

AFRICAN-AMERICAN HETEROSEXUAL WOMEN FACING THE HIV/AIDS
PANDEMIC: GIVING VOICE TO SEXUAL DECISION-MAKING

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DEDICATION

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ABSTRACT

Delthea Jean Hill

AFRICAN-AMERICAN HETEROSEXUAL WOMEN FACING THE HIV/AIDS PANDEMIC: GIVING VOICE TO SEXUAL DECISION-MAKING

HIV infection is escalating among African-American heterosexual women in alarming rates. African-American women are 23 times as likely to be infected with the AIDS virus as white women. African-American women account for 72% of new HIV cases among women in 29 states. The risk of contracting HIV virus is highest in African-American communities, which inevitably places African-American women at higher risk than other populations of women. The purpose of this study was to advance knowledge regarding what is unknown about risky sexual behaviors among African-American heterosexual women by giving them the “voice” to share their own personal experiences in their natural environments. I examined participants’ perceptions of risk for contracting HIV/AIDS in relationships with male partners. This qualitative research design focused on a constant comparative analysis. I conducted one focus group [four members and one recorder] along with seven individual interviews, of African-American heterosexual women involved in the *Women In Motion [WIM]* HIV/AIDS prevention program. The following three health behavior frameworks were examined as a means of understanding the limitations of existing models of sexual risk behaviors among African-American

women: The Health Belief Model (HBM), the Transtheoretical Change Model, and the Black feminist perspective. Gaps in the literature included insufficient knowledge of how cultural taboos and myths influence sexual decision-making. An overview of the findings of this study has been explicated under the following three main headings: (1) Observation, (2) Interpretation, and (3) Application. The results of the study are discussed under the following three main categories 1) Understanding Sexual Decision-Making, 2) Understanding Intimacy, and 3) Understanding HIV/AIDS Prevention With Male Partners. In conclusion, sexual decision-making in this inquiry became an all encompassing construct based on African-American women's perceptions of how they viewed the paradox of sexual needs in intimate relationships with male partners and the risk of contracting HIV/AIDS.

Carolyn J. Black, Ph.D., Chairperson

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INTRODUCTION

African-American women are 23 times as likely to be infected with the AIDS virus as white women, and they account for 71.8% of new HIV cases among women in 29 states (Kaiser Daily Health Reports, 2006; Lashley, 2000). African-American women are infected with HIV disproportionately in the United States (Gilbert, 2003; McBride, 1991; Wyatt, 1997). The rate of HIV infection among African-American women is transitioning their position of invisibility to one of public concern in the face of the HIV/AIDS pandemic. According to the Kaiser Family Foundation (2006), a non-profit health organization, black women are increasingly contracting this virus through heterosexual sex. The connection between perceived HIV risk and sexual decision-making among this population of women is a complex social problem heightened by the enormity of race, gender, and class, referred to as “the triple burden” (Perry, 2003). The phenomenon of “the triple burden” and its relevance to HIV risk among African-American women are explored through the literature review. As researchers and health care professionals are attempting to address this crisis, the identified causes for problematic sexual decision-making among African-American women range from the shortage of potential male partners, African-American men living a dual sex life by having relationships with women and undercover sexual encounters with men, to African-American women feeling pressured to have unprotected sex due to male counterparts' excessive turnover of relationships (Gilbert, 2003; McBarnette, 1996; McBride, 1991; Quinn, 1993). However, these plausible explanations are limited in their usefulness in regards to effective strategies to prevent the rate of HIV/AIDS from escalating within this at-risk population. For instance, traditional HIV/AIDS prevention

strategies fail to recognize that women do not necessarily perceive sexual behaviors in the same way as men [e.g., some men perceive pregnancy as affirmation of masculinity...condom use in this regard possibly will not have significance]. Also, HIV prevention strategies tend to assume equality in relationships between men and women, when in reality, power disparity exists in intimate relationships (Gilbert, 2003; McBarnette, 1996; McBride, 1991; Quinn, 1993).

