period of time, as with the first person, I really felt comfortable with him. The comfort level came a lot faster, just an attraction towards him. Maybe it was curiosity. I guess it just varies with different persons."

The key factors that determined whether or not she participated in sexual acts included "waiting until marriage," needing to feel comfortable, needing to take the time to know her sexual partner, and having a sexual attraction. There seems to be a contradiction between her thoughts and actions in that she emphasized the value of sex and knowing her sexual partner, yet overtly condemned attraction as a reason to have sex. Nonetheless her behaviors remain as evidence that attraction was, in fact, the motivation for having sex with her second sexual partner.

La Chingona reported being sexually abused by two different male perpetrators at an early age, with the first being her mother's brother and the second being her mother's husband for two years. She stated that she has had four sexual partners, and emphasized that her history of being sexually abused did not influence her present behaviors. She contrasted her own experience with her friend who was also sexually abused:

> La Chingona: "I feel like I've recuperated over it like really good. I don't see sex as anything nasty. I had a friend she told me she was abused by her step dad, and she never told her mom as far as I know, but she would use it as an excuse to sleep around. She's like, 'I learned about it so long' that she started sleeping around a lot. It's like that's not really an excuse for it. I wasn't really like that. I never really slept around, and I've never felt any weird about sex."

La Chingona attributed her lack of sexual promiscuity to feeling supported, and having positive communication about her sexual abuse with her teacher, mother, and first sexual

partner. This open communication resulted in the legal conviction of her step-father. La Chingona's criteria to engage in sexual activity changed over time with each of her four sex partners. The duration of time spent getting to know a potential partner in order to have sex became shorter, and the decision to have sex became less of a conscious choice. In addition, common features among her sex partners were that they were Latinos, that she felt comfortable and trust was established, and that she was able to connect with her sex partners. The following excerpt highlights her sexual encounters:

> La Chingona: "Like my first experience—I wanted my first time to be special, not just with anybody. So we dated for almost a year before we had sex. So at first I thought it was something special, and I wasn't going to do it with anybody. Second experience it happened about 3 months into a relationship, and I wasn't in love with the guy. I wasn't going to marry the guy. He was just a great guy. He treated me really good. He put up with everything, stuff it was like, 'Wow, would have never done that!" I felt comfortable enough to experience that with him. The third time it was with the guy I'm talking to right now. It happened within a month. We clicked, right away. About a month after that, October, we started having sex. I liked him a lot, very open-minded, again, really great. He's just really great guy, he's like better personality. We connected a lot better, and I don't know, it just happened. And then the fourth person I was with, it was a one night thing. I thought I would never have one but I did, so that was just something crazy. I was just like 'Why not?' I was like, 'Fuck it,' but that time I did use condoms with him. He's kind of a celebrity. I went to their concert and their music is really famous. I didn't plan for it. I was like 'Should I do it?' She [her friend] was like "Go ahead.' I was like. 'Okay fuck this.' I felt something crazy, something to tell later, so that was kind of crazy but I used protection."

Another commonality among her partners is that La Chingona felt validated by them either by the way they showered her with positive attention or by how they had an unusual level of tolerance for her behaviors and attitudes.

Leslie commented that sex, as she sees it, as an "expression of love," including compatibility in values, a sexual partner who is caring and does not place pressure on her

to engage in sex, and a marital commitment. These are the three key factors that determined whether or not she would consider engaging in sexual relations. She stated that in regard to her fiancé, she knew within the first four months that they would marry. She explained that during their courtship, she went about investigating her fiancé's sexual history by asking his childhood friends and by asking him directly about his past. Leslie also revealed in the following passage the importance of marriage and being a virgin.

> Leslie: "I tried find out about his background from people he grew up with by investigating through childhood friends if he is very sexually active. [Investigator: What kind of person were you looking for then?] A person that will do it, that will think the same way I think, that will have sex with a person because they loved them, not just for fun. After I met him for four months we decided to get married. I was 14 years old. We wanted to get married. He is 21 years old now but then he was 17 or 18. But we knew we were so young and that people will be against it, especially our parents. I wanted to be a virgin before marrying him. We started thinking about sex, but decided against it."

At the age of 14, she met her current fiancé, but waited to engage in her first sexual experience until they cohabitated when she was 16 years old, even though she had planned to consummate their relationship on their wedding night.

Princess has been involved with three sexual partners. When she was asked to identify the factors that contributed to her decision to engage in sexual relations with a "guy," she simply began discussing her sexual history. She lost her virginity at the age of 16 with her boyfriend of six months, and perceived the relationship as being "serious" and meaningful. During their break up, she was sexually active with two additional sex partners, before returning to dating her first boyfriend.

> Princess: "It was a couple of months with him, but what had happened was that I was dating him, and then we took a break for a while, and there was those two in the middle, and now I'm back with him. That was the very first time with him, too, and so we waited a couple months for that. With the two guys in the middle, it wasn't some huge

> decision. We were not in a relationship. The first one—it was a couple of months after me and the first guy, my boyfriend now, took a break and so I was out and trying to meet new people all the time."

Interestingly, Princess's devotion to her first sex partner is apparent, but her attitude and motivation behaviors with the second and third sex partners can be described as being less conscientious. Furthermore, her sexual behaviors may seem to be driven by feeling rejected by her first sex partner, and she, thereby, had a need to seek external validation through the form of sex with her other partners.

Sam lost her virginity at the age of 18 with her current boyfriend. She emphasized that long-term commitment and lack of pressure to have sex were two determining factors in deciding to engage in sexual relations. She stated, "I feel like if I didn't know that I was going to be with the same person, then I don't think I'd want to do things like that." Ultimately, the actual act of sex occurred spontaneously, even though she stated that their decision to have sex was a conscious one.

> Sam: "It was pretty conscious, we talked about doing things and I was just like, I don't want to do that right now, so let's just talk about it later, so we just put it off and then I don't know, it just kind of happened."

Themes among low number of sex partners. A general theme among the six female participants in the *low* category is that their values and thoughts were not necessarily congruent with their behaviors. Specifically, each participant emphasized the value of believing that the relationship with her sex partner had the potential for a long-term commitment or for marriage; yet, each of them engaged in sexual activity within the context of it "*Just-Kind-of-Happened.*" Leslie, for example, had made a conscious decision to "wait" to have sex with her fiancé, but still lost her virginity before marriage.

In other words, even the well-intentioned, highly value-oriented females subjected themselves to spontaneous sexual practices.

Will similar themes appear in the next category, where the participants have been identified as having been sexually involved with more than four but less than eleven partners? Six African-American and two Latina females have been categorized in the *Moderate Number of Sex Partners*. As with this subsection, themes will be derived from the summarization of participants' thoughts, as well as their past and present behaviors on sex.

Moderate number of sex partners among African-American females. Angel, who has been sexually active with seven partners, at the time of the interview, is engaged to be married. She stated that her reasons to engage in sexual relations included having chemistry, the ability to trust, and being emotionally and physically comfortable with her sex partners. However, her sexual history revealed that other factors, namely the *Wooed-Effect* and viewing *Sex as a Requirement* to be in a relationship, were the unconscious motivations involved in the decision-making process to have sex. Angel's first sexual encounter was at the age of 13 with a partner who was 18 years old at the time, and she justified this by stating, "He said all the right things to me, and I thought in order to be with him, or to keep him, that I needed to have sex with him." Angel's first sexual experience was further complicated by her 15-year-old girlfriend who pressured her to have sex. She stated, "I was kind of scared, and very apprehensive, but she was there and was like, 'It's fine.' And we went in the room, and it happened." Being *Wooed*, which is defined as her partner attempting to increase her self-esteem as a ploy to have sex , and

perceiving sex as a requirement to be in a relationship, were evident in six of her seven sexual partners.

> Angel: "In the past, [he] just won me over with charm. I feel every guy that I had sex with in the past, I feel I was misinformed. I felt they told me things that I wanted to hear to get me in the bed and that's why I'm not with them now."

Angel's thoughts and attitudes toward sex have changed over time and since her engagement. She stated, "I feel comfortable expressing my emotions," regarding her ability to be emotionally intimate with her fiancé, which resulted in this insight: "I realize that there is more growth to a relationship than just sex, and you should want to get to know the person more." She attributed this positive change to increased spirituality, the realization that older friends can be "stupid," and a desire for "real love," instead of meaningless sex.

Chi Chi, who was 22 years old, lost her virginity at the age of 18, and has had eight sexual partners. She explained that her focus on high school academics and her need "to be more comfortable with males," were reasons that she "was never young" when losing her virginity. Her first sexual relation was not in the context of a mutually-exclusive relationship, but instead, was with a person who she was "kicking it with and I just felt that it was the right time. That's it." She recalled that the majority of her past sexual relationships were with friends, or "that I met the guy and we started kicking it and had sex." She also asserted that most of her sexual encounters had been based on "some type of relationship with these people," prior to engaging in sex with them. Her sexual relations, however, typically involved a strong emphasis on being physically and sexually attracted to her partner and "feeling the urge" to have sex.

> Chi Chi: "Number one, if I'm interested in you, I got to be physically attracted to you. I can see people that I'm not really interested in that I'm attracted to that I might want to have sex with because physical attraction goes hand in hand with sex to me. If you attracted to somebody, you might do something you don't do usually."

She provided one instance when she engaged in sexual relations within a week's time of meeting her sexual partner and attributed it to feeling "horny," but attempted to explain her actions by emphasizing that it was an "experimental phase." Though Chi Chi's attitude and thoughts regarding sex have changed over time, her actions indicate that there is a pervasive and underlying apprehension toward establishing a long-term, mutually-exclusive relationship. In other words, she actively engages in sex under the guise of perceiving the relationship as friendship—a safe emotional distance. Her general outlook, however, is still characterized as having lack of trust toward men, which prevents her from becoming emotionally committed to any one partner.

> Chi Chi: "It's hard for me to show people how I like them, or embrace people when they are trying to love me or let somebody be nice to you or love you or show you emotions. It's a lot of deception going on out here with people telling you certain things or making you feel a certain way when actually they don't feel that way about you. Or if they do, that still doesn't stop them from messing around on you or they are still, there are still trust issues there."

Her most recent sexual partner was in the context of "a long time friendship," and while she desired a more mutually-exclusive, committed relationship from this friend, she still had mistrust toward men, in general, including her friend.

> Chi Chi: "I'm at the point of it's either going to be something else or we're going to stop dating. Because he has to make a decision as to what he wants when it seems like to me guys really can't have sex with just one woman. Not at a certain age. It seems like some can. I'm not saying all guys, but it seems it's hard for them to commit."

Chi Chi initially presented a laisser-faire regard for her sexual attitudes and habits in that she placed a high premium on the need to be physically attracted to her sex partners and having strong sexual urges to engage in sex. Upon further reflection, she revealed a more humane side that is comprised of a deep-seeded fear and mistrust toward men who are generally thought of as deceitful creatures. It seems that her attitude and behaviors regarding sex are incompatible. From a psychological framework Chi Chi seemed to resort to sexual encounters unwittingly in seeking approval from her male partners, but will embody a laisser-faire attitude as a form of protection.

Josephine, who is 22 years old, lost her virginity when she was 15 years old, and has been sexually active with five partners. She emphasized the importance of establishing trust as the primary criterion to have sex, and did so by engaging in candid discussions with potential partners regarding their past experiences. Conversely, feeling pressured to have sex, having sex-focused conversations, and failing to communicate were her reasons for not engaging in sexual activity. The following passage captures her disdain toward those who pressure her to have sex:

> Josephine: "And I know I have had guys that I'd been dating and it's just like, you know, 'Look, are we going to do this or what? We've been talking for three weeks, and this is the longest I've ever waited.' And I'm going, 'And you're going to wait even longer because you're not going to do me anyway.' For me, that's been the biggest thing that more of their verbals get them in trouble than even their actions."

When Josephine was asked to describe her sexual experiences, she stated that her first and most recent sexual experiences have been with the same person. Her first sexual encounter, at the age of 15, involved waiting for approximately five months, having positive feelings for him, being able to trust him based on their "honest" talks, and

knowing his sex history, all of which were part of her decision-making process to have sex.

Ladybug, who is 19 years old, has been sexually active with six partners, and lost her virginity at the age of 16. She initially viewed sex as "just something to do so it's just to say that you've done it," being "pretty overrated," and symbolizing a rebellious act against her mother and her father, who gave her a promise ring symbolizing that she remain a virgin until she wed. Her sexual history revealed that her first three sexual partners, with whom she characterized as being in a committed, monogamous relationships, were in the context of *Sex as a Requirement* in order to sustain a relationship.

> Ladybug: "If I wanted to be accepted by him, if I wanted him to really be my boyfriend and not go anywhere else, 'I'll be your boyfriend but since we're not going to have sex, then I'm going to have sex with someone else just so you know.' And I didn't want that. I wanted him to just be exclusively with me because that's how I wanted it to be."

Furthermore, not only did Ladybug believed that sex was a requirement, she was also a victim of it "*Just-Kind-of-Happened*" phenomenon with respect to her first sexual encounter:

> Ladybug: "It was talked about casually throughout the relationship, and then he came over to my house and it just happened. When you start kissing and stuff like that and then your emotions start flaring and, instead of me stopping it, like I said, 'What the hell.' I just did it."

Over time, Ladybug's reasons to engage in sexual relations changed from engaging in sexual relationships to having more of an emotional and meaningful connection as evidenced in the following excerpt:

> Ladybug: "Now that I am more experienced, and I know exactly what I'm doing—it's, once I reached the comfort level with you, and I feel that, I pride myself, I hold a lot of value in myself, and once I feel like I can give that to you, and you treasure and hold it as much as I do, then it's okay, we can go ahead and take that path.
>
> "In me saying the connection, I feel like I am tied to you because I lay down and let you have sex with me. Then I'm giving a part of me to you. And what, I'm always going to be in your life, regardless if you don't want to be or not."

Ladybug's behaviors unwittingly contradict her perception of sex, whereas she had sex with her first three sex partners under the guise of "keeping" them as a boyfriend, but engaged in whimsical sexual encounters based on her "sexual cravings," with the last three sexual partners. She explained in one instance that she had sex with a friend because, "It was that crave, that crave to just be held, to be made love to, so, it was just something to just quench that thirst." With regard to her partner who she met the same day, they engaged in sexual activity, she emphasized that "everybody else wanted him and he wanted me." Despite Ladybug's claim that her views of sex changed over time and went from being "nonchalant" to "I've given a part of myself to that person," the need to be validated and accepted by male sexual partners is evident in both her past and present sexual relationships. Furthermore, the contents of her thoughts are equally contradictory, since she views sex as an emotional lifetime bond; yet, in the same breath makes quip statements about sex as being overrated.

Spirit, who is 20 years old, has been sexually active with five partners. Spirit lost her virginity at the age of 17 with her boyfriend of a year. She reported that with each of her partners, becoming sexually active was a conscious decision. She is presently in a committed relationship, and referred to her most recent sex partner as her boyfriend. She denied engaging in one-night stands, and further elaborated on the importance of

compatibility with her sex partners. Being able to trust her sex partner, observing how her sex partners interact with others, including friends and family members, determining whether they "lie and are safe", and waiting on average three to four months before considering having sex, are all part of her decision-making process of whether to be sexually involved. Conversely, she will not pursue sexual relations if she senses that potential sex partners are untrustworthy or "fake" and "using bad lines." Interestingly, she made a point that consenting to sex is not dependent on perceiving her sexual relationships as commitment to marriage.

> Spirit: "Even if I would say 'I'm really into this person and I think they're the right one, some things are still shady,' but I would. It wouldn't be shady enough to make me say, 'I don't want to do this.' It's still conscious for me to know that I'm getting myself into this even though that maybe we're not going to get married in the future."

Spirit's values and thoughts regarding her own sexual practices seem congruent with her behaviors.

Tinay is 19 years old, and has been sexually active with five partners, two of whom were one-night stands. She lost her virginity at the age of 18 with her boyfriend of six months and she stated that it was both a conscious and mutual decision. Tinay's beliefs regarding becoming sexually active are both complex and contradictory to her own experiences. She declared that if she perceived a potential partner as having no prospects of being in a committed relationship, but finds him "cute and nice," and "wants some that night, then I'll do it [sex]" sooner than later. However, she also stated that if she was genuinely interested in her partner, then she would postpone engaging in sexual relations until a relationship has been established. This is illustrated in the following passage:

Tinay: "Well if I'm really interested in him, I don't do it until we have a relationship because I don't want him to think that she's easy. And then I try to hold myself back because I want him to know that I'm special, and want them to keep persisting after me because I know that's what they want, in general, but I want them to keep on staying around, not just giving it to them and then they can leave."

This excerpt also exposes another critical motive in delaying sexual activity—desiring the illusion of being wanted by her suitor. Tinay's sexual experiences, instead, revealed that she became prematurely sexually active with partners who she lacked interest in, and her behaviors were driven by her need to be accepted and wanted. The following excerpt described an incident with her second sex partner that involved alcohol and peer pressure:

Tinay: "One of them I didn't want to have. The people that I was with, they were trying to get me to drink and stuff. I'm a nice person and I kind of let people run over me and I have a hard time being like [saying], 'No.'"

Tinay's third sexual relation echoed a similar theme in that she became sexually active despite her own urgency of not wanting to have sex.

"The other time was with this one guy. It really wasn't the same situation, but I didn't want to do it to him either, and he just kept on saying the same thing, 'Come on, come on,' and I said, 'No,' plenty of times." I was like, 'You know what? Forget it. Just go ahead.' We did it and it was fine."

Tinay's emotional reaction of not wanting to subject herself to sexual activities was again evident in her fourth sexual relationship where she described submitting herself to sexual activities in the hope of physically protecting herself from a suitor's intimidating conduct.

"I wasn't as strong, kind of afraid because I know in one instance, the guy, he was over, and he wanted to stay the night, and I was like, 'Well, if I don't do that, I don't want him to get all rowdy with me.' I don't know what he was going to do. That's why one of those incidences I was like alright, go ahead."

Tinay's most recent sexual activity included both her female friend and her friend's boyfriend. Though the following passage did not explicitly reveal her reservations, or even a sense of urgency, to not engage in sexual behavior, it was implicitly alluded to:

> Tinay: "It was me and another female and she was my friend and I don't want her to get upset with me and I don't want to seem like I'm trying to lead people on, so that's why I kind of went on with it. It wasn't for that long."

In four of Tinay's five sex partners within a year's time, her behaviors indicated consenting to sexual acts, but were incongruent with her reservations and thoughts of not wanting to have sex. Her sexual history indicated that she conceptualized sex as a means to an end. Sex was a means in being accepted by her suitors or female peers and/or a form of protection when perceiving her situation as being physically or psychologically intimidating. Subjecting herself to sexual relations, despite her own thoughts and feelings, largely stemmed from pervasive and maladaptive thought processes, which included her fear of being judged as being a sexual tease, her self-perception of being weak that allowed others "to run over me," and a need to be accepted by others. Finally, there is a clear disconnect between her sexual history and her personal values of postponing sexual relations with those whom she is genuinely interested.

Moderate number of sex partners among Latina females. Goddess, who is 18 years old, and has been sexually involved with seven partners, believes that she has a "sixth sense" that enables her to assess within five minutes the quality and nature of her potential sex partner's personality, interpersonal relationships with his friends, and with Goddess, sense of mutual attraction, and availability in that he "doesn't have a lot of women around him." Despite her belief in her ability to ascertain with brevity, and in detail, his personality profile and his candidacy in becoming her sexual partner, she

asserted that she would require a minimum of six months of courtship as a means of "getting to know him" prior to engaging in sexual relations. Her sexual history reveals that she lost her virginity at the age of 14 to her boyfriend, who at the time was 18 years old, and asked her father permission to date her. She viewed him as being a "nice guy," and "the kind you take home to your parents." She has had seven sexual partners, and noted that a mutual attraction was present, which she stated was a requirement to have sex. In regard to her most recent partner, she stated, "We just clicked." However she admitted that the courtship was only two months old before she engaged in sexual relations with him. Being complimented and feeling validated, which has been described as the *Wooed-Effect,* played a role in her decision-making process to engage in sexual activities and is evident in her statement: "I drove him crazy," and "He always thought about me."

Vixen is 21 years old, lost her virginity at the age of 15, has been sexually involved with 10 partners, and stated, "I tend to fall for guys easily." The criteria of whether or not to engage in sexual relations with a potential partner included preferring her partner to be approximately one to two years older than she is, being lured by the *Wood-Effect* as she stated, "They make me feel special, that somebody wants you, that they pay attention to you, and give lots of compliments," and needing to feel comfortable, while hoping to avoid feeling rejected, after their sexual tryst:

> Vixen: "I want to feel more comfortable knowing that he's not going to just drop me after one night or that having sex with him is a good idea or a bad idea in the long run." "You are not just a number."