I caution against making broad generalizations about intimate male partners of African-American women. Unfortunately, black men share the burden of the disproportionate rate of HIV/AIDS prevalent in many African-American communities. Black male-female relationships must be examined beyond societal stereotypes (e.g., not all black men are abusing women, not all black women are promiscuous or engaging in sex with multiple partners). There is evidence to suggest that within committed heterosexual relationships the necessity for closeness and trust often lessen the perceived need for condom use (Exner & Ehrhardt, 1997; Lashley, 2000; Wyatt, 1997). Once sex has occurred without the safeguard of condoms, how are women to effectively initiate or reintroduce the use of condoms with intimate male partners? This rhetorical question illustrates the complexity of sexual relationships between men and women. The social and cultural aspects of sexuality, along with drug addiction and mental illness, only further complicate this phenomenon.

A comprehensive view of sexual risk behaviors of African-American women requires an acknowledgment of the social and contextual factors influencing their sexual decision-making. Failure to acknowledge these critical factors have resulted in life-threatening consequences for this population of women (Gilbert, 2003; McBarnette,

1996; McBride, 1991; Quinn, 1993; Wyatt, 1997). These consequences include the unequal status of women [e.g., victims of domestic violence] and their inability to control condom negotiation with male partners. Issues related to what is known and not known about African-American women's sexual behaviors are debated throughout the literature in regards to the increasing rate of HIV infection among these women. For example, some studies focus on power differentials and domestic violence between African-American men and women in relation to condom negotiation, but fail to explain the relevance of how gender roles and gender differences influence sexual behaviors in this society (Amaro & Gornemann, 1992). Risky sexual behaviors are not the same for men and women, but are often perceived that way in terms of potential HIV risk factors (Bassey, 2003; Gilbert, 2003; McBarnette, 1996; McBride, 1991; Quinn, 1993). In basic terms, strategies for convincing African-American men to wear condoms are different from teaching women effective strategies to persuade their male partners to wear condoms [gender differences in condom negotiation are examined further in the manuscript] (Gilbert, 2003; Wyatt, 1997). These gender and power dynamics are vital factors to be considered when examining risky sexual behaviors among African-American women. What appears to be the most logical conjecture by public opinion is that African-American women simply do not know they are at-risk for HIV infection from intimate male partners, or do they? Is a lack of knowledge really the issue? Another question debated in the discourse on HIV prevention among African-American women, Is the risk of being alone or unloved perceived by them as greater than the risk of HIV infection? Traditional theoretical models are restricted in providing the answers to these critical questions.

According to Amaro and Gornemann (1992), models of HIV risk behaviors assume sexual encounters are voluntary and manageable by the individual, without considering unequal power aspects of imposed sexual situations (e.g., impulsive sex acts influenced by alcohol, rape, incest). Also, these scholars acknowledge that the omission of gender is a critical limitation of existing models, resulting in a lack of research on how gender roles influence sexual decision-making. This gap in the literature has profound implications for African-American women. Further exploration will be given later in the text as to the limitations of current theoretical models dealing with HIV risk by examining several of the more familiar frameworks attempting to address risky sexual behaviors for at-risk populations. The lack of understanding regarding the influence of gender roles, racial discrimination, and social classism in relation to sexual practices of African-American women has resulted in barriers to effective prevention strategies. There is a need to rethink previous conceptual approaches that researchers have utilized in theorizing about HIV risk among African-American women. Thus, I chose an exploratory approach to better understand perceptions of HIV risk and sexual decision-making among African-American heterosexual women by involving participants from this target population in a qualitative study.

Disproportionate Risk of HIV

African-American women's dominant HIV-exposure risk categories include heterosexual transmission and substance abuse, with the acute age of infection between 25 and 44 years of age (Centers for Disease Control and Prevention [CDC], 2001). Activities likely to transmit HIV are considered "at-risk" or "risky" behaviors. Both males and females engage in at-risk behaviors when they have numerous sexual partners,

exchange blood or semen, or share needle. Anal sex is more likely to transmit HIV due to the thin lining of the walls of the rectum, whereas, the walls of the vagina are thick and stretchy. However, women may have undetected sores or lesions caused by STDs or sex play, resulting in blood contact (Lansky et al., 2001; Lashley, 2000; U.S. Department of Health and Human Resources [HHS], 2000).