Characteristics that she found unappealing included perceiving potential partners as either "too clingy" or being "too physically aggressive." Vixen reported feeling ready when she

described her first sexual encounter with her then 17 year old boyfriend, as she stated, "I was young, but still I thought I loved him." Her other sexual experiences did not necessarily involve being in a monogamous relationship. Instead, experiences typically involved going on a couple of dates even meeting her sexual partners (i.e., three partners to be exact) within a week's time before engaging in sexual relations. She described most of her sexual experiences as being "spur of the moment," and was able to recall a recent experience with a co-worker, whom she found attractive and went on a date. "Then one thing led to another, and it just happened. I was a little shocked that I did that because I don't normally do that, but it was one of those spur of the moment things." Vixen also emphasized the importance of finding *compatibility*, yet reveals in two scenarios with two different partners her apprehension to engage in sexual relations with them. With the first partner, she admitted, "I don't think I was too sure about it, but I really liked him," and they participated in sexual behaviors. With the second sex partner, a different reason motivated her apprehension: "I didn't want to ruin the friendship, but we ended up having sex."

Themes among moderate number of sex partners. Six complex themes were extracted from the data among the *moderate* category. The first, and most pervasive theme, is that six out of the eight respondents inadvertently exposed *Inconsistencies Between their Thoughts and their Behaviors*, a similar theme among the *low number of sexual partners* category. Angel, Tinay, and Vixen, for example, listed chemistry, emotional comfort, trust, cute features, nice personality, being sexually stimulated, and being complimented as their reasons to engage in sexual practices. However, their actions uncovered a more centralized attitude from various forms of pressure that resulted

in feeling fearful and apprehensive, and resulted in having sex. Angel, who was only 13 years old during her first sexual encounter, was coerced by her female friend to have sex, despite her own fears and apprehension. Tinay's sexual journey involved wanting to avoid sexual encounters with four of the five sex partners, but various forms of pressure by her female peers and male sex partners, as well as a fear of being perceived as a sexual tease, contradicted her own feelings, and subsequently she engaged in unwelcome sexual behaviors. Vixen also disclosed having strong reservations to engage in sex with two of her sex partners, one of which involved fear of jeopardizing a friendship. The other three participants also unmasked contradictions between their intentions and their behaviors. Chi Chi inferred having felt a sense of fear in a sexual encounter where she perceived him to be aggressive, but then quickly attempted to attribute it to having "sexual urges." In addition, despite her deep fears of having mistrust toward men, she still engaged in sex. Ladybug claimed that her attitude toward sex had changed, and presently viewed sex as a more lifetime emotional bond with her sex partner, and yet, her last three sexual encounters with three different sex partners were motivated by her sexual cravings and gaining a sense of validation from her partners. Finally, Goddess declared that six months of courtship before engaging in sexual activities with a potential sex partner is a requirement, yet she had sex with her most recent sex partner within two months of meeting him. The *Inconsistency Between their Thoughts and their Behaviors* is not well understood. It can only be surmised that the respondents lacked the awareness of their own contradictions between their thoughts, attitudes, intentions, and their behaviors. The explanation for such inconsistencies can be provided only by the respondents. The data analysis did result in one clear observation: that the motivations, intentions, and

behaviors among late-adolescent females are undoubtedly complex and contradictory. It is no surprise that great difficulty exists in generating gender-appropriate, culturally-sensitive, age-specific HIV/AIDS prevention that is geared toward this population who are at high risk for HIV infection.

Another theme that was evident in at least four of the eight participants in this *moderate* category is the interplay between being validated by their male sex partners, known as the *Wooed-Effect*, and their sexual behaviors. The *Wooed-Effect* came in several forms: being told compliments, being wanted when other female competition sought his attention, gaining a sense of self-esteem knowing that she was able to drive him "crazy," and a general feeling of being wanted. Regardless of the variation of being *Wooed*, the result was the same in that they eventually had sex with their male counterparts, which is a more accurate explanation for their motivation to have sex. Though Tinay did not directly mention that her motivation to have sex was based on being *Wooed*, she did imply her need for validation and acceptance, which is a broader concept of the *Wooed-Effect.*

Four of the eight participants plainly stated that *Attraction,* with a strong emphasis on the physicality of the sex partner, was a motivating factor to engage in sex. *Attraction* is an evolving concept, and can be conceptualized at multiple levels. It seems that the participants in this age bracket placed a high premium on the physical form of attraction, and perhaps, this is appropriate to their development. Two respondents, Spirit and Vixen, mentioned that compatibility was of importance in order to become sexually active with a person. Perhaps, then, compatibility is a form of attraction that incorporates more of the character, values, and behaviors of a person, rather than just the physical aspect, to which

they are drawn. Irrespective of the way *Attraction* is conceptualized, and whether it includes the term *compatibility*, it was an apparent motivation for these participants to engage in sex.

Four of the eight participants explained that many of their sexual encounters occurred in the context of it "*Just-Kind-of-Happened*" phenomenon, where sexual relations were not planned or intended. Ladybug and Vixen openly admitted that they had not intended to have sex with many of their sexual partners, while Tinay's sexual history clearly showed that she had not planned, but was instead pressured, to have sex, and Chi Chi explained that she was "just kicking it" with many of her sex partners and then decided to have sex. Her narrative implied that she had not anticipated to have sex at that time, but eventually did engage in sexual acts because of being "caught up in the moment."

While the theme, *Sex as a Requirement,* was mentioned with less frequency, it is important that it gets discussed in greater detail. Angel and Ladybug both discussed that they believed that sex was a requirement to sustain a monogamous relationship with their boyfriends at that time. In fact, Ladybug described how her boyfriend made it abundantly clear that he would have sex with other partners if she failed to comply with his request. There is strong suspicion that many of the other participants, and late-adolescent females, in general, may have fell victim to this threat of abandonment at one point in their sexual history. This mindset that sex is a means to maintain a relationship with their partners is a powerful motivation to have sex, despite these female adolescents' own intentions and wishes to abstain.

The results from Josephine's and Spirit's narratives were coded the least because they did not share similar themes as with the other six respondents in this *moderate* category. Both Josephine and Spirit placed importance on establishing *Trust* before engaging in sexual relations. Josephine explained that she had candid conversations regarding each other's sex history with her partner as a means to establish trust, whereas Spirit waits for approximately three to four months and observed her sex partner's behaviors, and interpersonal interactions with his friends and with her as a way of determining whether or not trust has been established. Spirit's motivation to establish trust is well-intended, but it's not necessarily a complete safeguard to protect herself in that she made no mention of having open discussions with her sex partners. Though their responses were atypical, they were, nonetheless, helpful in revealing the stark contrast in the factors that motivated them to have sex. The comparative analysis suggests that six of the eight respondents focused on little to no communication when sexual encounters were involved, and it was only one respondent, specifically Josephine, who resorted to open dialogue about her and her partner's sex history and sexual practices.

One major theme emerged from the *low number of sex partners* group, while six themes emerged from the *moderate number of sex partners* category. The next subsection will unveil themes from the participants, who have been identified as having been sexually involved with more than 10 partners. Three African-American and two Latina females have been categorized in the *High Number of Sex Partners.*

High number of sex partners among African-American females. Chocolate Princess, who is 19 years old, and lost her virginity at the age of 14, has been sexually active with 13 partners, three of whom were sexual encounters that occurred within five

days of their initial meeting. Her first four sexual partners were considered to be her "boyfriends" at the time, and she implied that they were in a mutually-exclusive committed relationship. Attending her first year in college and being criticized on her sexual performance by her ex-boyfriend were the impetuses for her increasingly sexually risqué behavior. She stated, "Once I got to school, freshman year, I just went buck wild." After the break up with her boyfriend, she engaged in anal sex with her next sexual partner.

> Chocolate Princess: "Maybe that has something to do with that because this was just recently that I started just not being boring. I try different stuff that I said I would never try before like anal sex."

Chocolate Princess also candidly revealed her first sexual experience in her freshman year in college stating, "He was just there. I was not attracted to him. I became a man." She achieved a sense of victory over her female peers who overtly rejected her on the basis of her dark skin color by engaging in sexual relations. She emphasized that "all the girls wanted him," when describing her first sex partner at the age of 14. A few years later, she also described her experience with a college-aged sex partner, stating with confidence, "I knew he was attracted to me because I heard him tell somebody." She described her experience further by stating, "It's already in the bag. And I felt proud afterwards." A similar pattern is evident in another sexual encounter as she explained:

> Chocolate Princess: "This guy that would always come to my job, and talk to me, and wink at me. I ended up having sex with him, and it wasn't a relationship or anything, but I knew him. Yeah, I think I saw dollar signs, too and he showed me a lot of attention."

Finally, she provided an excerpt of an impulsive sexual encounter with someone who she met less than 48 hours earlier.

Chocolate Princess: "The third guy, it was the first day I met him. He was making sexual advances at me that first day, and I was just like okay. But the second day, he came around, and he offered to give me oral sex, and I was like okay. That's how that happened. It led to the rest of the sex, but I didn't plan on having sex with him because at first I didn't even like him."

The *Wooed-Effect* elicited feelings of validation, a sense of victory over her female competition, and a need to rebel against her mother. In fact, the *Wooed-Effect* took precedence over being physically or personally attracted to a person when engaging in sexual behaviors, as evident by this statement: "I knew that I could; I even had sex with people who I wasn't attracted to."

Mary, who is 21 years old, a first-year graduate student in the Master of Social Work, and is interning at a local nonprofit AIDS agency, has been sexually active with approximately 30 partners. Mary's explanation for engaging in sexual activity have changed over time, and are demarcated into three time periods: high school, undergraduate years, and post-graduation from college. She explained that because her sexual relations in high school were in the context of a monogamous relationship, having sex became the socially appropriate and conforming moray as she stated:

Mary: "It was the whole being young, and not too independent, and going along with the whole thing of 'I'm your girlfriend and you're my boyfriend.'"

Mary referred to herself during her undergraduate years as being sexually promiscuous and attributed it to heavy alcohol consumption. Between the ages of 19 and 22, she estimated being sexually involved with eight partners and stated, "I really wasn't having too much sex." Her present views regarding her sexual behaviors are illustrated in the following statement:

Mary: "I got to be older. I'm a woman in charge of my own reproductive health. I can do what I want to do."

Mary's criteria of when to engage in sexual relations are dependent on how she perceives the degree to which her partner will commit. If she believes that there is no potential for a long-term relationship, and yet is able to find him attractive, she will engage in sexual activities "sooner rather than later". On the contrary, if she believes there is a potential for a long-term relationship with a partner, who is well-traveled and cultured, is financially stable, lives independently, and is not socially inept, and if she is able to trust and respect him, she will postpone engaging in sexual relations until a committed relationship has been established. Her sexual history found that the average age of her partners is approximately four to nine years older than she is, that she has participated in a one-night sexual affair, and engaged in sexual relations with a person whom she met just three days before. Mary also included a list of reasons why she would not become sexually active, and they are as follows: (1) if they have too many mutual friends; (2) if he attempts to have sex without the use of a condom; (3) if she is unable to find him sexually attractive; and (4) if he evidences disrespect for others. In one example, she was repulsed by her date who cursed at his mother in Mary's presence.

Poet is 22 years old, and has been sexually involved with more than 50 partners. Her sexual history dates back to her childhood when relatives sexually abused her.

Poet: "Not my parents, but by some relatives that were a couple of years older than me. And when I went to counseling that when it happens to you two things happen. Either that you get totally turned off or you get totally turned out. And in my situation, I ended up getting turned out and it's just like I was a nympho. I couldn't get enough of it. I just thought somebody looked sexy and looked like they'd be good in bed, give me a nice one."

Poet attributed losing her virginity at the age of 13 to her curiosity about sex. Her first three sexual partners were neighbors: "One person lived around the corner from me, and two people lived on my block." Poet's attitude and criteria to engage in sexual activity between the ages of 15 and 20 can be characterized as being carefree and careless as evident in the following statements: "I had relationships, but I wasn't faithful to anybody until I was about 21." At this time in her life she viewed sexual encounters as a means to obtain personal power.

> Poet: "And I liked to go after the guys who thought that they could have any girl that they wanted, and they'd just be a statistic after I had be done with them."

She also stated, "Before I even knew their name that I was going to do them." She even exhibited perpetrator mentality during this phase in her life.

> Poet: "It was hard for me to even find any more prey because everybody knew my game, and I can't find any more victims. Game over."

She also admitted that if the potential partner had a "small penis" and a "bad physique" she would not engage in sexual activity. Poet's attitude, values, and beliefs changed over time. Once she decided that the "game was over", she decided to "just lay low." Failed friendships, because of her sexually promiscuous reputation, and being infected with herpes by a partner who she thought she loved, were the impetuses of changing her attitude which resulted in being empathic for her partners. Since being diagnosed with herpes, she has "decided not to have sex with them until they know about my situation and I let them know" about her STD status.

High number of sex partners among Latina female. Morning Star, who is 20 years old, and has been sexually active with 12 partners, seems sexually liberated, in that she does not believe in waiting to have sex, especially when she knows that "I'm clean,"

referring to her STD status. Furthermore, she does not believe that sex is a "monumental thing." Though she admitted that many of her sexual encounters involved alcohol consumption, she asserted that she has been able to maintain personal control over her actions, implying that every sexual relation was a conscious and mutual decision. Morning Star exuded confidence when disclosing her ability to assess in detail a potential sex partner's character "within two hours," in whether or not he is genuine, will treat her well, and is not sexually promiscuous as evident in this statement: "Someone that I know that doesn't have sex with everyone on my dorm room floor." Characteristics that she finds unappealing and that help determine whether or not to have sex are if the partner publicly announces their sexual affairs, if he is "racist," and if he imposes his opinions onto others.

Morning Star's sexual history revealed that she lost her virginity at the age of 16 to a person who she met during a trip to South America, and who only spoke Spanish. She stated that the language barrier elicited feelings of powerlessness, especially when he requested to remove the condom, and prevented her from denying his request. Most of her sexual encounters occurred in high school, and she stated that alcohol and a sense of indifference were involved in her decision-making process to have sex. She believed that coming from a small town precluded her from STD infection because the "gossip in the small town" indirectly and naively gave her a sense of information about her sex partners. Without further elaboration, she then discussed her most recent sex partner who she just met at a holiday party. She explained that she thought he was "a really nice person," that he appeared genuine, that she was able to understand his worldview, and that they were essentially "compatible."

O'Connor is 21 years old, and has been sexually involved with 23 partners. Her sexual history dates back to the age of four when she was living in Mexico and was repeatedly sexually violated by her nannies and by her cousin. Her childhood sexual abuse impacted her outlook and perceptions on sex in that she has become both desensitized to it and views it as a form of vindication.

> O'Connor: "It was just taken from me when somebody wanted it, so now when I want it, I get it." In addition, "I don't see sex as a very special thing."

She is not only aware of her rebellious nature, she also attributed her sexual promiscuity to her history of sexual abuse, her father's death when she was 14 years old, and her mother's religious fanaticism, which created an emotional distance: "My mom and my brother weren't really there for me. All I had was me, myself, and I." Her raging hormones, a sexual tension between her and her potential sex partner, a possibility of a commitment, even with a one-night stand, and a sense of responsibility not to reject men sexually were her determining factors to engage in sexual relations.

> O'Connor: "It's almost like you're partly responsible for getting him that hot and heave and ready to go and it would be just almost rude to get him to that point and then walk away. That's something you'd do to someone you'd hate, not to someone you might want to see again. I mean not only are they going to experience a lot of physical pain with all that pent up stuff going on down there, but no one likes to get rejected so it would hurt in all kinds of ways."

O'Connor's sexual history revealed that she lost her virginity, in the context of mutual consent, at the age of 14, and marijuana was involved. She felt trapped and helpless in that "I didn't want it, but I couldn't get out of it at that point." Her tendency to blame herself for her first sexual encounter is apparent in the following passage:

O'Connor: "At the time I didn't...I just saw it as I let it get that far. I couldn't stop it now, so I just sat there, well laid there, and didn't feel much."

A pattern of feeling helplessness and feeling responsible for her partner's sexual urges emerged with her other sexual encounters.

O'Connor: "I always start off with the decision that I'm not going to have sex with him, and it just changed according to how the night goes."

The night usually progresses to kissing, then petting, pants coming off, and saying to herself, "Oh shit, we got to this point again and we can't go back." All but one sexual encounter occurred within less than a week of their initial meeting, two of which were one-night stands. Her most recent sexual partner has been the exception in that "He waited for me to come to him." She explained in detail how the relationship evolved, and it essentially moved from being co-workers to "cuddle buddies" to being sexually intimate within the context of being mutually-exclusive. Her sexual history and behavior indicate an underlying sense of helplessness and a responsibility "to not reject them," which is contradictory to her initial assertions that sex is a form of retaliation and personal power.

Themes among high number of sex partner. These young women's thoughts and outlook regarding the meanings associated with sex, as well as their recall on their sexual history, are complex in nature, and at times, contradictory, thereby making it difficult to delineate derived themes in succinct categories. Furthermore, there seems to be greater similarities across the racial/ethnic groups, than within the groups.

An apparent theme across the five participants is that many, if not most, of their sexual relations were in the context of *Nonmonogamous Relationships*, indicating that they were not involved in a mutually-exclusive, committed, long-term relationship. All

five females reported that they had experienced one-night stands and many of their sexual encounters did not occur in either a monogamous or emotionally meaningful relationship. Chocolate Princess described that once she realized that a potential sex partner found her attractive, the possibility of having a sexual encounter was "in the bag." Mary admitted that most of her sex partners were during her undergraduate years in college, and did not involve long-term commitments. Poet candidly stated that she had difficulty recruiting more "prey" as potential sex partners. The majority of Morning Star's sexual encounters involved alcohol. O'Connor admitted that she had sex with most of her sex partners less than a week of their first meeting. It is clear that a commonality among these five participants is that most of their sexual relations occurred in *Nonmonogamous Relationships.*

Traditionally, women have been covertly taught a ubiquitous societal message that sexual intercourse is a form of emotional intimacy, whereby partners are able to express their affection and love for one another. Some of the participants revealed that they defined sex in terms of emotional and intimate connection with their sex partner. A theme among these five women in this *high* category, however, is a shared sense of *Emotional Detachment and a Need for Retaliation are Mechanisms to Seek Personal Power and Control.* Chocolate Princess revealed that being rejected by her boyfriend motivated her to engage in anal sex as a means to prove to her boyfriend that she was not a "boring" sex partner, a behavior that she once found disgusting and immoral. She also seemed to use sex as a form of personal victory when she perceived her female peers as no longer being a threat. Mary described a "summer fling" which "served a purpose." Poet also used sex as a form of power and vindication over her sex partners, where she

actively sought men who she perceived as being desensitized to sex. O'Connor echoed a similar sentiment of vindication, stating that she has sex whenever it suits her because "it was just taken from me when somebody wanted it." *Emotional Detachment and a Need for Retaliation are Mechanisms to Seek Personal Power and Control* theme is comprised of having a sense of indifference, as it was echoed by Morning Star, that "sex is not a monumental thing," and experiencing a form of personal power and vengeance over male sex partners and female peers who were seen as competition.

All five participants exhibited, in one form or another, a desensitized attitude toward sex either by engaging in one-night stands or deriving a feeling of personal power and vengeance toward their sex partners. These participants made their air of indifference towards sex explicitly known as their explanation for what motivated them to engage in sexual relations, even against their own wishes, against their lack of attraction for their sex partners, and against their lack of better judgment because chemically altering substances, including alcohol, diminished their cognitive capacity. Ironically, underlying this public display of emotional detachment toward sex and their sex partners is a deep-seeded *Need for Validation and Acceptance.* This Need for Validation and Acceptance was more or less implicit in their responses, but nonetheless, clearly evident as their primary motivation to engage in sex. For example, Chocolate Princess was seeking validation that she was not a "boring" sex partner as her first sex partner asserted, that she was accepted by her male sex partners, even when her female peers rejected her, and that she felt externally validated by engaging in sexual relations, even when she was not attracted to her sex partners. Her sexual habits were largely motivated by external forces (e.g., ex-boyfriends, parents, female peers) in the hope of

proving to them that she is of equal importance and that she is worthy of being wanted. Morning Star made it a point to state that sex was not a "monumental thing," yet in the same breath she unwittingly revealed that she did not want her sex partners to view "her" as a mere number, or sex with her as a "random act." Implicit in her assertion is her need to feel important even though she, herself, exhibited a form of indifference towards sex. In the case of O'Connor, she admitted that most of her sexual relations occurred against her own intentions of not wanting to have sex, and yet what motivated her to subject herself to quick sex practices is a sense of responsibility not to reject her male sex partners. She stated, "no one likes to get rejected." Though that comment was intended for her male sex partners, perhaps it was ultimately directed toward herself in that she did not want to feel rejected, and that she used sex as a form of acceptance and validation. Mary also exhibited a need for validation and acceptance by her peers, especially when she was in high school, as she stated that having sex with your boyfriend was the thing to do. Though she did not elaborate on her sexual experiences during her undergraduate years in college, there is a strong suspicion that her need to be validated and accepted was present. She, after all, has been sexually active with more than 30 partners, and she is only 21 years old. The detachment toward sex was exhibited by all five participants, and seemed to act as a form of a defense mechanism to protect their underlying need to be validated, accepted, and wanted, which was equally evident among these participants.

Themes were derived from the participants' thoughts and attitudes, as well as their own past and present sexual behaviors. The following subsections will explore their perceptions on *Safe Sex,* and is outlined by a racial/ethnic group in determining the presence of cultural differences.

Definition of Safe Sex

African-American females. Table 6 summarizes the number of sex partners condoms were employed in various sexual acts among the African-American participants. All 10 African-American participants reported the use of *condoms* when asked to conceptualize safe sex, while three participants also referred to the use of *birth control* as a form of protection. Other forms of safe sex mentioned were *knowing their partner's sexual history*, being educated about the transmission of sexually transmitted diseases as well as knowing the types of "products," on the market, and *getting tested.* Mary, who is a graduate student in the Master's of Social Work Degree Program, provided several examples of "safer sex": "Safer sex, to me, is like using condoms, not sleeping around with too many different people, knowing your partner's sexual history."

Ironically, Mary's own sexual history showed that she had been sexually active with approximately 30 partners, five of whom she admitted failing to use a condom. Given her HIV/AIDS knowledge because of her work at a local nonprofit AIDS agency, she has been made aware of the fact that it takes only one incident to be infected, and yet she exposed her own fallacy by stating, "Not sleeping around with too many different people," is a form of "safer sex." Josephine offered, but equally gave, an unsettling response when she was asked how she protects herself when engaging in cunnilingus?

> Josephine: "The infamous question to his is always, 'Did you just wash?' He and I have not used a condom with oral sex so other than making sure, at least, because there is a trust level there, of monogamous that definitely just making sure that we've been properly washed and cleaned beforehand."

Her need to attain a certain degree of hygiene is not being called into question, but the assumption that being "clean" through the soap and water, alone, will protect her from a

STD is troubling because she is not the only person to share similar views, which may account for lack of condom use when practicing oral sex.

Table 6

Condom Use by African-Americans Females

Participants	Total *n* of Sex Partners	Total *n* of Sex Partners Condoms NOT Employed	Frequency of Condoms Employed (Fellatio in the past 12 months)	Frequency of Condoms Employed (Cunnilingus in the past 12 months)	Frequency of Condoms Employed (Anal Sex)
Ladybug	6	2	Consistently used condoms	Consistently Used condom	N/A
Tinay	5	1	0	0	N/A
Josephine	5	1	0	0	Consistently Used Condoms
Mary	30	5	0	0	Used Condom with 1st Sex Partner Did Not Use condom with 2nd Sex Partner
Chi Chi	8	1	1 time and used condom	0	N/A
Spirit	-	2	0	0	Anal sex on one occasion and used condom
Chocolate Princess	13	5	0	0	Anal sex on one occasion and did NOT use condom
Osa	1	1	0	0	N/A
Angel	7	2	0	0	Anal sex on one occasion and did NOT use condom
Poet	> 50	4			Anal sex on one occasion and used condom

Latina females. Table 7 summarizes the number of sexual partners condoms were employed in various sexual behaviors among the Latina participants. The most common response, which was mentioned by all nine respondents in defining the term safe sex is the use of *condoms*, while five of them also included the use of *birth control.*

Table 7

Condom Use by Latina Females

Participants	Total *n* of Sex Partners	Total *n* of Sex Partners Condoms NOT Employed	Frequency of Condoms Employed (Fellatio in the past 12 months)	Frequency of Condoms Employed (Cunnilingus in the past 12 months)	Frequency of Condoms Employed (Anal Sex)
Leslie	1	1	-	-	N/A
Sam	1	1	0	0	N/A
O'Connor	23	2/3 of the 23 SP	0	0	1
Morning Star	12	1	0	0	N/A
Goddess	7	1	0	0	N/A
Vixen	10	7	0	0	Engaged in anal sex on 3 different occasions with 3 different sex partners and did not use condoms in each of those times
Princess	3	1	N/A	0	N/A
La Chingona	4	3	1	0	Engaged in anal sex on 2 occasions with same sex partner and did not use condoms on either time
Butterfly	2	1	0	0	DK

Goddess, Princess, and Vixen believed that *knowing the partner's sexual history* was also a form of safe sex. Vixen, for example, stated: "Knowing who your partner is and knowing who they've been with. Just kind of making sure that you are ready for that and that you are protected."

La Chingona and O'Connor believed that being *tested* in the early stages of a relationship gives them a sense of protection against being infected.

> La Chingona: "I guess now my thing is, 'Okay, I'm going to use condoms at the beginning, but try to go get tested right away because I'm not really into using condoms.' So, as long as you get tested, it would be okay."

An underlying assumption in La Chingona's statement is that neither partner in the relationship would place himself or herself at risk for infection, whether it is through sexual contact or use of contaminated IV needles, throughout the duration of the relationship. She has been sexually active with four partners, but admitted to using condoms with only one of them. O'Connor offered a more complex response but it still was wrought with misleading assumptions.

> O'Connor: "If you've both been tested, and you know that you are both all well and good, and you are in a committed relationship with that person and you don't plan on sleeping with anybody during that relationship either than the two of you."

O'Connor's comment incorporated more conditional statements, such as neither partner would engage in extracurricular sexual activities with other sex partners, which thereby seemed more intrinsic in believing that she is safeguarded from a STD. O'Connor's own sex history ironically revealed that most of her sex partners were not in a serious, monogamous, committed, mutually-exclusive relationship. In fact, of the 23 partners with whom she has been sexually active, she admitted to failing in employing the use of

condoms with approximately two-thirds of her partners. The concern, and the general point, is that her well-intended thoughts regarding safe sex did not translate into practice, which consequently placed her in grave risk of HIV infection.

African-American and Latina females. When asked to define safe sex, all 19 participants cited *condoms* as a mode of safe sex. However, only 30% of the African-American females compared to 55% of the Latina females mentioned *birth control* as a type of safe sex, while there was equal mention ($n = 3$) from both racial/ethnic groups indicating that *knowing their partner's sex history* is another form of safe sex. Interestingly, only one participant from each racial/ethnic group discussed *abstinence* as a means of safe sex. The responses that were named with less frequency can be captured under a broader theme: *Myths in Practicing Safe Sex.* These college-educated female participants disclosed with candidness their fallacy regarding safe sex, including having "fewer" sex partners, implementing hygienic measures when engaging in oral sex, avoiding the "swallow" method when engaging in fellatio, practicing the "withdrawal" method when engaging in penile-vaginal intercourse, and getting tested. "Politically correct," thoughtful responses were verbalized, but not necessarily translated into action as evidenced by few of the participants. This section examined their level of understanding of safe sex from a conceptual point of view. The next subsection, which captures the essence of the study, explores their rationale and behaviors, as well as the type of circumstances in which condoms were not employed during sexual activity.

Motivational Factors Not to Employ Condoms

African-Americans females. All 10 African-American participants explained that being in a *Serious, Monogamous, Committed, Mutually-Exclusive Relationship* was their

primary rationale for not consistently employing condoms during their sexual encounters. Tinay, Ladybug, Josephine, Osa, Angel, and Poet may not have verbalized that being in a committed relationship was the reason for not using condoms, but their actions clearly indicated it. The times that they did not use a condom was because it was with their "boyfriend," a term that strongly implied that the relationships comprised of commitment, exclusivity, and trust. Mary verbalized that being in an exclusive relationship was her reason for not using a condom.

> Mary: "I don't use condoms when I'm in love. I mean like deep, deep love and I feel very exclusive"

Spirit talked about the steps that included communicating about one another's sex history and STD status, getting tested, and having a "general level of trust," in which she determined the seriousness of the relationship and when not to use a condom. She has been sexually active with five partners, but did not use condoms with two of them. Chi Chi asserted that marriage was the only context in which condoms do not need to be employed, as she stated, "I use condoms. I don't believe in having sex without using condoms if you are not married." Her behavior clearly contradicted her thoughts in that she has been guilty of not using a condom with one of her sex partners with whom she engaged in sexual activity in less than three months of their initial meeting. Five of the respondents indicated that being caught up in the *Spur of the Moment* was another explanation for failing to use condoms when engaging in sexual activity, specifically in penile-vaginal penetration. Osa's comments highlighted the essence of all five respondents:

> Osa: "I think it's more like I'm ready and/or I'm caught up in the emotion, and everything and there isn't, there is no condom around so instead of just letting all of the sexual tension die, I'll just give in."

These five respondents were direct when talking about being a culprit in not using a condom and some, particularly Mary, attempted to explain their guilt and hypocrisy.

> Mary: "I shouldn't have done it because after, I mean you can't not really be a sane person and have unprotected sex and then work in a AIDS service organization because you just feel so paranoid and so how can I say it, 'Stupid,' because I got, especially me, because I keep condoms in my candy dish for my friends, for everybody that comes to my house. But I have an ample supply of condoms so that's why I sometimes, I do let myself get caught up in the moment even me."

Ladybug, Josephine, and Osa also believed that *Getting Tested* for HIV is their green light to permit themselves to use condoms.

> Ladybug: "Being tested with current boyfriend. I haven't used them [condoms] because I've been trusting my birth control."

Being in a *Monogamous, Mutually-Exclusive Relationship*, being caught up in the *Spur of the Moment*, and *Getting Tested* are the most common responses given by the African-American female participants as to why they fail to employ condom usage during sexual activities.

Latina females. Being in a *Monogamous, Mutually-Exclusive Relationship*, and being caught up in the *Spur of the Moment* were of equal mention by four of the nine Latina participants as their explanations for not using condoms. Among the Latina females who attributed lack of condom use to being in a committed relationship, some also discussed that they would employ condoms in the beginning of their sexual encounters, but over time, resorted to other methods. For instance, Vixen's comment speaks to engaging in risky sexual behaviors.

> Vixen: "I was in a serious relationship for four years; and at first, for the first three months from when we started having sex, we used condoms and then after that we didn't, and I wasn't on anything and neither was

> he. I just kind of went with it, withdrawal from him and if there was an accident, I would go to a clinic and get the plan B, the morning after pill."

These participants were also frank when admitting that they were caught up in the *Spur of the Moment* as seen in the following passage:

> La Chingona: "In the heat of the moment you just don't care. You're just like, "Okay, who cares, we don't need a condom.'"

Condom Availability and *Adversity to Condom Usage* were of equal mention by three of the nine Latina respondents. The following two passages revealed the thought processes underlying their adversity to the use of condoms.

> Leslie: "I don't think is normal to have rubber going inside of you."

> O'Connor: "Well in the case with my boyfriend he can't wear them. He goes limp every time he puts one on. It might very well be a very psychological thing but it still happens. So, it's easier no condoms or no sex."

This theme seems to be unique to the Latina group, as it was not mentioned by the African-American participants. Overall, this subsection examined the motivation for failing to use and for employing condoms. The next subsection looks at the themes derived from communication patterns with sex partners that specifically focused on the topic of HIV/AIDS.

Communication Patterns with Sex Partners

The majority of sexual encounters occurs between two consenting participants where the negotiation of when, where, and how the sex encounters are to transpire materialize from direct and indirect communication, as well as through verbal and nonverbal cues. The concern is the kinds of conversation that takes place, and the way they are discussed with respect to the topic of HIV/AIDS. When the respondents were

asked how they talk to their sexual partners about HIV/AIDS, four themes emerged: *Getting Tested*, *Newly Acquired Information about HIV/AIDS*, *Cheating*, and *Condom Availability*.

Five of the ten African-American females and four of the nine Latina females reported that *Getting Tested* prompted them to address HIV/AIDS. Chocolate Princess, for example, discussed HIV/AIDS with partners with who she had unprotected sex, which should have been with five of the thirteen partners. When reading the following excerpts, there are several erroneous assumptions underlying their responses.

> Angel: "I generally ask if they have been tested. Majority of the time the answer is 'No,' unfortunately. [Investigator: "That they have not been tested."] "Yeah. And it's usually during a conversation about sex. I wouldn't just bring it up out of the blue."
>
> O'Connor: "I asked if they have been tested, but I don't specify, I just say tested. And it's almost assumed. I would say, it's assumed that it's everything, all STD's and HIV."
>
> Goddess: "I get a yearly and that's it. That's the best I can do. They're okay. I've had a lot of surgeries in the past couple years so if I had it, it would've shown up by now, and they would have notified me."
>
> La Chingona: "When we were playing that truth or dare, it was not until after I got tested that I decided not to tell him, to keep it to myself [that she was tested positive for an STD]. Anyways I told my roommate. 'It's none of his business anyways.' It's not like I'm going to give it to him. I'm gonna cure it, make sure that I'm fine, use condoms until everything's fine."

The discussion of HIV/AIDS takes place in a variety of contexts, but the most prominent context—or theme—is *Getting Tested*. There are several assumptions operating under this theme, one of which is the act of getting tested. The mere behavior of obtaining a STD test presupposes a form of safety measure that neither partner will be susceptible to being HIV-infected after receiving their supposedly negative HIV results. This is simply

untrue in that transmission of HIV, or any other STD, is possible whenever condoms are not employed because of the possibility that either partner may be engaging in at-risk behaviors (e.g., engaging in sexual encounters with another partner, or using contaminated intravenous needles) that put him or her at the risk to be infected with a STD. Another erroneous thought is that "getting tested" or getting "annual check ups" or simply getting blood drawn because of other related medical concerns assumes that antibody HIV ELISA test is included. However, a typical "annual check up" includes a breast exam, a pelvic exam, and a Pap Smear test to rule out cervical cancer, gonorrhea, chlamydia, and human papillomavirus (HPV), but it does not include testing for treponema pallidum that causes syphilis, herpes simplex virus that causes herpes genitalis, HIV, and hepatitis B and C. Goddess is under the assumption that she is HIV-negative because of her medical check-ups, but she, in fact, is ignorant of her HIV-status. A third, yet subtler, assumption is that even when STD tests have been sought, and then briefly discussed with their partners, talking about the actual, or being truthful in disclosing, results of the tests seems to be a separate social construct that is invisible to the sex partner. In essence, HIV/AIDS is not necessarily addressed directly, but it is implied when *Getting Tested* is mentioned. However, the act or the discussion of *Getting Tested,* as in the cases of many of the participants, is wrought with erroneous assumptions that have led them to believe that they are safe from infection, that annual gynecological check-ups include all STD tests, including HIV, and that the truth of the results would be disclosed.

Another motivating context—*Newly Acquired Information about HIV/AIDS* —is used to springboard discussions for four of the ten African-American females with their

sex partners. Josephine provided an example in how she initiated the topic on HIV/AIDS when learning about the epidemiology of HPV on campus:

> Josephine: "We've only talked, briefly, a few times about it [HIV/AIDS]. Just when I get some new information, or I've seen some numbers you know. 'My goodness, did you know it was going on like this?' Or just this morning I was telling him as far as on this campus is concerned, one in four women are infected with HPV, and he's going, 'What?' I said, 'Yeah, that would mean that if you line us up and you pull three out, out of every other one, you're gonna have that one that is infected.'"

All four participants acquired information on HIV through sex education course/pamphlet or media, such as the Montel Williams Show, that motivated them to increase their communication skills with their sex partners. Interestingly, no Latina females mentioned the use of media as a catalyst to discuss HIV/AIDS.

Another context, though it was mentioned with less frequency, specifically by one African-American female and two Latina females, is *Cheating*. Leslie, for example, is in a serious, and presumably monogamous, heterosexual relationship. She asked her partner to inform her if and when he "cheated" on her so that she is able to make the decision to leave and essentially protect herself.

> Leslie: "I tell him, 'Every time you feel like having sex with someone other than me, not just think about yourself, think about you gonna have sex with that person and then you gonna come back and have sex with me.' And if that person is infected that he is going to infect her too."

Most disconcerting, however, is Vixen's experience with a former sex partner who admitted to "cheating" on her on two different occasions.

> Vixen: "I found out that the guy that I was talking to had slept with somebody else. I was hurt, really shocked. He had told me, 'Yes, I used a condom.' I said, 'Oh, did it happen only once?' 'No, it happened twice.' 'Did you use it both times?' 'Yes,' because I guess he knew the girl, but really didn't know her. I kind of got scared, but I

> was happy in a way that he had the decency to actually use a condom because he had been with me and he didn't, we never used to, but that didn't last very much longer just because it was on my mind."

Vixen's cognitions are deeply flawed. The first, and most obvious, is that she assumed her former sex partner disclosed the truth regarding the use of condoms on those "two" occasions. There is a possibility that he may have been dishonest in regard to using condoms, given that he did "cheat" on her. The other supposition is that her partner had used a condom at the immediate onset of engaging in all sexual activities. Condom use, however, is rarely considered when engaging in oral sex, and yet were condoms used at this time? Condoms are employed at various stages of sexual intercourse, and during different kinds of sexual acts. For example, the male partner may penetrate his partner without the condom at the onset of vaginal intercourse, but then decides to put one on during mid-session, or he may use a condom for vaginal intercourse or anal sex, but not one for oral sex. It seemed that this level of detail regarding his sexual encounters was not revealed to her.

Another context for discussing HIV/AIDS is condom availability, or the decision to use condoms when engaging in sexual activity. One participant from each racial/ethnic group mentioned *Condoms,* which seemed to replace the actual discussion of HIV/AIDS. For Spirit, the topic of condoms is addressed with each sex partner, and usually when engaged in sexual "foreplay." O'Connor admitted in failing to communicate safer sex practices with most of her sex partners, but reported that she has taken the initiative with "the last few ones," and the ones with whom she had unprotected sex.

> O'Connor: "If you don't have any condoms, then you just have to make sure to the best of your abilities that you're not getting yourself into a sticky situation, and hope that they are telling you the truth."

The excerpt also exposed a subtle, yet important, gap in her thought processes in that she inquired the timing of their most recent test, but did not ask the type or the result of the test.

The four themes/contexts that motivated many of the participants to discuss HIV/AIDS include *Getting Tested, Newly Acquired Information about HIV/AIDS, Cheating*, and *Condom Availability*. More interesting is the reasons for failing to have frank and open talks about HIV/AIDS with their sex partners. Though no clearly defined themes emerged by the majority of the participants' responses, several reasons have been provided by a myriad of the female participants. *Both sex partners were either wearing a condom or were virgins*, according to Josephine, Sam, and Goddess, were reasons not to engage in talks about HIV/AIDS. Ladybug felt invincible from a STD because of *being with one partner* as she stated, "I guess it was when I started having sex. It wasn't like I only did it one time so it's not going to happen like that." Mary and Morning Star explained that the context of their sexual encounters, specifically *not being in a committed, long-term, mutually-exclusive relationship*, did not lend itself to discuss a "heavy topic" like HIV/AIDS. The following passage is from Morning Star:

> Morning Star: "With one-night stands type of people, I don't really sit down and talk to them about that type of subject. I probably should, but I don't. And with my long-term boyfriends, the topic of actual HIV and AIDS that explicit topic, I don't think I'd bring up. I do really bring up the subject of 'Have you ever been tested?' and additional questions about sex partner's sex history."

La Chingona's comment regarding the approach in which her sex partner talks about HIV/AIDS speaks to the difficulty in addressing a seemingly vulnerable topic, as she

stated, "Even if a guy just asked me like that, I would be insulted like damn you know." Yet, for Butterfly she did not address HIV/AIDS or safe sex with partners who she has been in *a long-term, committed relationship* because of being under the assumption that marriage will ensue. Leslie asserted that talks about safe sex and HIV/AIDS occurred more frequently at the onset of the relationship. O'Connor admitted that fear and being naïve attributed to her failure to have open discussions about HIV/AIDS with her sex partners:

The second portion of the communication patterns with sex partners focused on eliciting their thoughts in ways to increase more open dialogue about practicing safer sex. The data analysis revealed that no distinct patterns emerged that were unique to the respective racial/ethnic group. The most prominent theme, reverberated by three African-American and two Latina females, was to generate *Forums that are Dialogue-Oriented, Personal, and Candid,* compared to existing sex education classes. O'Connor, for example, emphasized the importance that guest lectures, who have been diagnosed with HIV and are living with AIDS, share their experiences, while the audience members have the opportunity, in turn, to ask sensitive, yet relevant, questions regarding HIV/AIDS.

> O'Connor: "What worked best for me, and what got me to start talking about it, was hearing that one, the AIDS, I want to say victim, but the AIDS victim who told us his story about how he was the homecoming king, he was the captain of the football team, he had the best grades, he never told us how he got it, but he did mention that he got sent to college, got into a fraternity, got heavy into drugs and alcohol, so I'm guessing it might have been through sharing needles, but I'm not entirely sure. Either way, it didn't matter because the point is that he did something, he covered the different bases of sex and drugs, so any of those things could have been it. I mean, he's not entirely sure, himself, how he got it."

The *Personal* component infers increased relevancy to the population that the messages are being targeted. Chocolate Princess, for example, reported increasing her HIV awareness when watching a Public Broadcasting Services special television programs that showcased an African-American young female who was HIV-positive and transmitted the virus to her child. Teenage pregnancy is a topic with which she was able to identify, given her own family history, where many of the young female family members (i.e., cousins) became pregnant at a young age. Being *Candid* in the type of and delivery of information seemed to be a motivational factor for these participants to increase their communication skills with their sex partners. Osa reported that "in your face" type of conversations that are considered taboo in public school settings, but were addressed in her sorority, increased her awareness in sex, sexual identity, and transmission of STDs, including HIV/AIDS.

> Osa: "My sorority did a safe sex thing this past week, and where I learned a lot of things they don't teach you in a health type class. I think just that type of conversations with people with make me have conversations with my boyfriend about safer sex."