In the United States, HIV disproportionately affects socially oppressed groups, such as women, gay males, and minority groups as illustrated by the 1994 CDC HIV surveillance report, in which 33% or approximately 130,382 HIV-infected individuals were categorized as African-American out of approximately 500,000 alleged to be living with HIV in the general population (Taylor-Brown, 1995). Researchers estimate that 240,000 to 325,000 African-Americans [about 1 in 50 African-American men; 1 in 160 African-American women] were infected with HIV in the United States in 2001, with close to a million living with HIV in the general population. Therefore, according to the statistics reflected in the CDC HIV surveillance report, the percentage of HIV infection has increased among African-Americans.

African-American women encompass approximately 13.6% of the United States female population. However, they account for 67% of all HIV [some reports indicate as high as 71.8% of all new HIV cases] positive women and over 57% of women diagnosed with AIDS in this country (CDC, 2001). According to Bassey (2003), “in terms of each ethnic population ratio to the overall population, African American and Hispanic females tend to bear the greatest burden of the HIV/AIDS problem” (p. 293). Recent statistics per CDC and HIV surveillance reports (CDC, 2000) indicate that of all U.S. women with AIDS, 56.6% are African-American, 22.4% are Euro-American, 20.1% are Latino, and

.99% are from other racial groups. As acknowledged in the introductory statement, African-American women are 23 times as likely to be infected with the AIDS virus in comparison to white women (Kaiser Daily Health Reports, 2006; Lashley, 2000). Although the exact numbers and percentages are not documented equivalently in the literature, the overall reported statistics indicate a prevalence of HIV/AIDS among African-American women.

The human immunodeficiency virus (HIV) is the contagion that causes AIDS, or acquired immunodeficiency syndrome. HIV is found in certain body fluids (e.g., blood, semen, vaginal fluid, breast milk), and can be passed from one person to another through contact with blood and other body fluids. There is a 3-6 month interval between the time an individual first becomes infected with HIV and the time their antibodies can be identified by a blood test. Once infected with HIV, a person becomes a carrier of the infection for life. HIV/AIDS can destroy the body's ability to fight off diseases, resulting in opportunistic infections. For instance, HIV can directly infect the central nervous system, causing neurologic disease (Lloyd, 1995).

Social workers are challenged with implementing effective interventions to reduce the rates of HIV/AIDS among at-risk populations, such as, low socioeconomic inner-city African-American heterosexual women (Taylor-Brown, 1995). The National Association of Social Workers (NASW) (2003) adheres to a policy for members of the profession to empower populations at a disproportionate risk for HIV/AIDS. The social injustice HIV-infected individuals encounter [evidenced by inequality in society based on race, sex, class or other characteristics resulting in health disparities including access to treatment] must be reversed in order to significantly impact the harmful consequences of

the HIV/AIDS epidemic (NASW, 2003, p. 180). As part of this empowering process, social workers have a responsibility to “examine the extent of risk for HIV transmission experienced by all clients as part of the assessment process, and they should educate clients about the ways to reduce their risk” (NASW, 2003, p. 180).

NASW, with over 150,000 members, advocates for vulnerable populations struck by the HIV/AIDS pandemic affecting people worldwide (e.g., supported the vision of *Keeping The Promise* to end the pandemic during World AIDS Day observed December 1, 2005). However, the enormity of this social issue demands advocacy on a wider scale. The NASW, the Council on Social Work Education (CSWE), and institutions of higher learning must collaborate in order to prepare professionals/students to meet the multidimensional needs of diverse groups struggling with HIV/AIDS. Also, social workers have to persevere with instructions to co-workers, clients, and the profession about prevention, intervention strategies, and HIV counseling/testing (HIV/CT). The process of empowering at-risk populations demands a shared responsibility among professionals.

The definition of empowerment is a conceptualization based on raising critical consciousness, and for minority groups and individuals living on the “margins of society,” it is a developmental process, “not an absolute process” (Lee, 2001, p. 5). Stated in a more defined way, empowerment in social work practice enables people to attain power for themselves and their communities through varied processes including, individualized skills building, focus group interactions [potential to serve as powerful evaluative tools and develop ownership within the group], community advocacy, and/or quantitative and qualitative research data (Lee, 2001).

Few studies have emphasized healthy black female sexuality patterns, nor the heterogeneity among this population. Sexual practices of “at-risk” African-American women are often perceived in a stereotypical manner, and the depersonalization of African-American women’s sexual norms has perpetuated myths in our society about their sexuality (Wyatt, 1997). However, for purposes of this study, risky sexual behaviors are defined as any behaviors, or practices that give support to HIV, and other sexually transmitted diseases (STDs), to enter the body through coitus or other intimate exchanges [oral sex and anal intercourse]. These infectious diseases are transmitted by contact with mucous membranes found in the mouth, rectum, eyes, penis, and vagina.

Leashore (1995) portrays the survival of African-American women in the United States despite hardships and stereotypes. This population of women is descendants of Africans who have similar cultural ties with the continent of Africa, with a legacy of being involuntarily brought to America in large numbers, along with male counterparts, as slaves who were exploited and oppressed. However, as citizens of the United States, African-American women fought and endured oppression in this country. The vulnerability of African-American women is illustrated by the racial disparities reflected in the following demographic indicators of marital status.

Intact families and marital patterns are indicators of quality of life in this society. In 1991, 38% of African-American women age 15 and over were married, 11% divorced, 39% never married, and 11.9% were widowed. In comparison, 59% of white women were married that same year. Leashore (1995) explains the impact of this disparity as it relates to the survival of African-American women. According to this scholar, differences in marital status reflect differences in mortality rates, with higher death rates and

incarceration for black men. Also, low wages and unemployment have discouraged many African-American men from marrying (p. 108).

Sex ratio imbalance among African-Americans also influences the availability of suitable and marriageable male partners. For example, with more available African-American women, men who are more interested in recreational sex will likely not engage in committed heterosexual relationships. When men are unwilling to commit to monogamous relationships, women frequently are left feeling vulnerable to rejection. These feelings of vulnerability can lead to women not insisting on condom use. The refusal of men to negotiate with women about wearing condoms only heightens women's feelings of susceptibility and powerlessness. As a result, a cycle of behavior in the seeking of multiple partners is created among a number of African-American men (Leashore, 1995). Despite these facts regarding marital patterns and suitable partner availability, African-American female-headed households have survived and supported children, even with fewer economic resources, and dependency on welfare and public housing (Gilbert, 2003; McBarnette, 1996; McBride, 1991; Quinn, 1993).

Along with intact families and marriage patterns, health status is another measure of quality of life in American society. Many risk behaviors are associated with HIV/AIDS and other poor health outcomes (e.g., TB, STDs, hepatitis, stress, victimization), diminishing quality of life for many client populations. Another critical risk factor rendering poor health outcomes is the co-occurring aspects of HIV/AIDS infection and crack-cocaine, described as "intersecting epidemics" (Edlin et al., 1994). These poor health outcomes are the result of risky behaviors leading to increased HIV infection and crack-cocaine abuse. This includes intravenous drug use [IVDU] and the

sharing of needles, which are central concerns for social workers and other related disciplines. According to Wechsberg and colleagues (2007), sociocultural factors contribute to the disproportionate use of crack-cocaine among African-Americans. Crack abuse is prevalent among all ethnic groups, “but it is most common among African-Americans residing in low-income inner-city neighborhoods”. Furthermore, these scholars report that the 2001 National Household Survey on Drug Abuse (NHSDA) indicated that African-Americans made up 12% of the U.S. population, but they represented 19% of individuals who had used crack in the past year (Wechsberg et al., 2007). Drug treatment programs are often based on models that “lack cultural sensitivity to minorities or women”, which places African-American females at a disproportionate risk of crack-cocaine abuse (Wechsberg et al., 2007).