Another theme that was represented by one Latina and two African-American females was to *Feel Comfortable and Safe* when talking about HIV/AIDS with their sex partners. Vixen, Angel, and Chocolate Princess emphasized the importance that they, or women in general, need not to be afraid, but to feel comfortable discussing this subject. This captured the essence of why young females are unable to discuss sensitive, emotionally-charged, psychologically-fearful topics with their sex partners. Fear, associated with the cognitions, needs to be researched further.

By the same token, Spirit, Tinay, and Poet, all of whom are African-American college students, asserted that a *Scare Tactic* is needed for them to increase their

communication with their sex partners. Poet admitted that at one time in her life she felt invincible until being diagnosed with a STD, which forced her to examine her attitude, thoughts, and behaviors regarding her sex practices, and essentially living with the consequences of a STD. Though Tinay and Spirit have not experienced a "scare" in their own lives, and concern with their mortality, they asserted that it is the motivational factor needed to address HIV/AIDS within themselves and with their sex partners.

> Tinay: "Probably if one of us caught something. That would be the thing." [Investigator: "Something that drastic has to happen though? Do you think there could be other measures that could help or no?"] "Well, for me to seriously talk to somebody about that, probably so, not me or him have to get it, maybe a friend caught something."

There were several other suggestions, usually offered by no more than two participants for each suggestion, but it seemed that listing them as a *Miscellaneous* category was worth mentioning. Getting tested as a couple, being in a committed, long-term relationship, having the male sex partner take the initiative to discuss HIV/AIDS, and becoming more future-oriented about one's career and health are other reasons listed by these female late-adolescent females as to the ways and reasons to increase communication with their sex partners. The next major section shifts focus from sex, safe sex, and communication patterns with partners, to their perceptions on HIV/AIDS messages, and suggestions to increase more effective HIV/AIDS prevention campaign and awareness.

Effectiveness of Past and Present HIV/AIDS Messages

This final section is divided into three subsections: Types of Past HIV/AIDS Messages, Types of Present HIV/AIDS Messages, and Suggestions to Increase Consistent Condom Use and HIV Awareness. Each of the subsections is further delineated by

racial/ethnic group and by topics. The first subsection looks at the types of HIV/AIDS messages that these participants heard while growing up. Next, a comparison is made between the responses of the African-American and Latina females as well as an examination of the effectiveness of past HIV/AIDS messages in these populations. The second subsection follows a similar format, but instead focuses on present HIV/AIDS messages. The third subsection focuses in extracting innovative ideas in increasing consistent condom use and HIV-awareness.

Types of Past HIV/AIDS Messages

African-American females. In this subsection, themes were derived to determine the types and degree of effectiveness of past HIV/AIDS messages among the African-American and Latina participants. Among the African-American females, the most common HIV/AIDS message, which was cited by six of the ten participants, was to employ consistent *Condom Use.* Five identified the use of *Fear Tactics*, which elicited a sense that HIV is a "death sentence," as another HIV/AIDS message primarily heard during their upbringing. Spirit's excerpt captured the essence of this theme:

> Spirit: "I think more growing up, it was just kind of fearful. Like, people are going to die, and that's where my whole notion of like, 'Ok, somebody's gonna get AIDS. They're gonna die. Everybody's gonna get AIDS. We're all gonna die.'"

HIV is either a gay-disease or that IV drug use as a method of infection (a.k.a. Familiar Past Messages) is another theme, and was mentioned by five African-American females. Mary's quote was a snapshot of this theme:

> Mary: "HIV was a White man's gay disease. Back then, it would be so medical, like you got a doctor with a white coat, and he's all old and stuff and talking about HIV and then IV drug users. I mean, growing up in the suburbs, that is so far from what I even ever...that was like so not me."

Four African-American females reported that *Everybody is At-Risk of Infection* as another HIV/AIDS message. Spirit's comments indicated that she had come to the realization that HIV does not discriminate.

> Spirit: "You can die from it. It doesn't matter age, race. It doesn't have a face or anything on it. Anybody can be affected from it, and that's why it's very powerful."

Latina females. Themes, *Familiar Past Messages* and *Condom Use,* were discussed by these participants and were also mentioned by the Latina females. Five of the nine Latina females identified *Using Condoms* as a HIV/AIDS message they had heard during their childhood. Morning Star's comments summarized using condoms theme with succinctness as she stated, "If you are going to have sex, wear a condom." The *Familiar Past Messages* theme emphasized "dirty IV needles" as a mode of transmission or that HIV is a gay disease was cited by four of the nine Latina participants. O'Connor's comment best captured this theme:

> O'Connor: "Just the sayings: wear condoms, AIDS is bad, that it's mainly for problems for homosexuals and drug users more often than not. It's referred to for homosexuals and drug users."

Another important theme that emerged, though with less frequency by three of the Latina females, was that being sexually involved with *Multiple Partners* increased their chances of being HIV-infected. Interestingly, this theme was not echoed by the African-American respondents.

African-American and Latina females. When comparing the themes across racial/ethnic groups, the most prevalent theme was *Condom Use*, which was mentioned by a total of 11 of the 19 participants. Five African-American and

four-Latina females recalled *Familiar Past Messages,* with an emphasis that HIV is a "gay disease," and/or that HIV is associated with "drug users," as the second most common theme. Between-group differences were more apparent than the *Fear Tactic* theme, which elicits a sense of ominous doom of being a life-long sentence that HIV ultimately leads to death. This theme was discussed by five African-American females, yet only by one Latina participant. Interestingly, three Latina females reported having heard the message that having *Multiple Partners* increased their risk of HIV infection and four African-American females discussed that *Everybody is At-Risk of an HIV Infection.* However any mention of these themes was curiously absent from other members of their respective racial/ethnic groups. One Latina and two African-American females remembered *Abstinence* as being an HIV/AIDS message they recalled during their childhood. Another Latina and two African-American participants reported that *Pregnancy* was more of a salient concern, rather than being worried about becoming infected with a STD.

Effectiveness of past HIV/AIDS message. Table 8 summarizes the number of respondents reporting the effectiveness of past HIV/AIDS messages by quality and by three categorical responses and by race/ethnicity. With regard to the efficaciousness of past HIV/AIDS messages, six of the ten African-American females and four of the nine Latina female respondents reported that they found the messages to be effective, while three Latina females stated that they were ineffective.

Table 8

Effectiveness of Past HIV/AIDS Messages

	Effective Past HIV/AIDS Messages	Ineffective Past HIV/AIDS Messages	Mixed Reaction to the Effectiveness of Past HIV/AIDS Messages
African-American Females	6	0	4
Latina Females	4	3	2

The following example by O'Connor offered illustration:

> O'Connor: "Not very because I wasn't homosexual and it was mostly geared to homosexual men so it didn't really apply to me."

Goddess's own sexual history revealed that she has been sexually active with seven partners, one of whom she reported not using a condom with. O'Connor's statement revealed an important truth about the ineffectiveness of past messages, in that they were not geared toward populations other than the "White Gay Man." Vixen's response appeared to encapsulate a cognitive-oriented defense mechanism of having a sense of invincibility, a common characteristic to this age range's psysocialsexual development.

Two Latina and four African-American participants provided more complex responses regarding the effectiveness of past HIV/AIDS messages. Chocolate Princess reported that her fifth grade sex education class placed more emphasis on topics such as reproductive health matters and were consequently less effective than vicarious "learning moments", such as when her cousins and best friend were impregnated before they graduated from high school. Real-life circumstances of close people increased her awareness of at-risk sexual behaviors. Ladybug believed that the fear tactics of past HIV/AIDS message were effective for young children until they reached puberty became

"curious" and developed an "everyone is doing it" attitude. According to Ladybug, at this stage of development, specifically at puberty, HIV/AIDS messages need to focus more on age-appropriate subject matters. Osa spoke about her experience of what felt like being the "only virgin," especially when being a freshman in a university setting. She stated the messages were effective as she remained "abstinent for a long time," but became less effective as she aged and her female cohorts became increasingly more sexually experienced. Mary reported that she was uncertain as to the effectiveness of past HIV/AIDS messages. She attributed practicing safe sex (i.e., use of condoms) to the fear of pregnancy. As she stated, "I knew that I didn't want to have a baby." La Chingona believed that past HIV/AIDS messages were helpful in her own life, as she tended to employ condoms with "one-night stands," but found them to be less so with respect to long-term relationships and stated:

> La Chingona: "When it comes to long-term relationships, like when you get into a real relationship, like the stuff I've heard, I don't feel like that's been very helpful, because I mean once I get to a point where I feel comfortable and I trust the guy ...off they go... the messages weren't too effective."

Finally, Princess asserted that the messages were effective as it helped her become more conscientious with her sex partners. However, she found them to be inapplicable to her life circumstances, given that she was sexually inactive at the time the messages were being conveyed. A good number of the female participants assessed the HIV/AIDS messages they heard while growing up as ineffective and their responses were honest and direct, which will aid in future HIV/AIDS prevention campaigns. In addition, the data revealed that the perceptions of past HIV/AIDS messages were complex, circumstantial, and situational. The next subsection reviewed the themes derived from the female's

perceptions on present HIV/AIDS messages. Have the messages changed over time? Will they find the messages to be more, or less, effective?

Types of Present HIV/AIDS Messages

African-American females. The content of this section shifted focus from determining the participants' perceptions on HIV/AIDS messages that were heard during their upbringing to eliciting their perspective on present HIV/AIDS messages. It seems that the themes were more varied, and less clearly defined, for this section, especially among the African-American females. Three of the ten African-American respondents reported that the present messages were *Conflicting HIV/AIDS messages that center on Mortality versus Longevity.* Spirit's comments, for example, were multifaceted in that she talked about that one's quality of life and the mortality rate seemed to hinge on one's economic plight.

> Spirit: "In a way, now, I almost feel they show a lot of people who live with it now. So, it at times it almost seems it's not fatalistic at all. But knowing other things that I know. Like, to look at the thing going on in South Africa and in Africa where it's 1.53 million or something like that are living with AIDS, and to know that they're dying because of the lack of medical attention and things like that. But then to look in the US, where there's a lot of people living with it. It's like, you hear in certain places like South Africa are dying of AIDS."

Ladybug addressed similar issues regarding Magic Johnson, who was reported to have the financial means to pay for the medical costs affiliated with his diagnoses of being HIV-infected, while others who are less financially fortunate to sustain a healthy quality of life, were "dying from it" because they lacked access to medical care. Osa also recognized the AIDS pandemic in third-world countries, such as South Africa, and emphasized the death rate among the youth, as she stated, "How young the people are starting to die too." Increased awareness of the *Epidemiology and Statistics of HIV/AIDS*, increased messages

on condom use, and P*ublic Awareness Promoted by Celebrities* were equally mentioned by two African-American females for each theme. Though the theme of *Black Men on the Down Low* (DL) was mentioned by only one female, Mary, it is an important topic to address:

> Mary: "I hear now a lot about the whole deal brothers on the down low thing and about how a lot of black men are having sex with other men, and infecting a lot of black women, and I feel that that has something to do with the fact that women are, black women, are the fastest growing group of women with AIDS and with HIV with new cases."

Mary's assertion is accurate. The present HIV/AIDS messages, according to this African-American female sample, conveyed less unified themes, and instead, provided deeply complex and varied responses as to how they perceived present HIV/AIDS messages. Did the Latina females hold similar views on the present HIV/AIDS messages?

Latina females. Among the Latina females, six of the nine participants indicated that the types of HIV/AIDS message they hear presently includes increasing the *Practice of Safe Sex* through the use of condoms, while two reported that *Knowledge of Partner's Sex History* has been promoted with greater frequency. Another theme, *Conflicting HIV/AIDS messages that center on Mortality and Longevity,* was echoed by two Latina females. Butterfly, for example, heard from televised talk shows that people are presently living with AIDS, while Sam indicated that knowing that children are living and dying with AIDS scared her. Another theme similar to Mary's observation was resonated by Butterfly with regard to the connection between *HIV and infidelity.*

> Butterfly: "Different people talking about their experiences—there were even people that were infected with HIV that talked about their own experiences where they didn't think about it or the person they had

> been with had not been truthful. It's just ironic. There's a Latina magazine, and I was reading it, and they talked about women who had got infected with HIV/AIDS with their husband, who never really told her because he was having an affair with somebody that was infected and he got her—and he divorced her, and so it was a really sad story, but it does kind of affect you in a way, the way of your thinking."

African-American and Latina females. Though the themes derived from the data among the Latina females were less varied than the data from the African-American females, they were, nonetheless, equally complex compared to that of the themes from the African-American females' perception on present HIV/AIDS messages. While 66% of the Latina females paid attention to the HIV/AIDS messages that focused on the *Practice of Safe Sex*, only 20% of the African-Americans spoke about the same topic. Another difference is that there was no mention of *Knowledge of Partner's Sex History* by the African-American females, but was mentioned by two Latina participants. Conversely, there was no mention of either the *Epidemiology and Statistics of HIV/AIDS* that impacts people of color or the promotion of HIV/AIDS awareness via celebrities by Latina participants, but it was addressed by African-American participants. Both groups mentioned, with equal frequency, *Conflicting HIV/AIDS messages that center on Mortality versus Longevity*, and the connection between HIV and Infidelity, whether it is via heterosexual contact or by men having sex with men, and then with their heterosexual partners. Perhaps these intricate themes can speak to the ways in which AIDS has become a more complicated and diverse social pandemic or that the messages are becoming more relevant to these late-adolescent females' lives. The central focus underlying the examination of past and present HIV/AIDS messages is addressing the effectiveness of these messages, and the direct impact it may have on their sexual behaviors.

Effectiveness of present HIV/AIDS messages. Table 9 summarizes the number of respondents reporting the effectiveness of past HIV/AIDS messages by quality and by three categorical responses and by race/ethnicity. Among all 10 African-American female participants, seven reported that there was a general improvement, while two indicated that there was no change, and one respondent stated a decline in the effectiveness when comparing from past to present HIV/AIDS messages. With regard to the general improvement, an important subtheme surfaced from the data, in that four of the seven females cited the present messages as having *More Relevance* to the targeted population, specifically African-American communities.

Table 9

Effectiveness of HIV/AIDS Messages across Time

Subgroups	Improvement	No Improvement	Decline	No Response
African-American Females	7	2	1	0
Latina Females	4	3	1	1

Osa, for example, explained that the notion of "everybody can get it" no longer left her feeling invincible from the virus, while Poet attributed celebrities, such as Magic Johnson, to her increased HIV awareness that "it could happen to anybody." Mary made a clear distinction in how past messages were ineffective, as they were geared to other populations at risk, whereas the present messages are geared more toward the African-American communities and stated:

> Mary: "Yeah. They are different because when you heard it growing up, it was so not you. I mean, like, the people in the commercials now,

> they got on the clothes that I'm wearing, even if they are not black, they are my age, you know what I mean, or even if they're not you now, my age, they are a woman or something like that."

For the two respondents who indicated that there was no change between past and present HIV messages, Angel did mention there was an increase in HIV/AIDS statistics, while Chi Chi stated that there were "less of them." Both, however, asserted that the effectiveness and content of the HIV/AIDS messages did not change. Finally, Spirit is the one female participant who reported the effectiveness had declined over time because of the perception that AIDS is no longer a "death sentence."

> Spirit: "Oh you can live with it. Cuz if you give too much of a lackadaisical approach, I would say I wouldn't think about it as much. If you're embedding it into my head that I can die from this, and this is a big deal. It can be very fatal, that then, I would feel I need to take every necessary precaution I can ever in my life to not be in that situation. And then look at some of the messages that they say now, it seems you don't even think about it as much as I used to."

Among the Latina females, Goddess also implied that there was a decline in the effectiveness of HIV/AIDS messages as she made the following observation:

> Goddess: I went to a class called LAM, and there was two or three hick towns like mine, and they always say a lot of people get pregnant because there's nothing else to do in those towns, and that's very common in those towns where there's absolutely nothing to do, so all they would do is resort to sex, and that's probably why kids are having sex younger because it makes them feel more adult I guess."

Though she did not directly state that the effectiveness of the messages declined over time, it is apparent that they continue to be ineffective. Three other Latina females also reported similar views in that the effectiveness of the present HIV/AIDS messages have not improved. Vixen's comment of "they are basically the same thing, be protective when you are having sex," captured this category. Four participants believed that the

messages have improved with regard to the effectiveness of them, according to Morning Star, La Chingona, Butterfly, and O'Connor. HIV has become "a real issue," according to Morning Star. She had a first-hand experience in helping those living with HIV/AIDS when she participated in an intensive week-long volunteer experience helping the homeless and those living with HIV and AIDS. La Chingona implied that seeing that resident assistants in the dormitories "giving out condoms like candy" suggested to her that prevention of STDs, including HIV, has improved. O'Connor stated that being in a college setting has increased her exposure to STDs, and the promotion of using condoms when engaging in oral sex. Butterfly believed that the messages improved, as she stated, "Those kind of messages affect you more when you know that its within your community," emphasizing the identification an article read in a Latina magazine of a married Latina woman who had been infected with HIV by her husband, who was a culprit of practicing infidelity. She stated, "I guess that's why it affected me more because it was someone that was from my community, from my background, from my cultural values." Princess did not comment on this general topic.

In general, the data revealed that approximately 58% of the respondents perceived the HIV/AIDS messages have improved over time, while 26% and 10% of the total number of participants believed that there was no improvement, and there was a general decline in the effectiveness of the messages, respectively. The need for HIV/AIDS awareness can always improve as is evident from the responses in this sample. Another related, and critical, topic is the examination of the themes obtained from the participants' suggestions in ways to increase consistent condom use and awareness of the HIV/AIDS pandemic.

Suggestions to Increase Consistent Condom Use and HIV Awareness

When the participants were given the opportunity to address factors that would help young women in similar predicaments, such themselves to increase consistent condom use during sexual encounters, and ways to "halt the spread of HIV," several themes became apparent from the responses of both African-American and Latina females.

Table 10 summarizes the themes derived from this subsection, *Suggestions to Increase Consistent Condom Use and HIV Awareness, by* types of messages and by race/ethnicity. Of the 10 African-American participants, five reported that *Empowerment-Focused HIV/AIDS Prevention Campaigns* were much needed. According to Spirit and Josephine, the messages need to teach young women to "care for themselves," and to impart clear signals that they "are worth something," while Chi Chi believed that they need to be more future-oriented, as well as goal-focused, which will help them think about the long-term consequences associated with at-risk sexual behaviors.

Chocolate Princess and Angel shared similar views that women need not to be "ashamed for asking questions," and that "they have the right to speak up," in order "to protect their bodies." Their statements captured the essence of what it means to *empower* young women in re-directing and attending to their feelings and thoughts, especially with regard to engaging in sexual relations and in protecting themselves from a STD.

Table 10

Themes Derived from Ways to Increase Condom Use

Types of Messages among African-American Females $n = 10$		Types of Messages among Latina Females $n = 9$	
Empowerment-Focused HIV/AIDS Prevention Campaigns	5	Condom Use	6
Direct, Fact-Based, and Honest	4	Direct, Fact-Based and Honest	6
Age-Specific HIV/AIDS Prevention Campaign	3	Issues Centering on Testing	5
Issues Centering on Testing	3	Empowerment-Focused HIV/AIDS Prevention Campaigns	4
African-American-Focused HIV/AIDS Prevention Messages	3	Age-Specific HIV/AIDS Prevention Campaign	3

Another theme, voiced by four of the ten participants, was that the prevention campaigns needed to be more *Direct, Fact-Based, and Honest* in the delivery of HIV/AIDS information. Specifically, the messages need to convey that HIV will eventually "lead to death," that it needs to be "in your face" advertisements, conveying that HIV can inflict "me and my community," according to Josephine. More information needs to focus on the biological component of how STDs attacks the body. Three of the participants stated that *Age-Specific HIV/AIDS Prevention Campaign* needs to occur at each grade level, and topics that are grade- and age-appropriate. The prevention campaigns also need to involve *Interactive and Discussion-Oriented Forums,* according to three other

respondents. Mentors should lead and have similar sexual experiences as the peers, and mentors can generate honest discussions about intimate issues concerning safe sex practices, fears associated with discussing HIV/AIDS, and addressing embarrassing sex-related questions. The prevention campaigns should also include ways to increase discussion about *Issues Centering on Testing*, such as promoting the benefits of, normalizing the fears associated with, and conducting role-play in getting tested as well as discussing condom use. Three participants reported the importance of having *African-American-Focused HIV/AIDS Prevention Messages* as a means to convey, more effectively, the urgency of the HIV pandemic having direct impact on their community. Josephine, for example, suggested sending flyers to African-American women on campus that directly addresses the statistics regarding the African-American community. Mary stated that the role models and celebrities that currently talk about HIV/AIDS in the mass media need to resemble better the targeted population, the average African-American, late-adolescent female.