The lack of services targeting the multidimensional needs [e.g., early or routine HIV screening; access to universal health care; transportation; in-patient drug treatment] of African-American women has negatively shaped HIV prevention outcomes. Peterson (1995) asserts, “Efforts to prevent the increase in HIV among women have been largely ineffective, and often HIV/AIDS programs do not address the reality of women’s lives” (p. 1325). Furthermore, Peterson’s stance is reinforced in the literature, as it relates to the lack of effective HIV programs targeting African-American women (Doyle, 2001; Gilbert, 2003; Icard & Schilling, 1995; McBarnette, 1996; McBride, 1991; Quinn, 1993; Wyatt, 1997). This population of women frequently struggle with gender inequality, racial discrimination, and financial liability, and yet within this group, environmental factors (e.g., educational attainment) influence their sexual experiences differently (Doyle, 2001; Gilbert, 2003; Icard & Schilling, 1995; Wyatt, 1997). Even though the

focus of this study is on examining sexual decision-making among African-American heterosexual women and how their perceptions are influenced by the HIV/AIDS pandemic, it is essential to acknowledge the diversity regarding their life experiences.

Overview of the Research Problem

Global patterns of HIV infection with regard to women indicate that the predominate mode of HIV transmission is presently through heterosexual contact. It is important to establish the link between African-American women disproportionately infected with the HIV virus and other economically at-risk women globally. AIDS is prevalent in areas of socio-economic deprivation on an international level. This trend of economic vulnerability is evident in the United States among African-American women. According to Lloyd (1995), "Early assumptions that knowledge about the virus and its modes of transmission would motivate people to change risky behavior were proven wrong" (p. 1264). For example, public messages regarding condom use are forbidden due to religious beliefs in many countries. Also, mother-to-child transmissions, non-sterile skin piercing rituals, and transfusions of HIV-infected blood in underdeveloped regions heightened the problem of HIV infection (Lloyd, 1995).

The World Health Organization [WHO/UNAIDS] (2005) summarizes these increasing trends of HIV transmissions. In mid-July 1996, an estimated 21.8 million adults and children worldwide were living with HIV/AIDS, of whom 20.4 million (94%) were in the developing world. Of the adults, 12.2 million (58%) were male and 8.8 million (42%) were female. Furthermore, by 2005, it was estimated that 40.3 million adults and children worldwide were living with HIV/AIDS. Approximately 38.0 million were adults and 2.3 million were children under the age of 15. Additionally, in 2005,

women accounted for 17.5 million individuals living with HIV internationally, with an increase of 1 million since 2003. Sub-Saharan Africa represents 25.8 million cases of HIV/AIDS (64%).

It is critical to note that the impact of HIV-infection among young people is escalating in Eastern Europe, Central Asia and South-east Asia. Then again, Thailand has documented achievement in the reduction of HIV infection, specifically among commercial sex workers, due to a national multi-sectoral initiative. As a result, the percentage of men in Thailand visiting sex workers declined from 22% to 19% according to surveys conducted in 1990 and 1993. Similarly, Singapore successfully maintains low prevalence of HIV among sex workers by promoting condom use at STD clinics and brothels. However, Singapore sex workers traveling overseas are the primary concern of HIV transmission in Singapore (WHO/UNAIDS, 2005).

Heterosexual women are several times more likely to contract the disease from random sexual encounters, because of women's exposure to infected semen from a large number of bisexual and heterosexual men (Lloyd, 1995). The vulnerability of contracting this disease is attributed to other factors beyond biological variations, as examined by scholars interested in the socio-economic inequalities, and other differentiations associated with HIV/AIDS internationally. For example, because 70% of the world's poor are women, they have fewer economic alternatives. One in three women world-wide has been affected by gender-based violence, and poor women are more likely to engage in sex trade for food, school fees, and other necessities (WHO/UNAIDS, 2005).

This lack of needed resources creates vulnerability for women to have forced or coerced sex, along with the inability to negotiate condom use with male partners. Also,

women with fewer assets are not as likely to have access to expensive medications. Moreover, women and young girls are more likely to become burdened with caring for ill family members devastated by AIDS (Lloyd, 1995; Peterson, 1995; WHO/UNAIDS, 2005).

de Bruyn (1992) cites the following four reasons for these HIV/AIDS disparities in developing countries: (1) women are stereotypically viewed as the “vectors of HIV transmission,” resulting in delayed diagnosis and treatment, violation of human rights, and stigmatization, (2) women are at increased risk of exposure to HIV infections for reasons related to their gender, (3) “psychological” and “social burdens” are greater for women due to such factors as rejection from marital partners, pregnancy and motherhood, financial losses, and greater demands to cope with the ramifications of the disease, and (4) women's lack of power and “low socioeconomic” status. This scholar argues that even though programs are developing to target sex workers, more services are needed for women in general, including adequate health care, and greater opportunities to earn wages (de Bruyn, 1992).

de Bruyn's (1992) argument for enhanced services for non-commercial workers in developing countries is supported by analyses released by WHO/UNAIDS (2005). For example, while Thailand has achieved substantial gains for HIV reduction among sex workers, this country reports low frequency of condom use among intimate partners, and particularly among HIV-discordant married couples, when the husband is HIV-infected and the wife is not.

Likewise, Coovadia and Hadingham (2005) support a more holistic approach to the global problem of HIV/AIDS, and target the weak health infrastructure as a major

barrier. According to these scholars, despite increased funding for health initiatives in poor countries, “bottlenecks” in the distribution of funds and health services hinder effective AIDS interventions. On the other hand, Mertens (1995) recommends the focus of AIDS prevention efforts and funding be placed on proper surveillance systems to identify areas in need of specific HIV/AIDS interventions. For instance, along with the increase of AIDS among women, there are some countries still struggling with an increase of mother-to-child transmissions of HIV, whereas, some regions appear to be stabilizing with these types of transmissions, such as, southern Zaire, parts of Uganda, and Thailand. Therefore, Mertens (1995) advocates for country-specific strategies and care programs based on a proper model of HIV/AIDS incident factors and surveillance.

India is exemplary of a developing country in need of a model designed for surveillance and country-specific interventions. No formal evaluations have occurred on a large-scale basis regarding HIV/AIDS prevention efforts in India. According to WHO/UNAIDS reports, the Indian AIDS Control Organization (IACO) estimates that 5.134 million Indian people were living with HIV in 2004 [only South Africa has more people living with HIV] and 1.9 million were women. The spread of HIV has been diverse among a nation with a population of one billion, inclusive of many major languages, and hundreds of dialects. In 1986 during the early onset of AIDS in India, only the poor and injection drug users were thought to be at risk, with stigma and discrimination creating barriers to health care among these vulnerable groups. However, HIV infection is spreading into the general population, escalating the frequency of heterosexual and mother-to-child HIV transmissions (WHO/UNAIDS, 2005).

Even though behavioral changes vary across countries, India historically has struggled with low literacy levels, and minimal awareness about sexually transmitted diseases (STDs) among the lower socioeconomic regions. Even in wealthier and more educated areas, fear of HIV infection has not triggered a widespread public acknowledgement of the need for condom use (WHO/UNAIDS, 2005). In particular, government leaders do not appear to have a consensus on the level of commitment needed to combat HIV/AIDS.