Similar themes were evident among the Latina sample, with one exception in that six of the nine Latina females reported that an increase in *Condom Use* is needed, which was not mentioned by the African-American participants. Goddess, Butterfly, and Sam, specifically, believed that condom availability should take place in both the high school and college settings. Butterfly and La Chingona focused their attention on ways of addressing the feelings of embarrassment and shame associated with condoms, while Vixen believed condoms that cause vaginal irritation should be publicly addressed. There was equal mention on the importance of generating more *Direct, Fact-Based, and Honest HIV/AIDS Prevention Campaigns*. Morning Star, Butterfly, and Sam suggested

that the messages need to center on the epidemiology of HIV that specifically impacts their community. Morning Star, for example, suggested that increasing the publication of the day and a life of a person living with HIV would be helpful. O'Connor discussed the importance of increasing conversations about Latina males being on the "DL" (down low), where Latino men are in heterosexual relationships, but will also engage in having sex with other men. Five of the nine Latina females reported the need to increase messages that focus on *Getting Tested* and issues that are associated with it, such as the emotional component of talking about the fears and embarrassment of getting tested, as well as the logistical aspects of testing, such as what tests are involved and which clinics provide such tests. Four Latina participants recommended that the HIV/AIDS prevention campaign needs to incorporate more *Empowerment-Focused* messages, such as having them think more future-oriented, campaigning the message, "you deserve to live," and finding that acceptance and validation need not come from the male sex partner. The other theme, voiced by three Latina females, is that *Age-Specific HIV/AIDS Prevention Campaigns* are needed. All three participants placed an emphasis on gearing the messages toward the "younger girls," since they are engaging in sexual practices at an early age.

In comparing the themes derived from the African-American and Latina females' responses, the Empowerment-Focused HIV/AIDS Prevention Campaigns, Direct, Fact-Based, and Honest, Issues Centering on Testing, and Age-Specific HIV/AIDS Prevention Campaign were discussed. Themes that became evident were approximately shown with equal frequency by both groups. The stark difference is that the increase in the use of Condom Use, the most prominent theme, among Latina participants was not discussed by

the African-American respondents. Conversely, the African-American participants promoted an increase in African-American-Focused HIV/AIDS Prevention Messages, but there was no reference for increased culturally-specific prevention campaigns among the Latina females.

Summary

The primary function of this chapter was to communicate the results of the following areas: the survey portion from the HIV/AIDS open-ended questionnaire, a brief biography of each of the participants, and the themes derived from the three major sections of the open-ended interview, which included the following areas: Knowledge regarding HIV transmission, thought and behaviors about sex, participants' sexual experiences, safe sex, and communication patterns with sex partners, and effectiveness of past and present HIV/AIDS messages. Given the myriad, and often complex, responses and themes that were offered in this chapter, the next chapter will contextualize, explain, and account for the many of the topics discussed in a cohesive, conceptual manner. The purpose is to provide a more effective age-specific, gender-appropriate, and culturally-relevant HIV/AIDS prevention campaigns.

CHAPTER 4: DISCUSSION

The overall purpose of this research study was to investigate the African-American and Latina late-adolescent females' perceptions about their conceptualization and experiences on sex, safe sex, communication with their sex partners, and on ways to improve existing HIV/AIDS messages. The aim was that their responses could be translated directly into creating HIV/AIDS prevention programs that are culturally-relevant, gender-appropriate, and age-specific to the target group of interest. This chapter addresses the very crux of this study by summarizing the major findings, providing recommendations that promote appropriate and relevant HIV/AIDS prevention messages, acknowledging the limitations of this study, and offering future research implications.

Knowledge of HIV Transmission and Awareness

A common, yet misguided, belief is that oral sex, and even anal sex, are alternative forms of safe sex, despite the fact that the medical literature clearly indicates that all forms of sexual contact, where bodily fluids can potentially be exchanged, are modes of transmitting all forms of sexually transmitted diseases, including HIV. Determining the female adolescents' knowledge on this specific topic is of critical importance. Myths centering on HIV transmission continue to place people in jeopardy, even those who are college-educated.

Sexual contact, including vaginal, anal, and oral sex, as well as *intravenous drug use* and *exchange of bodily fluids* were most common, and expected, themes when assessing the participant's level of understanding in HIV transmission. Blood transfusion, which was a concern in the 1980s and early 1990s, is still being echoed in the 21st century by those in this sample. Blood transfusions, and exchange of bodily fluids, were equally mentioned between the groups, even though blood transfusions have an

insignificant bearing on the increased rate of HIV infection among late-adolescent females. According to Donegan (2003), the majority of HIV-infected cases before March of 1985 were because of infected blood transfusions; yet, by 2003 the risk of HIV transmission per unit transfused had significantly decreased to between 1 in 1.4 million and 1 in 1.8 million units. In addition, HIV/AIDS Surveillance Reports by CDC (2001) showed that by December of 2003, only approximately 1% of HIV and AIDS cases, including adults and adolescents, can be attributed to HIV-infected blood transfusions, blood components, or tissue. An updated CDC report (2004) analyzed data between 1999 and 2002 from 29 states and found that 35% of all new HIV cases were explained by heterosexually-acquired HIV infections, not by HIV-infected blood transfusions. Furthermore, 64% of heterosexually-acquired HIV infections occurred in females and 74% occurred in non-Hispanic blacks (CDC, 2004).

Blood transfusions—a mode that significantly decreased the likelihood of transmitting HIV, given the present-age technology, where all donated blood is screened for HIV—seem to have an influence in the way college-educated, African-American and Latina late-adolescent females conceptualize the degree of threat of becoming HIV positive. In other words, does this once-relevant concern play a role in preventing them from considering the seriousness and relevance of HIV/AIDS impacting their lives?

More disconcerting is that approximately one-half of the respondents (47%) admitted that they never thought of themselves in relation to HIV, even though each participant had a sexual history that exposed them to the opportunity of infection to a sexually transmitted disease. This detachment was more pronounced among the Latina participants (67%) compared to their African-American counterpart (30%). The most

common explanations provided by these participants included knowing their partner's sex history and having "few" partners, which led them to believe that they are not susceptible to contracting HIV.

Essentially, the majority of this sample identified the various modes of HIV transmission in a seemingly rote manner. Yet, blood transfusion was a repeated theme that should not have been as frequently mentioned as it had in this sample. This is indicative to how past HIV/AIDS messages have lingering and unwanted impressions. In addition, erroneous assumptions, which served to distance the participants cognitively from the idea of being HIV-infected became more evident when discussing how they might think of themselves in relation to HIV. This issue suggests that more updated information about HIV transmission, such as fears underlying HIV/AIDS, and how it can impact specific communities, needs to be targeted better to the populations that it is being addressed.

Multiple Definitions of Sex

The typical theme, *penetration,* in defining the term sex is from a behavioral perspective, which incorporated other related responses: vaginal, oral, and anal sex, as well as the exchange of bodily fluids. Four participants, two from each racial/ethnic group, conceptualized sex from an emotional perspective in that it was viewed as an expression of love, a form of *Emotional Intimacy.* Two Latina females defined sex in terms of sexual orientation in that sex is a *Heterosexual Sexual Activity,* which suggests that they defined sex as coital intercourse.

When participants were conversely asked whether or not anal and oral sex constitutes sex, seven of the nineteen participants' responses were less than clear and thereby were unable to be categorized in clearly definitive themes, whereas the other 12

participants reported that oral and anal sex is defined as sex. Six respondents, four of whom are Latina females, perceived oral sex as having a "less than" value, in that it was viewed as "foreplay" and that it is not "penetration" like that of penile-vaginal intercourse. The results suggest that these participants may be disillusioned into feeling safeguarded from being infected with a sexually transmitted disease. Though five of the seven participants defined anal sex as sex, two Latina females had competing views in that one thought anal sex was "less dirty" because it is not a form of "losing" one's virginity; whereas, the other Latina female believed it being "dirtier" because she did not consider it "normal" sex, implying that it is not coital intercourse.

In assessing the themes derived from the data in the area of defining sex, the way the questions are posed elicit different responses. For example, subtle, yet important, differences emerged when asking the females "to define sex" versus asking, "Is oral and anal sex considered sex?" The literature to date has little understanding about the psychological reasons, the social benefits, and the sexual risks involved in engaging in noncoital sexual behaviors (Prinstein, Mead, & Cohen, 2003). In fact, Boekloo and Howard (2002) reported that oral sex is not specifically measured in most health surveys of adolescents. Gurman and Borzekowski (2004) echoed a similar concern in that past research studies that look at adolescent sexual behavior did not distinguish between anal or oral sex in the general term *sex*. Further delineating specific sexual behaviors—cunnilingus, fellatio, and anal sex—is important to incorporate in the present HIV/AIDS research, since it has a direct bearing on the transmission of HIV and prevention efforts (Prinstein et al., 2003). A research implication is elucidating further within a qualitative framework as to the reasons condoms are not used for each of the specific sexual

behaviors among adolescents, but particularly among female adolescents and women who are at high risk of infection. Reasons may vary from one sexual act to the other, which will subsequently influence the direction of HIV/AIDS prevention messages (Prinstein et al., 2003).

The prevalence of inconsistent condom use during oral and anal sex is illustrated by this sample, in which approximately 14 and 17 participants reported failing to use condoms when engaging in fellatio and in cunnilingus, respectively. Of the nine respondents who reported in partaking in anal sex, six admitted in not using a condom. In other words, approximately 32%, 74%, and 89% of the sample did not use condoms when engaging in anal sex, fellatio, and cunnilingus, respectively. The evidence in this sample is consistent with previous research. The study conducted by Gurman and Borzekowski (2004) found that among their sample of 1,821 Latino college students, fewer than 5% of the participants employed a condom in their most recent oral sexual encounter.

The findings may account for one of the reasons condoms are used with less frequency when engaging in anal and oral sex. Ford and Norris (1993) hypothesized that Latina females may simply be less knowledgeable about sex and have conservative values with respect to sexual behaviors. Another study suggested that adolescents view oral sex as more acceptable and less risky sexual behavior (Cornell & Halpern-Felsher, 2006). Yet, when Cornell and Halpern-Felsher (2006) examined the reasons why adolescents engaged in oral sex, they found that physical pleasure (35%), improving the relationship or being popular (30%), perceiving oral sex as being less risky sexual behavior compared to vaginal penetration (16%), and feeling pressured, forced, or fearful

by peers (11%) were the most common explanations provided by their sample of 425 ninth-graders. Various external pressures, including peer pressure, the need to sustain the romantic relationship, and popularity status, were themes that were also echoed in this study. These external pressures, which may be a more accurate explanation for increased inconsistent condom use, are legitimate obstacles that female adolescents encounter daily. The Theory of Gender and Power acknowledges and accounts for the pervasive and insidious role in which the social and institutional forces influence a woman's perception on appropriate gender roles, her own sexual identity, and the failure to seek protection against STIs in fear of rejection by both her male and female peers. The *structure of cathexis,* a component of this theory, particularly speaks to the emotional and sexual attachments that women have towards their male sex partners. This structure can also perhaps address their attachments to their female peers as well and their desire to maintain a certain status quo within their peer group relationships.

A prevention recommendation is to increase awareness in differentiating penile-vaginal penetration and noncoital sexual behaviors as well as in educating how these discrete sexual behaviors are efficient modes of HIV transmission (Cornell & Halpern-Felsher, 2006). Though there has been more interest in studying noncoital sexual behaviors among adolescents (Prinstein et al., 2003), the focus has been more on oral sex than on anal sex. Yet anal sex and the use of condoms are a paramount importance and therefore, in specific, concrete terms, must be incorporated in the sex education programs. Knowledge, that the route of HIV transmission to the bloodstream is more efficient via anal sex than either vaginal or oral sex, needs to be communicated. Since the mucous membranes in the anus are thinner, tearing occurs more easily, and there is no

natural lubrication when compared to the vaginal area (San Francisco AIDS Foundation, 2006). Essentially, the HIV/AIDS prevention campaigns need to emphasize that condom use is necessary at all times, and at all stages, of sexual activity.

This study found that much of the sex information was garnered from *school-based sex education programs.* However, a contrast did appear when family members were involved in educating these participants. The results revealed that 60% of the African-American families compared to 33% of the Latino families had a role in educating their daughters. When family members were involved among the Latino group, they were given indirect, yet clear nonverbal, messages that sex was "bad" and that sex was to take place only in the context of marriage. The results from this study may be explained by a culturally-driven barrier that "the 'good' woman is not supposed to know about sex," (Ford & Norris, 1993, p. 316). Whitaker, Miller, May, and Levin (1999) recognized that having open discussions between the parent and the child about sex are made difficult by sociocultural taboos and cultural norms. The cultural assertions made by these studies are congruent with the Theory of Gender and Power as it speaks to the multicultural racial/ethnic groups that tend to be more patriarchal and more conservative about a woman's sexual identity and her sexual relationships. The theory acknowledges the negative impact that the power imbalance between the daughter and traditional, patriarchal family dynamics has on the failure to promote healthy sexual identity in young women as well as the failure to engage in open dialogue on emotionally-charged, deeply personal issues of sexual attitudes and behaviors.

HIV/AIDS prevention efforts need to be in tuned with the sensitive nature of discussing discrete sexual behaviors, coupled with couching these talks within cultural-

driven norms and framework. Among the Latino community issues such as (1) female gender roles (marianismo) that promote abstaining from sex until marriage, (2) the decision-making processes that occur at the collective, rather than at the individual, level, and (3) the value of *familismo* (central role of the family) need to be part of the fabric of family communication (Gurman & Borzekowski, 2004). In addition, given the important value placed on families for both racial/ethnic groups (Kirby, 2002), prevention campaigns should have parents be involved in sex discussions with their teen. The extant literature strongly indicated that communication between the parents and their child regarding sex-related behaviors delays initiation of first-time sex, to have fewer sex partners, and to use condoms (Fasula & Miller, 2006; Kirby, 2002; Whitaker et al., 1999; & Metzler, Noell, Biglan, Ary, & Smolkowski, 1994).

Lastly, the majority of the participants in this study reported that they began learning about sex in *Middle School*, the same time when half of the adolescent population has reported engaging in some form of sexual activity. Yet, sex-based curriculums in public school settings continue to promote abstinence, as opposed to the use of condoms, even in the Wisconsin Department of Public Instruction's directory of resources that is intended for educators, policymakers, and parents on ways to increase AIDS education and HIV prevention among their youth (Wisconsin Department of Public Instruction [WDPI], 2001). Yet this directive and other education-driven institutions, including Public Education Network [PEN], agree that policymakers, community agencies, school systems, and families need to increase communication with each other, and work more cooperatively before imparting critical information, such as health and sex-related topics, to children (WDPI, 2001; PEN, 2002). This means that effective

HIV/AIDS prevention messages go beyond a 30-second media blip that attempts to get the youths to abstain simply from sexual practices.

Practical Implications Drawn from Past and Present Sexual Experiences

Among the varying themes in each of the three categories of low, moderate, and high number of sex partners, four prominent themes emerged. Many, if not most, of the participants' actual sexual encounters were not necessarily planned; they "*Just-Kind-of-Happened.*" The participants in the *high* category (being sexually involved with more than 11 partners) were not coded under the theme of it "*Just-Kind-of-Happened*," but they were coded for engaging in *Nonmonogamous Relationships*, whereby the sexual activities typically occurred in a noncommitted relationship which suggest their sexual rendezvous were unplanned too. The motivating factors seem to be based on timing, sexual foreplay (including petting, kissing, and other forms of sexual intimacy) and the mere "moment," as contributing explanations to the "unplanned" sexual liaisons.

Evident across the three groups is the overarching theme, *Forms of External Pressures and Threats*, that motivated these participants to have sex, even when it was against their better judgment, but more importantly, when it was against their wishes and intent not to engage in sex. Five subthemes are subsumed under this broader theme of external pressures and threats. The first subtheme is the *pressure of female peers*. Angel, Tinay, and La Chingona had a common experience in that they had sex either by the encouragement of, or the coercion of, a female friend. Tinay, especially, was coerced by her female friend as she reluctantly participated in a ménage tois with this friend.

External pressures and threats were disguised in other forms, including *feeling victorious over female "competition,"* which is the second sub-theme. "Everybody else

wanted him, and he wanted me," Ladybug stated. This was a shared sentiment echoed by La Chingona's and Chocolate Princess's sexual experiences. These two sub-themes are consistent with previous research in the area of peer influence on adolescents' sexual conduct (Kirby, 2002). Metzler et al., (1994), for instance, found in their study that the largest direct predictor of adolescents' risky sexual behavior was associated with deviant peers. The research, which usually focuses on the ages between 14 and 18, has established that adolescents' sexual conduct is strongly influenced by the sexual attitudes and behaviors of their peers and friends (Upadhyay & Hindin, 2006). This trend of being heavily influenced by peers seems to continue into the late-adolescent age group, including college-aged population as evidenced in this study.

The third subtheme under the broader umbrella of forms of external pressures and threats is *feeling rejected* either by female peers or by male sex partners. In the case of Osa, who admitted that feeling alienated by her female peers based on being what felt like the "only virgin," largely explained why she lost her virginity. Chocolate Princess also admitted feeling rejected, but by her ex-boyfriend who claimed that she was a "boring" sex partner. Princess's narrative implied that her second and third sex partners were motivated by feeling rejected by her first sex partner with whom she felt was in a long-term, committed, monogamous relationship.

The fourth kind of external pressure and threat is the *threat* of *being emotionally abandoned by their sex partners*. The participants consequently felt that they were required "to have sex" as a means to sustain their romantic relationship. Angel, Ladybug, and Mary explained that their boyfriends, at that time, employed verbal coercive threats

in order to engage in sexual relations and to maintain their committed, monogamous relationship.

Being verbally, and perhaps physically, pressured to have sex by their male partners is the fifth and yet most apparent form of external pressure and threat. Tinay, and many other participants, are examples of females who felt pressured by their male partners to have sex, even against their own intent. The results from this study are similar to the findings of other studies. Specifically, social/external explanations, including maintaining social status and improving romantic relationships, may account for unwarranted sexual activities (Cornell & Halpern-Felsher, 2006). Furthermore, being pressured by their male partner speaks to the issues of gender, power, and control regarding sexual activity (Cornell & Halpern-Felsher, 2006; Wingwood & DiClemente, 2006; and Prather, Fuller, King, Brown, Moering, Little, & Phillips, 2006; Quina, Morokoff, Harlow, Zurbriggen, E., 2004).

The five subtypes of *External Pressures and Threats* can be best contextualized within the Theory of Gender and Power. The *sexual division of power*, one of the three social structures of this theoretical model, directly explains about the abuse of power men have over women in sexual relationships. These abuses of power and control come in various forms, such as when, and if, a condom is employed, verbal pressures to engage in sexual relations, and the physical force to have sex against their will. The verbal and physical pressures to engage in sexual activity were not only echoed by the female participants in this study, but it also has been intrinsically related to issues of gender, power, and control (Cornell & Halpern-Felsher, 2006; Wingwood & DiClemente, 2006; and Prather, Fuller, King, Brown, Moering, Little, & Phillips, 2006; Quina, Morokoff,

Harlow, Zurbriggen, E., 2004). These pressures also manifested itself in the form of psychological threats of fearing rejection and abandonment. This psychological threat is particularly an effective tool to manipulate women to engage in risky sexual behaviors as their livelihood has been shaped by gender socialization, in that they are to seek approval from others, to maintain a rich social fabric of social relationships, and to desire monogamous sexual relationships. Fearing rejection by their male sexual partner or female peers is in turn fear of rejecting themselves and their sense of identity. The *structure of cathexis*, the other social structure in the Theory of Gender and Power, accounts for this social programming. The *structure of cathexis* also accounts for the gender socialization that women need to maintain social harmony and status quo in peer relationships even if it is at the expense of their own well-being, thereby explaining why women are increasingly placing themselves at risk of HIV infection. The female participants in this study revealed that they have at one time fallen victim to these external pressures in hopes of maintaining social status and romantic relationships. Cornell & Halpern-Felsher (2006) produced similar findings in that maintaining social status and improving romantic relationships accounted for their participants' sexual activities.

The third broad theme is *The Need for Validation and Acceptance*, which included the Wooed-Effect. Even though it was not fully endorsed as a theme in the category of low number of sex partners, two respondents inferred that feeling validated and accepted largely motivated their sexual behaviors. The other participants, however, made more explicit comments that illustrated how validation moved them to engage in sex, as evident in the following: "I want them to continuing wooing me," said Tinay;

"He showed me a lot of attention," and "I knew he was attracted to me because I heard him tell somebody," said Chocolate Princess; "I felt like they told me things that I wanted to hear to get me in the bed," said Angel; "That someone wants you and makes you feel special," said Vixen; "Like someone that I know that doesn't have sex with everyone on my dorm room floor," said Morning Star; and "He was, like, paying so much attention to me," said La Chingona.

The majority of studies focusing on antecedent factors in predicting and accounting for adolescent sexual behaviors largely attended to the ways in which peers and family relations play a role. Given that the majority of the studies employed a quantitative approach, they were often limited in measuring teens' perceptions by resorting to assessing their perceptions on their peers' sexual attitude and behavior (Kirby, 2002; Metzler et al., 1994). These studies were insufficient in understanding the specificity of the cognitive mechanisms operating within the external pressures (family and peers) that drive these participants, and adolescents, in general, to engage in sexual behaviors. This study revealed important cognitive and psychosocial mechanisms—"Just-Kind-of-Happened," same-sex peer pressure, same-sex competition, fear of abandonment by sex partner, social isolation, and the need for validation and acceptance by partner—underpinning their sexual behaviors and attitudes. This data have direct impact on generating specific and more effective prevention campaigns.