While some countries, such as, Thailand, Singapore, and Philippines report increased condom use among sex workers, India appears to have low condom use among sex workers, who frequently have numerous clients daily (WHO/UNAIDS, 2005). Even though de Bruyn (1992) and Mertens (1995) provide a forceful stance on the necessity for country-specific HIV/AIDS interventions and models for accurate surveillance data, India's public policies and cultural norms appear to render poor populations at the mercy of public workers with limited resources. Perhaps, a holistic approach advocated by Coovadia and Hadingham (2005) will prove more advantageous by building trust in families and communities, along with dispelling myths and misconceptions about HIV/AIDS.

One unique aspect of India is this country's road networks, the largest in the world, with an estimated 2 to 5 million long distance truck drivers. The drivers stop at roadside hotels, and pick up women, and few drivers acknowledge the use of condoms. With heightened public efforts to target HIV/AIDS reduction strategies among truck drivers, many regions have successfully increased condom use among drivers, and decreased HIV infection among sex workers. One region, Mumbai, actually initiated an

HIV awareness campaign at the transport authority offices where drivers get their licenses renewed on a yearly basis. HIV/AIDS is one of the most challenging public health problems ever faced by India (WHO/UNAIDS, 2005). By the same token, this disease has created a national concern in the United States, with increasing prevalence rates among heterosexual women.

A similar pattern of the global heterosexual HIV transmission became discernible in the United States after a marked increase of HIV infections among women were reported to the Centers for Disease Control (CDC), ranging from 3% in 1981, to 6.8% in 1983, and up to 9% increase in the number of HIV cases in 1989 (Peterson, 1995). By 1992, women represented 14% of AIDS cases in the United States, and by 1999 the level increased to 20%, with women in the age category 20-24 most likely contracting the disease through heterosexual contact, and women 35-44 more likely to become infected through injection drug use (WHO/UNAIDS, 2005).

While de Bruyn (1992) makes a case for enhanced services, such as improved health care and income opportunities for women in developing countries, Peterson (1995) argues for comparable considerations for women in the United States. Overall, women were virtually invisible in the early progression of this disease, when the conspicuous population associated with AIDS was white gay men (Taylor-Brown, 1995). HIV/AIDS cases have surged all over the world since the late 1970s, and the latest trend of HIV/AIDS transmission is predominately through heterosexual contact. The circumstances relevant to African-American heterosexual women are examined in detail concerning the context of HIV/AIDS among this population.

Context of the Research Problem

This study examined sexual decision-making among African-American heterosexual women and barriers to HIV/AIDS prevention, such as power disparity (e.g., condom negotiations] in their relationships with their intimate male partners. Sexual decision-making involves a process of evaluating attitudes, values, and environmental conditions (Gilbert, 2003). Changes in women's attitudes and sexual behaviors require a course of action built on holistic approaches, contrary to quick-fix solutions, based on a complex interplay of cultural norms, and gender roles influenced by ethnicity (Gilbert, 2003; Peterson, 1995; Semple, Patterson, & Grant, 2002; Wyatt, 1997). Much of the literature pertaining to women and HIV/AIDS links sexual behavior, sociopolitical, cultural, and gender aspects along the following dimensions: micro, mezzo, and macro levels of influence.

First, the micro level of change is based on the individual's ability to make decisions and initiate control over personal life issues (e.g., development of positive self-concept, individual educational strategies, personal competence to obtain needed resources, vocational training for career options). For example, on an individual basis [micro level] interface with a client "involves an interactive process where meaning is constructed so that understanding of the individual client in his or her unique context is possible, leading to mutual planning and change for action" (O'Connor, 2002, p. 777). The communication process and mutual interaction have the potential to result in empowerment for participants through the process of mutuality, while conducting diagnostic assessments (e.g., focused interviews, participant observation, data analysis) (Lee, 2001; O'Connor, 2002; Schriver, 1998).

A client presenting with a history of childhood sexual abuse might be engaging in high-risk promiscuous behavior due to unresolved conflict around this matter. Because of increased concern for HIV, the social worker and client could contract to work on her feelings of helplessness and skill building in order to empower the client to reduce the risk of contracting HIV. Child sexual abuse is an HIV indicator for risky sexual behavior, and requires further diagnostic assessment upon initial contact with clients (O’Leary, 2000).