The final theme, *Emotional Detachment and a Need for Retaliation are Mechanisms to Seek Personal Power and Control,* appears to be unique, in particular, to the participants in the category of *high number of sex partners.* Regardless, it needs to have further explication. In the cases of O'Connor and Poet, both of whom admitted to

being sexually abused, each clearly stated in their narratives that, since their innocence was "stolen" from them, that they were, in turn, going to take it away from their partners. Chocolate Princess's sexual history strongly suggested that her motivations were often couched in similar sentiment. This is an important area to examine, as this group increased the risk of infection because of the sheer number of sexual partners with whom they have been active. Furthermore, this seems to be one of the more critical, though less prevalent, explanatory factors for engaging in risky sexual practices. A possible hypothesis to account for this theme is determining which participant has been a victim of child sexual abuse (CSA), and whether the CSA influenced their present sexual practices.

Poet and O'Connor volunteered information regarding their sexual abuse when being interviewed, but the question of whether or not participants have had a history of being sexually abused was not posed to all the participants in this study. In hindsight, determining this specific information should have been pursued, and is needed in future research, especially since the women, in general, are more susceptible to child sexual abuse than men. Fergusson and Mullen (1999) estimated that 8% to 62% of women and 3% to 29% of men have suffered from CSA. Paolucci, Genuis, and Violato (2001) cited that CSA cases occurred, on average, between 15% to 20% of children and adolescents. Furthermore, approximately one third of women with an HIV infection have a history of CSA (Koenig & Clark, 2004). Koenig and Clark (2004) conducted a systematic literature review in examining the relationship between CSA and HIV/AIDS among women and concluded that CSA "is overrepresented among women with HIV" (p. 87).

Research found a well-established connection between CSA and engagement in high-risk sexual behaviors as an adult, including sexual compulsivity, indiscriminate or

impulsive sex, a high number of sexual partners, and a low incidence of condom use (Zurbriggen & Freyd, 2004; Paolucci, et al., 2001). Zurbriggen and Freyd (2004) explored the relationship between power-sex link and sexually acting out in an aggressive style. Their chapter illuminated in detail various cognitive mechanisms, including *reality-detecting mechanism, cheater detectors, and dissociation* that may mediate between CSA and sexually risky behavior. The reality-detecting mechanism, specifically, asserted that the perpetrator, often in an authoritarian position, will distort the child's reality by saying, for example, "All daddies do that with their daughters," (p. 148). Consequently, the child's mechanism from which to differentiate between reality and lies is compromised as a child. This child, thereby, has difficulty as an adult in assessing reality, which includes appropriate risk evaluation. Another mechanism, cheater detectors, is used to determine trustworthiness in others. When a person has been "cheated" on, a natural defense mechanism is to leave the abuser, but the dependent child is frequently forced to continue to be in the presence of the abuser who is often the caretaker. Consequently the cheater detector is compromised in order to function in the abusive relationship. This defected cognition continues to be evident in adult relationships. The third cognitive mechanism, dissociation, is to detach from one's own feelings of fear, pleasure, or safety when being sexually abused, and this dissociation continues to be played out in adult relationships. Furthermore, Zurbriggen and Freyd (2004) proposed that those who have a history of CSA will dissociate even when being presented with sex- and health-related topics as they have difficulty in sustaining attention and encoding, as well as processing HIV/AIDS information.

Understanding these cognitive mechanisms has a significant bearing on future HIV/AIDS prevention campaigns. Addressing these mechanisms in the prevention classes can help them understand their worldviews and behaviors as to why "they do the things that they do," with regard to their sexual behaviors. African American and Latina females will subsequently be more motivated to find ways to increase safer sex practices, as they gain a clearer understanding of the cognitive mechanisms underpinning their sexually risky behaviors.

The apex of the seemingly varied and complex themes is that the sexual history of these females, their intent, behaviors, and attitudes suggest that their sexual identities have largely been dependent on others, through female peer pressure, or by the pressures exhibited by their male partners, or through the need to seek external validation from their partners, or through the external gratification gained from competing with their female peers. Their sexual identities have yet to solidify largely as their behaviors and attitudes have been more or less shaped by other's evaluation, while failing to take into account their own needs and their own source of self-esteem. They have essentially divorced themselves from the decision-making processes when their sexual practices are involved.

To Use or Not to Use Condoms

When asked to define the term safe sex, all 19 participants cited *condoms*. However, only 30% of the African-American females compared to 55% of the Latina females mentioned *birth control* as a type of safe sex, while there was equal mention (n = 3) from both racial/ethnic groups indicating that *knowing their partner's sex history* is another form of safe sex. Interestingly, only one participant from each racial/ethnic group discussed *abstinence* as a mode of safe sex. The responses that were named with

less frequency can be captured under a broader theme: *Myths in Practicing Safe Sex.* This sample, who are college-educated, candidly disclosed their fallacy regarding safe sex, including having "fewer" sex partners, implementing hygienic measures when engaging in oral sex, avoiding the "swallow" method when engaging in fellatio, practicing the "withdrawal" technique when engaging in penile-vaginal intercourse, and getting tested, which was mentioned by two Latina and one African American respondents. "Politically correct," thoughtful responses were ideas that were verbalized, but not necessarily translated into action as evidenced by few of the participants. This subsection examined their level of understanding of safe sex from a conceptual point of view. The next subsection, which captures the essence of the study, explores their rationale and behaviors, as well as the type of circumstances, in which condoms were not employed.

All 10 African American females and 44% of the Latina females explained that being in a *Monogamous, Mutually-Exclusive Relationship,* was their rationale for not using a condom during sex. The danger lies in the meanings derived from the terms "monogamous" relationship or "my boyfriend" as they imply feelings of safety, trust, and exclusiveness. However, these words do not necessarily translate into "really knowing" their sexual partner, as many of them engaged in sex without the aid of a condom in relationships of less than three months. This perception of being in a mutually-exclusive relationship equates to trust, and thereby, false perception of safety from HIV-infection.

Both racial/ethnic groups demonstrated with equal frequency that being in the *Spur of the Moment* to have sex was another reason for failing to employ condoms when engaging in sexual activity. There is a strong suspicion, however, that many other

respondents would have admitted to being a victim of the *Spur of the Moment* phenomenon had the question been posed directly to each one of them. In other words, it is believed by the researcher that most of the respondents, if not all of them, would have admitted to practicing unprotected sex, at one point in their sexual history, because of being in the "heat of the moment." Though this is an unwelcome response, it is, nonetheless, a reality that requires further investigation, and certainly needs to be incorporated in the HIV/AIDS messages for women of all age groups.

Getting Tested was discussed by three African-American females and one Latina participant, La Chingona, as the explanation for not using condoms. Many of the participants believed that by the mere act of talking about getting tested they assumed safety, and that getting tested is a form of prevention from contracting a sexually transmitted disease, even though a person can apparently become infected after getting tested. La Chingona stated, "Try to go get tested right away because I'm not really into using condoms. As long as you get tested, it would be okay." In addition, for those who believed that their partner has been tested without proof or certainty, they were again relying on the concept of trust. A case in point is with La Chingona who admitted to having a positive STD test, but failed to inform her partner of the results.

Conversely, concerns regarding *Condom Availability and Adversity* were evident among the Latina group, but were briefly mentioned by only one African-American female. Issues regarding condom availability were an expected response, but adversity to condoms was an unexpected theme that occurred among the Latina females in how they viewed condoms as being a foreign object, as improperly fitting on the male partner, or as decreasing sexual performance. Perhaps *Adversity to Condom Use* is a cultural

phenomenon that is unique to the Latino group. A future research implication is an assessment of the Latino male perception on the use of condoms.

Essentially, this sample, as a whole, identified *Condoms* as a form of safe sex; yet, *Myths in Practicing Safe Sex* continue to prevail in many of the participants' perceptions, attitudes, thoughts, and behaviors. More perplexing are the reasons that were provided as to their motivation in not using condoms. The four most visible themes—*Monogamous, Mutually-Exclusive Relationship, Spur of the Moment phenomenon, Getting Tested, and Condom Availability and Adversity*—seem to be build on two intrapersonal constructs of trust and impulsivity that lay dormant until the opportunity arises and becomes manifested in interpersonal relationships. Implicit in these themes of being in a mutually-exclusive relationship and getting tested is an underlying sense of trust that these participants seem to place on their partners. Specifically, the notion of infidelity does not occur after getting tested or of being in a presumably monogamous relationship is misleading. The impulsivity is also evident in the other two themes of being in the spur of the moment and accessibility to a condom. Being impulsive prevents considering the consequences associated with sexually risky behavior. Rather than resorting to the popular adage incorporated in the present prevention campaigns of "use a condom," the intrapsychic-oriented root, trust and fear of thinking about the adverse, long-term consequences (impulsivity), is undoubtedly associated with risky behavior and, therefore, needs to be integrated into the HIV/AIDS messages and prevention campaigns.

A future research implication in this area is to examine a possible relationship between family dynamics among African-American and Latino families, and adolescent behavior. African-American and Latino cultures tend to possess more conservative

values, whereby an authoritarian style (Baumrind, 1991) that is typically dictated by a male figure, and who is seen as head of the household, can have an oppressive-style effect. Since this family dynamic, where rules are automatically adhered without question, indirectly and unwittingly evoke a sense of trust in male-dominating figures among the female adolescents in the family. This is a habitually learned, albeit implicit, tendency to trust and may be carried over to the adolescent's sexual relationships. In other words, is there a relationship between being raised by a domineering male figure and the adolescent's sexual conduct with her sex partner?

Hypothesizing that the relationship between specific types of culturally-driven family dynamics and an adolescent's sexual behavior, this will direct the type of HIV/AIDS prevention campaign. Psychoeducating the Latino and African-American parents about various parenting styles, and the effect it may have on their children, will aid in increased communication with their children and develop sensitivity to their emotional development.

Summary of Communication Patterns with Sex Partners

Direct and poignant conversations that solely centered on HIV/AIDS failed to materialize among this sample of females. It seems that HIV/AIDS is disguised in several contexts. Two of the more prominent contexts included *Getting Tested* and *Newly Acquired Information about HIV/AIDS.* There are several assumptions operating under this theme of *Getting Tested*, one of which is the act of getting tested. The mere behavior of obtaining a STD test presupposes a form of safety measure that neither partner will be susceptible to being HIV-infected after receiving their supposedly negative HIV results. This is simply untrue in that transmission of HIV, or any other

STD, is possible whenever condoms are not used because of the possibility that either partner may be engaging in at-risk behaviors (e.g., engaging in sexual encounters with another partner or using contaminated intravenous needles). Another erroneous thought is that "getting tested" or getting "annual check ups" or simply getting blood drawn because of other related medical concerns assumes that antibody HIV ELISA test is included. However, a typical "annual check up" includes a breast exam, a pelvic exam, and a Pap Smear test to rule out cervical cancer, gonorrhea, chlamydia, and human papillomavirus (HPV), but it does not include testing for treponema pallidum that causes syphilis, herpes simplex virus that causes herpes genitalis, HIV, and hepatitis B and C. Goddess, for example, was under the assumption that she was aware of her HIV-status, but in fact, she remained ignorant. A third, yet more subtle, assumption is that even when STD tests have been sought, and then briefly discussed with their partners, talking about the actual, or being truthful in disclosing, results of the tests are separate social constructs that are invisible to the partner. In essence, HIV/AIDS is not necessarily addressed directly, but it is implied when *Getting Tested* is mentioned, but the act or the discussion of *Getting Tested* as in the cases of many of the participants is wrought with erroneous assumptions that have led them to believe that they are safe from infection, that annual gynecological check-ups include all STD tests, including HIV, and that the truth of the results would be disclosed.

Other contexts, specifically *cheating* and the notion of *Perception of Relationships as being Insignificant,* were the other derived themes. Discussion of HIV/AIDS or STDs, in general, is connected with the notion of infidelity. Vixen's

narrative regarding her former partner who admitted to "cheating" on her on two different occasions is not only disconcerting, but it is also deeply flawed:

> Vixen: "If I knew he was cheating on me, then I would be like, 'Hey. Who have you been with, and did you use condoms or any type of protection?' I just went through that recently. I found out that the guy that I was talking to had slept with somebody else. I was hurt, really shocked. He had told me, 'Yes, I used a condom.' I said, 'Oh, did it happen only once?' 'No, it happened twice.' 'Did you use it both times?' 'Yes,' because I guess he knew the girl but really didn't know her. I was like, 'Oh. It's like that?' I kind of got scared, but I was happy in a way that he had the decency to actually use a condom because he had been with me and he didn't, we never used to, but that didn't last very much longer just because it was on my mind."

Vixen's thought processes are wrought with assumptions. The first, and most obvious, is that she assumed her former partner disclosed the truth regarding the use of condoms on those "two" occasions. There is a possibility that he may have been dishonest in regard to using condoms, given that he did "cheat" on her. The other supposition is that her partner had used a condom at the immediate onset of engaging in all sexual activities. Condom use, however, is rarely considered when engaging in oral sex, and yet were condoms used at this time? Condoms are employed at various stages of sexual intercourse and during different kinds of sexual acts. For example, the male partner may penetrate his partner without the condom at the onset of penile-vaginal intercourse, but then decide to put a condom on during mid-session, or he may use a condom for vaginal intercourse or anal sex, but not one for oral sex. It seems that this level of detail regarding his sexual encounters was not revealed to her.

In addition, *Cheating* and *Perception of Relationships as being Insignificant* seem to correlate with the construct of trust. In other words, the degree of trust established in the relationship seems to be correlated with when or if the topic of HIV/AIDS occurs. In

one instance, "one-night stands" that evoke meaningless, emotionally detached sexual encounters is not a sufficient motivation to initiate a discussion that is emotionally-laden and content-loaded like HIV/AIDS. In another instance, however, once the relationship has been established in the context of monogamy, the idea of infidelity ignites conversations centering on topics including STDs, getting tested, and HIV/AIDS. Essentially, communication patterns among this sample of female participants are more complex than expected, suggesting that more in-depth studies that focus on the concept of trust and HIV/AIDS are needed in order to ascertain the art of communication in these target populations.

Three themes were identified for the motivation to increase communication with partners: (1) *Forums that are Dialogue-Oriented, Personal, and Candid,* (2) *the Need to Increase Feelings of Comfort and Safety, and* (3) *a Personalized Scare Tactics.* These themes, at first glance, seem contradictory, but on further examination, these themes give a more complex response about the ways to increase communication skills. The seemingly competing themes between *Personalized Scare Tactics* and *the Need to Increase Feelings of Comfort and Safety* are comprised of a fundamental emotion of fear that is going in diametrically opposing directions and is highly integrated in these participants' perceptions and experiences. Interestingly, extant research on anxiety and performance show that moderate levels of anxiety are needed to attain optimal performance. Could the same principle be applied to generating meaningful messages that have a greater utilitarian impact on communities at risk of infection? Could the messages have a component of content that elicits fear, such as, HIV does lead to death, but yet also include it with a sense of hope that prevention is the key to preventing death?

Furthermore, when delivering these messages, the participants are informing the research communities of the need to be honest and candid in the delivery of knowledge. Lastly, an important research implication based on this study is in the area of assessing and determining what types of HIV/AIDS-related messages produce fear and to what extent. Messages that evoke moderate levels of anxiety can then be added to the prevention campaigns.

Bertrand, O'Reilly, Denison, Anhang, and Sweat (2006) recognized that there is a call for more evidence-based communication programs as it is at the heart of the HIV/AIDS response. Though there are extensive studies on parent-child communication (Bertrand et al., 2006; Durant, Wolfson, LaFrance, Balkrishnan, & Altman, 2006; Fasula & Miller, 2006), there is a lack on the studies about the ways adolescents communicate with each other about safe sex practices, including methods and reasons to prevent STDs, including HIV. Three participants, in particular, described ways they address sensitive sex-related topics with their partners, and perhaps can be applied to communication-skill building programs in practicing safer sex. Poet explained her approach in addressing her STD status to prospective partners by using a "screening" technique.

> Poet: "It's uncomfortable for me as a person that has herpes, especially, if I haven't told the person yet. If we are sitting there and were watching TV and we're cuddling and this woman comes rowing a boat and talking about, 'Before Valtrex, my herpes just took over my life. Now it's not such a big deal.' That is some bullshit. It is still a big deal even with the Valtrex. That is still some 'BS." There's no lighthearted way to deal with it. Usually the way that I do it is, I talk to the person and say, 'Hey, you say you like me and you know all this stuff. Think about this. This is a really great question. Don't give me any silly little answers. If there was one thing, not one thing, but what things could you find out about me that would make you say, in spite of all your good qualities, I just can't mess with you?' And usually they'll say, "If you jealous or if you are a liar." I say, 'No, I'm not talking about this. I'm talking about real world wide stuff like if I was

> a psycho, if I was abusive, if I was a habitual liar, if I like to set stuff on fire, if I liked to steal from people, if I just went crazy, if I had an STD, and I would bring something after that so I wouldn't leave it at that.' I let them pick out those things and I don't leave it at just the way I said it, 'If there's anything you can think of along those lines like if I like women or stuff like that. Real life stuff that people actually do but you really don't think that happens to people that you know but they may happen behind closed doors because if you find out about these things, how would you feel? Which of these things or anything else that you can think of have you not thought of in spite of all of the good things that you know about me?' And if they say the herpes, then I know where to go. I know that's the way of me, kind of doing, kind of like doing an interview without them knowing."

La Chingona illustrated the use of a "truth and dare" approach, even though she was less than truthful to her partner.

> La Chingona: "I would play a lot of truth or dare with this third boyfriend I'm with, and that was just one of the questions, but we played this game before we got tested for STD's so after that I never really told him, after I found out, we were already talking as friends, but we hadn't had sex, so I was really happy. Thank God we hadn't had sex before I got checked. So I told him, 'I'm gonna go get checked or whatever,' and I never told him the results, it just never came up, he just knew I was tested." [Investigator: "Do you think that truth and dare, that kind of game is a good idea in terms of a way to find out information about another person."] Yeah, it is cuz we were really honest about each other when we were playing that truth or dare. It was not until after I got tested that I decided not to tell him, to keep it to myself. Anyways I told my roommate, ' It's none of his business anyways,' It's not like I'm going to give it to him. I'm gonna cure it, make sure that I'm fine, use condoms until everything's fine, but yeah that worked out real good, that truth or dare game. We asked so many daring questions, it worked out real good."

La Chingona's admission that she refrained from informing her partner the truth of her STD status is indicative of the lapse in communication. Furthermore, the way the late-adolescents believe that their level of communication immediately implies honesty is erroneous, and certainly is not a sufficient measure of protection again HIV infection.

Tinay candidly admitted that directly addressing sensitive topics, such as STD, is often masked under a quip comments and sarcasm.

> Tinay: "Actually I haven't talked to any of them, maybe except for the guy that was my boyfriend. We would make jokes about other people, not joke about them, but you know like, 'Oh that would never happen to me,' kind of pushing it off to the side, make light of the situation. Basically not joke about it if we ever talked about it which was pretty much rare. We don't usually get into it that deep of a STD, but we'll talk about syphilis and all that type of stuff. Even with my friends, we would joke. If my friend had a cold sore, we would joke, 'Ahh, you got syphilis.' We just make jokes about STD's, but we don't talk that much about it. I don't ask anybody, 'Do you have anything like that?'"

Though Tinay's comments seem less than effective in communicating topics on STDs and HIV/AIDS, she was, nonetheless, able to discuss it with her friends in the form of humor. Humor can be implemented in communication-skill building programs as a method of broaching a seemingly "uncomfortable, content-heavy," topics.

The use of a "screening" approach to assess whether or not the partner is willing to discuss STDs by employing a "truth or dare" technique that allows for an honest, yet non-threatening, conversation to ensue, or integration of age-appropriate humor are techniques that could be included in future programs that focus on communication skills-building.

Utility of Evaluating HIV/AIDS Message

The purpose in evaluating past and present HIV/AIDS messages is to ascertain the kinds of, and the extent of, messages understood from the past, and grasped in the present, as well as to determine its effectiveness over time. The examination of these messages will aid in deciding more appropriate and effective prevention campaigns geared to the populations, specifically the African-American and Latina female communities, that are disproportionately at-risk of HIV infection.

The HIV/AIDS messages have shifted focus in the past two decades. According to Bertrand et at. (2006), previous efforts using mass media focused on increasing HIV-awareness, modes of transmission, and means of prevention. Yet, another study cited that these early prevention efforts that used knowledge-based sexuality education were found to have little impact on adolescent sexual behaviors (Durant, Wolfson, LaFrance, Balkrishnan, Pharm, & Altman, 2006). In this sample, *Promotion of Condom Use,* has been a continued theme, which five African-American and five Latina females, while only two African-American and six Latina females, mentioned this theme as a past and a present HIV/AIDS message, respectively. A significant change is that there was no discussion of *Familiar Past Messages that emphasized HIV being a "gay, IV-drug disease"* as a present message. The participants' perceptions are consistent with the evaluation of early intervention and prevention efforts, which focused almost exclusively on white gay men and injection use (Prather, Fuller, King, Brown, Moering, Little, & Phillips, 2006).

Another significant shift in the types of messages is in the area of the *fatality of HIV.* Six respondents asserted that HIV will, eventually, lead to death as a past HIV/AIDS message, while five explained that being HIV-infected led to confusing results in that mortality and quality of life were dependent on socioeconomic status and access to health care. *Promotion of abstinence and concerns of pregnancy* were issues of the past, but have less weight in the present day and age. Topics, *Getting Tested* and *Infidelity*, were in the context of present HIV/AIDS message, but not in respect to the past.

Upon evaluating the efficaciousness of HIV/AIDS messages over time, 47% of the total number of participants reported that the *HIV/AIDS Messages Increased in Prevalence and in Relevance*, but specific mention of HIV, as being relevant to the targeted population, was discussed by only one Latina female participant, Butterfly, as evident in the following excerpt:

> Butterfly: "Yeah, they are very different. I think that they affect those kind of messages affect you more when you know that it's within your community. If there's things that you know that relate to your community, I guess that's because that article was on a Latina women, who was married. I guess that's why it affected me more because you know, it was someone that was from my community, from my background, from my cultural values."

The other participants discussed how the messages occur with greater frequency and convey that "everybody can get it." Yet, there were more Latina females (16%), compared to their African-American counterparts (11%), asserting that there was no difference, while additional 11% of the total number of participants reported that there was a decline in the effectiveness from past to present HIV/AIDS messages. Spirit, for example, explained that the prevention efforts focused on the perception that those who are HIV-infected are able to "live" with the disease, thereby implying a precedence of complacency has been set in practicing safe sex.

> Spirit: "And then look at some of the messages that they say now. It kind of seems like you don't even, I don't even, think about it as much as I used to."

In total, approximately 36% of the sample explicitly stated that the effectiveness of HIV/AIDS messages across time had little to no positive effect. The results from this study were reiterated by Fasula and Miller (2006) who concluded from a meta-analysis of intervention evaluations that current programs are often ineffective in encouraging

adolescents to delay intercourse. Koenig and Clark (2004) argued that the general population, at large, does not respond to prevention messages. They further asserted that prevention messages and programs that emphasize standard communication and condom skills-building interventions are less effective for those who have a history of child sexual abuse (CSA). This begs the following question: What types of interventions or messages would have a more meaningful impact on the attitudes and behaviors of populations at risk of HIV-infection?

The next research topic for this study identified themes obtained from the participants' perceptions on ways they feel would have greater practical and functional messages to increase consistent condom use and HIV-awareness. Overall, the themes appeared similar, but the degree of emphasis varied, among the two racial/ethnic groups. Approximately half of the total number of participants (53%) advocated for more messages focusing on various issues surrounding *Condom Use*, but more Latina (37%) compared to the African-American (16%) females placed emphasis on this issue. The results suggested that the topic on condoms needed to be addressed in future prevention messages. Both racial/ethnic groups, however, promoted increased access to free condoms need to be part of prevention campaigns in both colleges and high school settings. Another concern associated with condom use is the social stigma in purchasing condoms and the physical aspects of condom use (e.g., irritation or the correct size of condom). Prevention campaigns, therefore, need to incorporate the implicit problems associated with access to, and the use of, condoms.

Another theme, *Direct, Fact-Based, and Honest HIV/AIDS Messages*, were mentioned by approximately half of the total number of participants (53%), an aggregate

of 32% of the Latina and 21% of the African-American females. Several respondents demanded that there is a need for more "in your face" messages that do not "sugar coat" the long-term consequences of being HIV-infected, and be more explicit in detailing the biological mechanism in the transmission of the virus and in the physiological impact on the body (e.g., various forms of sex acts and how the virus transmitted). Furthermore, the messages need to be more relevant to the populations at risk, which was echoed by many of the participants. Bertrand et al., (2006) recognized that the mass media campaigns to date have primarily focused on members of the general public, but not on other high-risk populations. An implication drawn from the results of this study, as well as the literature, is that prevention messages need to consider televising—in documentaries, public service announcements, daytime talks shows (e.g., El Show de Christina, The Tyra Banks Show, or The Opera Winfrey Show) that cater to specific ethnic groups (e.g., Black Entertainment Television and Spanish-language television), evening news specials (e.g., 20/20 and Dateline)—young females of African-American and Latino/Hispanic/Chicano heritage who appear healthy, yet contend with the social, medical, and psychological complications of being HIV-infected. Essentially, these images of young women diagnosed with the virus must be visually present in various forms of mass media on a continual basis, not just merely for a "one-night" television special. This specific prevention campaign would effectively attend to the needs of the populations, specifically late-adolescent African-American and Latina females.

Empowerment was an equally important theme that was mentioned by 47% of the total number of participants. Furthermore, both racial/ethnic groups equally resonated with this theme with an emphasis on the following areas: (1) the approval need not come

from external sources, such as their female peers or male sex partners; (2) women should not be faced with the double standard of carrying a condom, where they are perceived as "sluts" or "whores;" (3) women of all ages have the intrinsic right to speak up when sensing discomfort as in the case of Tinay or to ask questions without judgment; and (4) young females must be more future-oriented with regard to their personal, vocational, and educational goals, which will help them deliberate over the long consequences connected with their impulsive behaviors. Generally, there is a call for HIV/AIDS prevention campaigns to convey a clear message as Morning Star succinctly stated, "We care, you deserve to live, you should care too." An intrinsic assumption is that both intervention and prevention efforts should incorporate self-esteem enhancement programs, but empirical studies suggest otherwise.

Several studies have focused on understanding the relationship between self-esteem and risky sexual behaviors among adolescents (Biro, Striegel-Moore, Franko, Padgett, & Bean, 2006; Ethier, Kershaw, Lewis, Milan, Niccolai, & Ickovics, 2006; Goodson, Buhi, & Dunsmore, 2006; and Upadhyay & Hindin, 2006). A common belief is that self-esteem has been related to a host of sexuality-related factors (Goodson et al., 2006). With regard to cultural variance, Biro et al., (2006) showed self-esteem in the area of physical appearance declined by the age of 11 among Caucasian girls, but stabilized at the age of nine through fourteen among African-American girls. Yet, there seems to be contradictory evidence in the empirical association between psychological factors (i.e., self-esteem, depression, stress, and anxiety) and sexual risk among adolescents (Goodson et al., 2006). The study conducted by Goodson et al. (2006) canvassed 38 studies that examined the relationship between self-esteem and adolescents'

sexual behaviors, attitudes, and intentions. They found that self-esteem did not serve a protective effect for various risky behaviors, which they attributed to inconsistent operationalization and measurement of the self-esteem construct. Ethier et al. (2006) concluded from their study that adolescent females with lower self-esteem are more likely to have unprotected sex, while the same sample who reported as being emotionally distressed are more likely to have more multiple partners. They concluded that there is a significant relationship between self-esteem and unprotected sex risk behavior. Irrespective of the research findings, a recommendation not to place a high premium in incorporating self-esteem in the intervention and prevention programs were noted, especially since there is a gamut of other psychological factors to consider (Ethier et al., 2006; Goodson et al., 2006).

In reviewing the results of this study and the literature on self-esteem and risky sexual behaviors among adolescents, instilling empowerment does not necessarily correspond to having low self-esteem. They seem to be two different constructs that are worth empirically investigating. Is the type of content associated with *Empowerment* described by these participants similar to the wide-variety of measures attempting to tap into the self-esteem construct? Irrespective of the future outcomes on such prospective studies, these participants are clearly imparting a clear message that they need to feel comfortable and empowered to voice their thoughts and concerns, to seek approval internally, and be encouraged to contend thoughtfully with their long-term educational and vocational aspirations.

Another theme, *Getting Tested*, seemed to garner extensive attention from this sample, but little in the research community. Of the eight participants, five Latinas

compared to three African-American females, addressed a range of issues underlying the theme, *Getting Tested.* Specifically, both racial/ethnic groups explained that more information is needed to address several areas, including the promotion of, normalization of, and ways of getting tested. Health-related, medical-based tests geared for women should be discussed in the health-education programs at an early age, as early as elementary and middle school. The demystification of the assumptions underlying the concept of *getting testing* needs to be clear and accurate. The fact is that gynecological exams do not include all STD tests, or having blood drawn does not automatically screen for STDs. Finally, a thoughtful message should also address infidelity and other potential risks involved after obtaining the presumably negative results from the HIV-test. Specifically, sexual or drug-related behaviors that place those at risk for infection is a seemingly apparent issue once being tested, but it seems it is less apparent among this sample of participants.

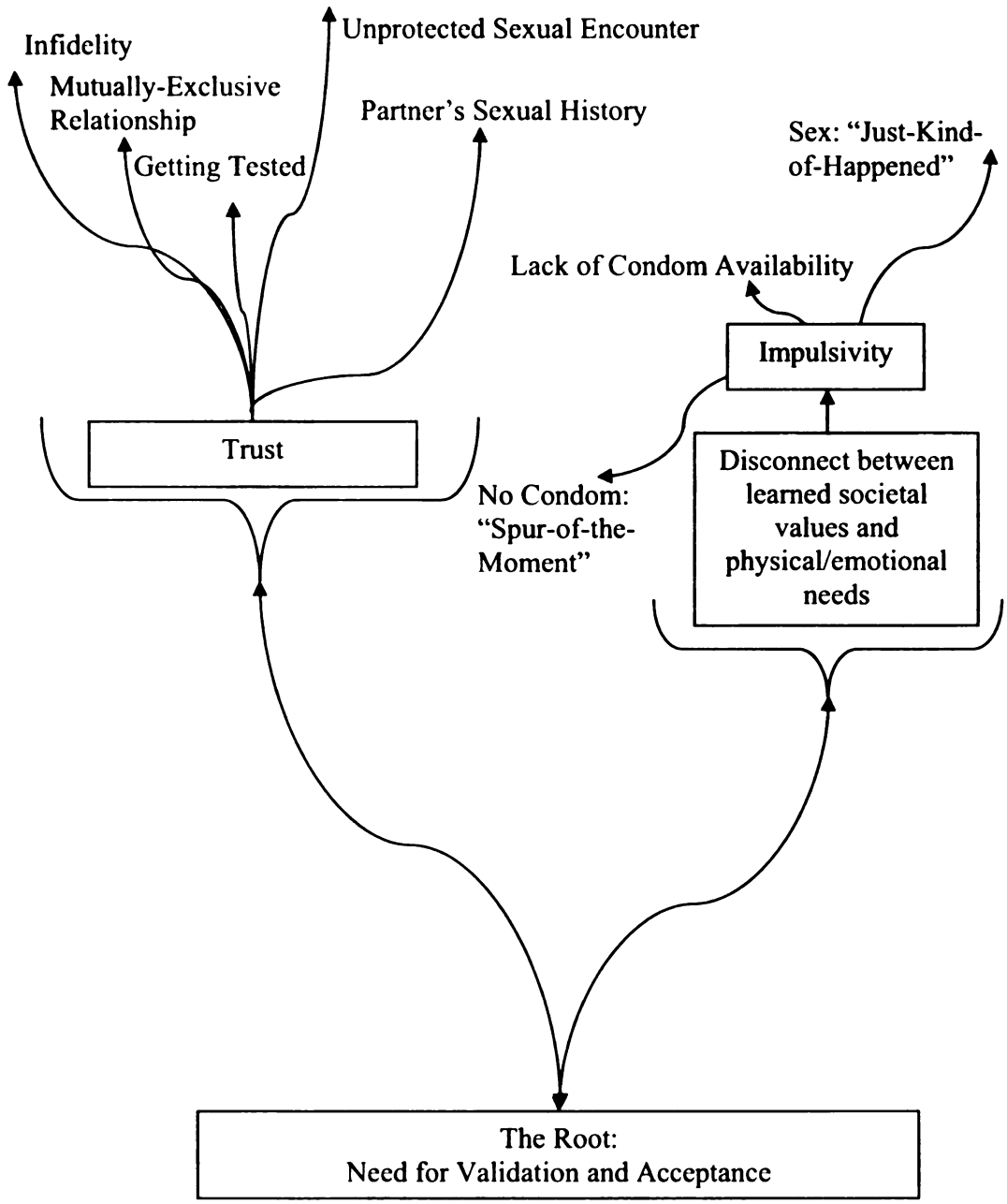
Conceptualization of the Themes: The Big Picture

The plethora of themes garnered from the following major areas of this study is analogous to the pieces of a jigsaw puzzle. Curiosity intrinsically asks the next level of inquiry: what big picture will emerge from the jigsaw pieces, that is, from the themes? Figure 1 illustrates the configuration of the key themes in explaining how the participants' need for validation and acceptance is the primary root, which moves them to engage in a variety of sexually risky behaviors. This primal need intrapsychically triggers two cognitive-oriented defense mechanisms: 1) the *trust* mechanism in which the individual will instill trust in several behavioral and cognitive domains, including "getting tested", being in a mutually-exclusive relationship, believing the partner's

disclosure of his sex history, and remaining monogamous, while relinquishing control of one's body and behaviors; and 2) the *disconnect* mechanism in which the individual experiences disconnect between her emotional need to be validated and her internalized familial values which are culturally-situated in a larger systemic sphere. There is also a *disconnect* from the long-term consequences of her sexually risky behaviors and her future outlook. This disconnect then activates impulsivity in the individual, which accounts for such phenomena, including it "Just-Kind-of-Happened" when describing how these participants engaged in a sexual encounter, and lack of condom availability and the "Spur-of-the-Moment" to explain why these participants did not use a condom. The need for validation essentially is the root that branches into the two limbs, or cognitive defenses, and then into smaller branches, which is the analogy of various sexually risky behaviors. These cognitive-oriented defense mechanisms serve to manage discomforting feelings of anxiety, shame, and embarrassment, especially when the individual's primal need for validation and acceptance triumphs over external messages, for example, to practice safe sex.

Figure 1

Conceptualization of the Themes: The Primal Motive and Its Effect



In the R*eview of the Literature* chapter, existing theoretical models, such as the Theory of Planned Behavior and the Information-Motivation-Behavioral Skills Model, were under assault primarily because they failed to account for the social and environmental factors that impact young women's lives and safety (Wingood & DiClemente, 2000), while mainly attending to the cognitive-oriented, individually-driven, and intrapsychic influences, such as the construct of self-efficacy. Ironically, the conceptual figure derived from the data analysis of the females' experiences and perceptions in this study ostensibly aligns with cognitive-oriented, intrapsychic framework, the very concepts that were under attack. However, upon greater scrutiny, the intrapsychic and cognitive forces are not the same when comparing the models of the past and with the present figure. In fact, the concept of self-efficacy is irrelevant in the present model and instead addresses more salient concerns for these participants, which is the their need for validation, ability to trust in others, and mechanism to detach emotionally from her social environment, her long-term goals, and from the consequences associated with risky sexual behaviors. The concepts that make up the "intrapsychic" forces and "cognitive" mechanisms are conceptually different and may better able to account for the wide variety of complex and intersecting antecedent factors of sexually risky behaviors among adolescents, but also explicates the rationale and motives for late-adolescent African-American and Latina females to place themselves at risk of infection.

Furthermore, this conceptual model has been proposed to complement the Theory of Gender and Power. Figure 1, for example, focuses on the intrapsychic forces that operate within the individual and in relation with others, while the Theory of Gender and

Power account for the environmental context in how the cognitive and emotional mechanisms operate within the individual as well as in the behavioral and interpersonal domains (e.g., getting tested, being in a mutually-exclusive relationship). The Theory of Gender and Power primarily focuses on the gender inequality manifesting itself in power imbalances, and it consequently may affect women's ability to navigate through social and sexual environments. The theme, *External Pressures and Threats*, experienced by this sample of female adolescents as their explanation to engaging in often unwanted sexual activity is a critical example that can be part of the Theory of Gender and Power. Prather et al. (2006) summarizes the Theory of Gender and Power by illustrating the construct of imbalance and how it can account for a woman's willingness to adopt and maintain sexual risk reduction strategies within heterosexual relationships as it pertains to her perception of power, her commitment to the relationship, and her role in the relationship.

As previously cited, the extant literature on HIV/AIDS among adolescents and minority women indicated a need for more gender-appropriate, age-specific, and culturally-relevant HIV/AIDS prevention programs that have greater utilitarian impact on such communities that are at high risk of HIV-infection. Practical implications that will support in spearheading a more effective HIV/AIDS prevention program ensue in the following section.

Practical Implications: New and Improved HIV/AIDS Prevention Campaign

To tackle the "What, When, and How" questions regarding HIV/AIDS prevention programs, this section will identify the "what" of the messages by listing several new content domains that should be considered, the "when" of the messages by addressing at

what grade level relevant information should be discussed, and the "how" of the messages by explaining better ways of delivering the information. Concentrating on these critical questions will create meaningful prevention messages that hopefully will translate into positive behavioral changes.

"What" of the Message: Content

Knowledge, alone, does not necessarily translate into safer behaviors as evidenced by the majority of the respondents who had the knowledge of the various modes of HIV transmission, and yet did not practice safe sex consistently. Furthermore, each one of them has placed themselves at risk of a STD at some point in their sexual history. In addition, approximately 37% of the total number of participants in this study stated that HIV/AIDS prevention messages had little to no positive effect. Though inaccurate perceptions of blood transfusion as a common mode of HIV-transmission may linger in the minds of these participants, more current and accurate information on the modes of transmission is needed by directly addressing that blood transfusion is no longer a threat of transmission. The message needs to place greater emphasis on the fact that heterosexual contact, especially among women and adolescents, is the primary means of HIV transmission. Identifying and discussing discrete sexual acts (e.g., cunnilingus, fellatio, and anal sex), another content area, needs to be addressed as studies show that condoms are used inconsistently and during different sexual behaviors. As previously stated in the literature review and in this study, condoms are used with less frequency during oral sex than penile-vaginal penetration and anal sex. Cultural values regarding sexual practices need to be incorporated when talking about the noncoital sexual behaviors, as it may have negative connotations in the Latino culture.

The majority of the participants, even those who reported being sexually involved with fewer than four partners, fell victim to engaging in sexual encounters under the guise of the "*Just-Kind-of-Happened*," phenomenon. In addition, being in the *"Spur-of-the-Moment"* and *lack of condom availability* were the participants' explanation for not using a condom during a sexual encounter. Underpinning these themes is the construct *impulsivity*, which in turn, is triggered by the activation of *disconnecting* between their emotional needs and family values that are situated in a culturally systemic set of norms and that have been learned over time. Practical implications suggest that HIV/AIDS prevention efforts need to impart a clear message that female adolescents need to be more insightful and future-oriented about their vocational, educational, and personal goals.

Being in a mutually-exclusive relationship, getting tested, implicitly believing in knowing the partner's sexual history, and questioning the fidelity of a relationship are subsumed under a broader category, *Trust*, whereby the participants entrust themselves into these specific cognitive and behavioral domains while relinquishing personal control. Greatly needed are future prevention campaigns that create skill-building programs that focus on ways to increase more accurate levels of trust in a sex partner and on better methods of appraising their own reasons for entrusting themselves to others.

Prevention efforts need place greater emphasis on the psychosocial construct of *Getting Tested.* Sex-based curriculum must increase awareness in the following areas: 1) demystifying the assumptions underlying *Getting Tested,* 2) obtaining medical facts about each of the tests taken during an annual gynecological exam; 3) learning about logistical aspects of *getting tested* such as accessing free HIV tests; 4) overcoming fears and anxiety associated with *getting tested*; and 5) communicating to the partners the

results of the tests. Prevention programs, for instance, could include role-modeling ways to discuss the topic of *getting tested* with friends and with sex partners, or promote *getting tested* as a *couple-oriented activity*, in hopes of placating fears and anxieties of getting tested. Lastly, prevention programs must convey a clear, yet succinct, message that getting tested is not indicative of lacking trust in the relationship, and instead, can be associated with a more neutral concept of being health conscious.

Lastly, the participants collectively stated that there is an urgency to address topics associated with condoms: 1) accessing, addressing the social stigma of purchasing, and using condoms; and 2) increasing messages of empowerment for women and young females by having them feel safe in speaking up, by not having a double standard in carrying condoms, and by asking questions without the fear of being judged. Their suggestions are congruent with the observations made by the researchers in that the content, or the "what" of the prevention programs, must center on critical areas including 1) accurate and current information about transmission of HIV; 2) empowerment messages that help them to be more future-oriented and to instill less trust in others while having more trust in themselves; and 3) relevant topics associated with getting tested and with accessing and using condoms.

"When" of the Message: Grade Level

Given that approximately half of the adolescents by the age of 14 engage in penile-vaginal intercourse, sex-curricular programs directors and parents, alike, must consider disseminating critical topics (e.g., the complex nature of sexual behaviors and feelings, condom use, and HIV testing) as early as fourth grade and for each subsequent year thereafter that is grade-appropriate. Essentially frank discussions offered by both

the public school systems and parents on socially-sensitive topics are one of the avenues to halting the spread of HIV.

"How" of the Message: Ways to Deliver Relevant Information on HIV/AIDS

According to the participants, needing more "in your face" messages that do not "sugar coat" the impact of the disease is needed in future prevention campaigns. They are asserting that there are insufficient levels of fear to motivate them to practice safer sex. The results of the data analysis also suggested that programs need to teach adolescent females how to communicate with their partners on obstacles associated with addressing HIV-topics. Specifically, perceiving a sexual relationship as being insignificant impeded these participants to initiate a "heavy-loaded topic."

Prevention efforts also need to attend to helping young women managing their anxieties associated with carrying, purchasing, and using condoms as well as negotiating more effectively the ever-present external pressures, while seeking a greater sense of internal validation. Literature shows that one of the sequelae of child sexual abuse is dissociating. The dissociative process occurs during the actual sexual experience and continues into their adult lives in various behavioral and cognitive arenas, such as when information on HIV is being imparted. Prevention efforts need to take a closer look at how facilitators can assess for dissociation and to implement Gestalt-like techniques that help the female adolescents to stay in the here-n-now so that they are able to make more thoughtful, informed decisions. Perhaps to capture the targeted audience's attention more effectively, programs might also incorporate a gender-appropriate, age-specific, culturally-relevant lexicon of colloquial terms with which they can identify (e.g., The *Wooed-Effect, Spur-of-the-Moment, Just-Kind-of-Happened).*

Finally, HIV/AIDS prevention programs need to instill more interactive, dialogue-oriented discussions that allow for increased communication between female teens and their parents as well as with their sexual partners and peers. Two respondents suggested the use of a "screening" approach or a "truth and dare" technique that allows for the initiation of sensitive, heavy-loaded topics in a cautious and non-threatening manner. In addition, sex-based education programs should consider including both the parent and the child in an open discussion, where fears are first discussed. Parents, for example, are given the opportunity to voice their concerns regarding the discussion of sex as a fearful topic, while the young teen among his/her peers simply listens. Conversely, the young teen voices her wishes in the kind of knowledge she want to hear from her parents regarding sex and information about sex-related topics. This open dialogue will breakdown communication barriers as well as address many of the myths associated with sex practices.

Limitations

Considering the limitations of a study is necessary. This research project is not impervious to the assertions made by Gelso and Feltz (2001) in that no one study is without its flaws. Employing a qualitative-based research design has three significant limitations, one of which is the reliance on a demographically-narrowed, non-representative, small sample size. Inherent in recruiting a small sample is the lack of generalizabilty to the population being targeted. Another limitation is the difficulty in replicating the results given that there is no set standard in analyzing the data. Also, the wealth of data in several domains (e.g., HIV knowledge, sexual practices, condom use, and HIV/AIDS messages) in an already complex, intricate subject matter (HIV/AIDS epidemic) makes replication of the results a strenuous and time-consuming task. A third limitation is the research-bias effect. This study relied solely on one researcher who was fully immersed in the data and consequently could have fallen victim to biasing the data. Though these limitations may have attenuated the merits of this study, this project at the onset clearly indicated that its primary purpose was exploratory in nature in hopes of providing a more fruitful direction in the application of HIV/AIDS prevention campaigns and innovative research directions. In light of the limitations and the data reviewed, the ensuing section details the direction of future research implications.

Future Research Implications: Where to Next?

There are approximately five research avenues that warrant further investigation. The first is differentiating the term *sex* into discrete sexual acts (i.e., cunnilingus, fellatio, and anal sex) in future research studies on HIV/AIDS and sexually risky behavior, given that condom use may vary from one act to another. For example, this sample alone

illustrated that 67% of the those who did practice anal sex did not use a condom, while 89% of the those who engaged in oral sex did not use a condom and 100% of the sample who engaged in penile-vaginal intercourse did not use a condom. Research may profit from investigating into the reasons, as they may fluctuate, in deciding when to use a condom during different sexual acts (Prinstein et al., 2003; Cornell & Halpern-Felscher, 2005). The data derived from this intricate level of inquiry would create more relevant and practical prevention efforts.

The second recommendation focuses on ascertaining future participant's child sexual abuse (CSA) statuses as there is sufficient evidence in the correlation between CSA and adult sequelae, specifically in having an increased number of sexual partners. More research is needed in identifying women who have experienced CSA and how it may have impacted their outlook, attitude, and behaviors regarding their sexual practices and their sexual identity.

Another related future research topic is based on the conceptualization of the themes (see Figure 1) and the two cognitive-oriented defense mechanisms, *disconnect* and *trust*, which serve to manage the individual's feelings of anxiety. The themes of *dissociation* and *trust* may speak to the literature on internal attributions and locus of control constructs. Can these multifaceted cognitive processes intersect and moderate in a way that may explain for the justification and rationalization of engaging in sexually risky behavior among adolescents females? More specifically, is there a relationship between external locus of control and risky sexual behavior? Could these findings help create more effective prevention in gearing the prevention campaigns to assist the disenfranchised and marginalized women to seek more internal locus of control?

Furthermore, these cognitive defense mechanisms may help account for approximately half of the respondents in this sample who were unable to identify at a personal and emotional level with the HIV/AIDS epidemic. Could these cognitive defenses be employed as a means to dissociate themselves from the possibility of being HIV-infected?

The fourth research topic continues in the area of *trust.* The construct of *trust* is a learned behavior that seems to be passed from parent to child. In this sample, there is evidence, based on this study, that traditional Latino families, where male-dominating figures that place emphasis on compliance teach their children to intrinsically trust men. Could this intrinsic tendency to trust men be translated into their sexual relationships, where they are encouraged not to ask questions and simply comply? Cross-cultural studies among various racial/ethnic groups that come from a wide range of parenting styles may garner rich data in how compliance and trust are implicitly intertwined and become manifested in risky sexual behaviors. Present research on the relationship between self-esteem and associated behavioral problems are inconclusive. Perhaps the underlying construct in explaining an adolescent's behavior is not necessarily with regards to self-esteem, but issues of the learned behavior of implicitly trusting older men. This trust may account for the power and control issues in the female teen's relationship with her parents and in her sexual partners.

The fifth research recommendation is examining a potential relationship between types of messages (e.g., One can live with AIDS versus one can die from AIDS) and the degree of fear the messages elicit. Based on the data, participants suggested that there is a need for more fear-enhanced messages to motivate them to discuss sensitive topics,

while simultaneously having a need to feel safe when addressing HIV/AIDS to the prospective sexual partner. Given the conclusive results that moderate levels of anxiety educe optimal performance, perhaps the same principle may be applied to ascertaining the types of messages needed to evoke moderate levels of anxiety in order that positive behavioral change (i.e., consistent condom use) ensues.

In summary, delving in the minds of African American and Latina late-adolescent females was a complex journey in an already complex topic on HIV/AIDS prevention. Creating and implementing more effective messages and recommending new avenues of much needed research are equally complex. Though this study has contributed to the body of HIV/AIDS prevention in providing concrete prevention messages and elucidating the intricate, cognitive mechanisms that account for the reasons and behaviors of these adolescents' sexual behaviors, seemingly insurmountable obstacles continue to persist. Behavioral change at the individual level, specifically having adolescents increase consistent condom use, requires funding and intense levels of cooperation and communication between and through several spheres including federally funded agencies, policy-makers at both the state and the local levels, sex and health curriculum committees, communities, parents, peers, and the individual. Tenacity, education, collaboration, and funding at all levels are necessary components to halt the spread of HIV/AIDS.

APPENDICES

APPENDIX A

FLYER

DID YOU KNOW?

- Heterosexuals who are between the ages of 15 and 24 are MOST AT RISK for contracting HIV/AIDS infection
- Among 20- to 24-year-olds there were 19,997 AIDS cases and 11,818 others known to be HIV-positive, most of whom probably contracted HIV as teenagers
- African-American adolescents are at a vastly disproportionate risk, as they currently account for 37% of persons diagnosed with AIDS between the ages of 13 and 29 years
- AIDS incidence in 2000 for Latino people was 22.5 out of 100,000 people, a figure that is approximately three times the rate for Caucasian people (i.e., 6.6/100,000)
- HIV is more likely to be transmitted from men to women than from women to men

WHAT CAN WE DO ABOUT THIS EPIDEMIC?

We are interested in finding more culturally appropriate and gender-specific prevention campaigns against the spread of HIV/AIDS. Exploring your perceptions and understanding on HIV/AIDS-related topics will guide us in creating a more relevant prevention message uniquely geared toward African-American and Latino female late-adolescents. Hence, you are invited to take part in this innovative research study to explore your perceptions on several related topics concerning HIV/AIDS: meaning of sex, protection against HIV/AIDS (e.g., use of condoms), communication barriers to condom use, and your thoughts on existing HIV/AIDS prevention messages. The semi-structure interview will be in a one-on-one, face-to-face setting.

WHO CAN PARTICIPATE & WHAT'S INVOLVED?

- If you are:
  - ✓ African-American/Black or Hispanic/Latino/Chicana
  - ✓ Female
  - ✓ Ages: 18–22
  - ✓ Heterosexual

  You are eligible to participate in this project
- You will be asked a set of open-ended questions about your health, HIV testing, sex practices, communication barriers to condom use, and your thoughts on existing HIV/AIDS prevention messages. The interview will take about 90-120 minutes. The interview will take place (time and location) that is convenient to you.
- Participants will be given $15.00 **as** a form of gratitude
- Privacy and confidentiality are insured.

WHO TO CONTACT?

If you are interested in participating and/or inquiring more about this project please feel free to contact me. Callie Bair, M.A., LLPC at baircall@msu.edu or 517-282-4297

APPENDIX B
SCRIPT

SCRIPT

Introduction and Purpose of the Study

Hi, my name is Callie Bair, and I'm a fourth year doctoral candidate in the Counseling Psychology program.

You have been invited to participate in this research project that will explore YOUR perceptions and YOUR experience on several topics related to HIV/AIDS

- HIV/AIDS knowledge, Needs, and perceptions
- Terms and Definitions to Sexual Behaviors, Safer Sex, and Barriers to safer sex
- Communication Patterns with sex partner
- HIV/AIDS messages

We are interested in finding more culturally appropriate and gender-specific prevention campaigns against the spread of HIV/AIDS.

Exploring your perceptions on your understanding on HIV/AIDS-related topics will guide us in creating a more relevant prevention message uniquely geared toward African-American and Latino female late-adolescents. Do you have any questions so far?

Protocol of the actual Interview:

This is a semi-structured interview that will consist of me asking you a series of open-ended questions. You will then answer each of the questions accordingly to your own understanding and personal experience.

I want to remind you that there are no RIGHT or WRONG answers.

In addition, some of the questions are personal in nature, but you are highly encouraged to answer to the best of your ability.

However, you are free to reframe from answering any question that causes you discomfort.

The interview should take up to 1-2 hours of your time and afterward you will be provided $15.00 as a way to express our gratitude for your participation.

Please take the time to read the informed consent so that you will know your rights as a research participant. (I will go through the consent form with each participant and emphasize the points of confidentiality component of the study. They will sign and date it if they agree to participate). (After reading it, I will ask...).

Do you have any questions?

I will also need to ask the following questions to ensure that you meet the criteria of research participant: Are you...?

- African-American/Black or Hispanic/Latina/Chicana
- Female
- Ages: 18 – 22
- Heterosexual

Let's begin.

APPENDIX C
INFORMED CONSENT

INFORMED CONSENT FORM

A Qualitative Approach in Examining HIV/AIDS Prevention Messages among African-American and Latino Late-Adolescent Females

Purpose and Background

You are invited to participate in this research study to explore your perceptions on several related topics concerning HIV/AIDS: meaning of sex, protection against HIV/AIDS (e.g., use of condoms), communication barriers to condom use, and your thoughts on existing HIV/AIDS prevention messages.

Procedures

If you agree to be in this study, the following will occur:

a. You will be asked a set of open-ended questions about your health, HIV testing, sex practices, communication barriers to condom use, and your thoughts on existing HIV/AIDS prevention messages. There are no right or wrong responses to the questions; we are interested in personal perceptions and opinions.
b. The interview will take about 1-2 hour(s).
c. The interview will be audiotaped. The tapes will be used to ensure that your responses have been properly recorded. Tapes will be labeled with an ID number only. Any names or identifying information you use will be omitted from all written transcripts of the tapes. I can refuse to be taped without affecting your participating in the study. You can also change your mind about the taping any time.

   You agree to be taped: Yes:_____ No:_____

d. Your study interview will take place (time and location) that is convenient to you.
e. At the end of the study, if you want to know, you will be told the results of the study.

Risks/Discomforts

There are no known risks involved in participating in the interview. Nonetheless, you might find that there are interview questions and discussions that may make you uncomfortable or upset. There are several ways to deal with these discomfort feelings, if it were to arise:

a. You may consider speaking with the interviewer who may be able to help with your concerns.
b. You may consider speaking with a counselor about your reactions (e.g., you could contact the MSU Counseling Center at 355-8270).
c. You are free to decline to answer any questions you do not wish to answer or to stop the discussion at any time.

Benefits

Though there is no direct benefit from participating in this study, you may gain an increased awareness of important issues for yourself. Furthermore, the information that you provide may help service providers better understand how to meet the needs of people impacted by HIV as well as to contribute the need for a culturally-relevant, gender-specific HIV/AIDS prevention campaign.

Confidentiality

The confidentiality of your responses during the interview will be protected to the maximum extent permissible under the law. The following precautions will be taken to protect your confidentiality. No individual names will be used in any reports or publications that may result from this study, and your name will not be on any of the surveys or tapes. Instead, any responses you provide will only be associated with subject identification numbers.

Participation

Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at anytime without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed, your data will be destroyed.

Compensation

In return for your time and effort for participating in this study you will receive $15.00. You will be reimbursed at the end of the interview.

Contact

If you have questions at any time about the study or the procedures, (or you experience adverse effects as a result of participating in this study) you may contact the principal investigator, Callie J. Bair, M.A., LLPC, at baircall@msu.edu; at 517-355-8502. If you have questions about your rights as a participant, contact the chairperson of the University Committee on Research Involving Human Subjects (Dr. Ashir Kumar at 517-355-2180, email: ucrihs@msu.edu), or by writing: Committee on Human Research, 202 Olds Hall, East Lansing, MI 48824-1046. The office hours are from 8:00 a.m. to 12:00 noon. and from 1:00 p.m. to 5:00 p.m., Monday through Friday. Please make sure that you have all your questions answered before you sign this consent form.

Consent

If you have read the information and consider yourself to be fully informed about this research study, please print and sign your name below indicating your agreement to participate in this research on a purely voluntary basis. Please give the signed form to the interviewer and keep the other copy of the consent form for your records.

Participant's name (print) _____

Participant's signature _____

Date _____

APPENDIX D

SEMI-STRUCTURED INTERVIEW: QUESTIONNAIRE

SEMI-STRUCTURED INTERVIEW and HIV/AIDS QUESTIONNAIRE

777 = Does not Apply

888 = Declines to Answer

999 = Doesn't Know

ID Number:

__ __ __ __ __

Today's Date: __ __ / __ __ / __ __

Month / *Day* / *Year*

Interviewer: (Read Aloud): Let me start with some basic questions about your understanding of HIV/AIDS. Please keep in mind that there are no right nor wrong responses; the study is looking at your perceptions.

HIV/AIDS: KNOWLEDGE, NEEDS, AND PERCEPTIONS

1. Tell me what you know about how HIV is passed on from one person to the next person.

SEX: DEFINITION, SAFER SEX, AND BARRIERS

Interviewer: (Read Aloud): I'm going to ask you questions and some will be hard to answer because they are very personal, but I want you to know I'm doing this to help women in this community and so HIV/AIDS won't affect them.

1. What types of acts constitute "sex"? In other words, how would you define sex?

2. A. Where do you get your description of sex from?
   [For example, are you thinking about things you read, things on TV, people you know...?]

   B. When did you begin learning about this?

3. Do you think that oral or anal sex is considered "sex"?
   [Depending on the previous question, follow up with "how or what helped you to define that?"]

4. When you meet a guy that you are interested in, when do you decide to have sex with that him for the first time?

5. When you meet a guy that you are interested in, when do you decide not to have sex with that him?

Interviewer: (Read Aloud): This next question will be personal but it is important to be honest and remember this information will be kept confidential; e.g., no one will know you shared this information with me.

6. The question is, Have you met a guy and had sex with him on the same day you met him?
   Yes___
   No____

   If Yes: What led you to this decision?

7. What does "safe sex" mean to you?

8. When using these methods, what do you think you are protecting yourself from?

9. When do you not use these protective methods, specifically condoms?

10. If you ever had anal sex, how do you protect yourself?

11. A. If you were to perform oral sex on him, how would you protect yourself?

B. If he were to perform oral sex on you, how would you protect yourself?

Interviewer: (Read Aloud): Those were tough questions and we really appreciate your honest responses. I know this study and your responses will help the women in your community from getting hurt.

COMMUNICATION WITH SEX PARTNER

1. Tell me how you talk to your sexual partner about HIV/AIDS?

2. What needs to happen for you and your sexual partner to talk more about practicing sexual partner?

HIV/AIDS MESSAGES

1. What kinds of messages did you hear, WHILE GROWING UP, related to HIV/AIDS prevention?

2. How effective were these messages for you to practice "Safe Sex."

3. What types of messages do you hear NOW about HIV/AIDS prevention? Are these messages different from the ones you heard growing up?

4. What type of messages do you think will get you to use condoms on a more consistent basis?

Interviewer: (Read Aloud): Before we begin this survey, please remember the answers you give me will be confidential, and this paper does not have your name on it. Try to be accurate as you can. What gender do you consider yourself to be?

_____Female
_____Male

What race/ethnicity do you consider yourself?

		No	Yes	Don't Know	Decline To Answer
a.	Hispanic or Latino	0	1	8	9
b.	Black or African-American	0	1	8	9
c.	Asian or Pacific Islander	0	1	8	9
d.	Caucasian or European American	0	1	8	9
e.	Native Alaskan or Native American	0	1	8	9
f.	Other (specify)	0	1	8	9

What is your Date of Birth __ __ / __ __ / __ __
Month / *Day* / *Year*

That makes you how old?
Currently __ __ Years old

What is the highest grade in school you completed?

Grade __ __

Use Codes
No Formal Education = 00
GED = 13
Some College or Associates Degree = 14
Graduated College/Bachelor's Degree = 15
Beyond Bachelor's degree (some/completed Graduate school) = 16
Decline to Answer = 99

Interviewer: (Read Aloud): Next I'd like to ask you a few questions about sex. Please think about all the people you had sex with in the past 12 months. In the last 12 months, how many men have you had sex with?

__ __ __ Male partners

Use Codes
None = 000
Don't Know = 888
Decline to Answer = 999

In the last 12 months, how many times did you have vaginal sex? [Interviewer: if respondent has trouble estimating, probe for the average number times a week, and then multiply by 52]

Times

__ __ __

Use Codes
None = 000
Don't Know = 888
Decline to Answer = 999

In the last 12 months, how many times did you use a condom while having vaginal sex? [Interviewer: if respondent has trouble estimating, probe for the average number times a week, and then multiply by 52]

Times

__ __ __

Use Codes
None = 000
Don't Know = 888
Decline to Answer = 999

In the last 12 months, how many times did you have anal sex? [Interviewer: if respondent has trouble estimating, probe for the average number times a week, and then multiply by 52]

Times

__ __ __

Use Codes
None = 000
Don't Know = 888
Decline to Answer = 999

In the last 12 months, how many times did you use a condom while having anal sex? [Interviewer: if respondent has trouble estimating, probe for the average number times a week, and then multiply by 52]

Times

__ __ __

Use Codes
None = 000
Don't Know = 888
Decline to Answer = 999

In the last 12 months, how many times did you have oral sex? [Interviewer: if respondent has trouble estimating, probe for the average number times a week, and then multiply by 52]

Times

__ __ __

Use Codes
None = 000
Don't Know = 888
Decline to Answer = 999

In the last 12 months, how many times did you use a condom while having oral sex?
[Interviewer: if respondent has trouble estimating, probe for the average number times a week, and then multiply by 52]

Times	Use Codes	
		None = 000
		Don't Know = 888
		Decline to Answer = 999
__ __ __		

Interviewer: (Read Aloud): Next I'm going to ask you some questions about HIV Testing. How many in your lifetime have you been tested for HIV?
[Interviewer: if respondent has trouble remembering, ask her to estimate]

Times	Use Codes	
		Never = 00
		Don't Know = 88
		Decline to Answer = 99
__ __		

When was your Most Recent HIV test?

Tested In: __ __ / __ __ / __ __
Month / *Day* / *Year*

Use Codes	
	Not Applicable = 77/77/77
	Don't Know = 88/88/88
	Decline to Answer = 99/99/99

Did you receive your results for that most recent test?
___ No
___ Yes
___ Not Applicable
___ Declines to answer

Why didn't you get your results?
[Interviewer: Avoid Reading list. Prompt as needed. Check all that apply]

___ (1) Fear/Don't want to know Serostatus
___ (2) Difficult to access test site (issues of transportation/location of test site)
___ (3) Dislike or distrust testing site/providers
___ (4) Hours Inconvenient
___ (5) Other competing concerns (e.g., food, housing, money, drugs)
___ (6) Don't want to be seen at test site (stigma)
___ (7) No need (perceive little risk)
___ (8) Test results not ready yet
___ (9) Test provider did not disclose results (e.g., hospital or jail)
___ (10) Arrest
___ (11) Other (Specify)
___ (77) Not applicable

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