This ability to initiate control over decision-making and personal life issues [micro level] is debated along the postmodern paradigm, in which the goal is to deconstruct “ways of knowing,” or the critical approaches to science, in which the goal is to emancipate the oppressed, versus the traditional approaches to science based on positivism, in which the goal is to predict (Schrivier, 1998, p. 85). A major area of study along the traditional paradigm has been the cognitive-behavioral investigations funded by evidence-based establishments (e.g., National Institute on Drug Abuse [NIDA], National Institutes of Health [NIH]) seeking to predict effective strategies to reduce the frequency of HIV/AIDS among at-risk women. This effort to predict effective HIV interventions targeting women is examined in the following systematic review.

Exner and colleagues (1997) reviewed 47 studies focusing on HIV interventions [36 published articles; 11 published abstracts]. Of these 47 published studies, 30 articles evaluated HIV interventions for women, and the remaining 11 included both men and women. The literature search included AIDSLINE [1980-December 1995], PsychLit [January 1987-November 1995], and MedLine [1980-December 1995]. Research was conducted in the US, Canada, and Puerto Rico.

Many of these studies in the Exner and colleagues' review explored condom use and condom negotiations, since a woman who chooses to engage in penetrative intercourse typically will rely on her partner's use of the male condom as the primary option for protection [recently female condoms became available]. However, with numerous studies focusing on the quantitative measurement of condom use, other variables for consideration must include: (1) some women who are monogamous do not perceive themselves at risk, (2) studies differ regarding whether they report condom use separately for oral, vaginal, or anal intercourse, (3) some women refuse condom use related to pleasure and stimulation, and (4) condoms are also used as a contraceptive (Exner, Seal, & Ehrhardt, 1997). Therefore, evaluating outcomes of condom effectiveness are challenging for researchers, and quantitative methodologies frequently do not capture the complexity or consequences of condom negotiations for women.

Nevertheless, this review establishes that gender and culturally-specific strategies are needed, particularly when they are skills-based. The most effective skills-based approaches include teaching women good negotiation skills. However, even with effective negotiation abilities, environmental conditions that hinder behavioral changes must be examined. Exner and associates (1997) suggest that along with a better understanding of women's sexuality, a thorough understanding of acceptable options for behavioral changes from the female perspective is essential. Also, a clear interpretation of findings (e.g., power analysis, sample size analysis, attrition rate, follow-up sequences of events) is imperative in making appropriate prevention recommendations. Related systematic reviews in the literature cite the need for a comprehensible interpretation of findings.

McKay (2000) acknowledges one primary limitation in the systematic review she examines. This restriction is related to the design, which is “selective for favorable outcomes that provided support for the development and implementations of HIV/STI interventions in different populations” (p. 117). Based on McKay's reasoning, the design of the review does not allow for systematic comparison of effective versus ineffective interventions (e.g., the consistent reporting of power sizes of studies). This observation is significant when exploring effective interventions for at-risk populations, including women.

McKay (2000) discusses behaviorally effective strategies for different populations (e.g., street youth, men who have sex with men [MSM], heterosexual women). The analysis involved recent articles [time frame not specified, but approximately 1995-2000] conducted in North American settings, while Mize and colleagues (2002) conducted a meta-analysis of the effectiveness of HIV behavioral prevention intervention for women [24 articles from the US were included from 1989-1997]. Both reviews used popular databases, which included Medline, PsychInfo, Eric, Academic Index, and others. Even though Mize and colleagues (2002) allow for a statistical analysis for their review, these scholars reveal that the sample size of the meta-analysis restricted the generalizability of the study.

Regardless of the limitations revealed with these reviews, several themes related to HIV/AIDS and at-risk populations are significant. McKay (2000) observes that most of the effective behavioral HIV/STI interventions share common distinctive tactics (e.g., promoting condom use, theoretically-based practice models, skills training), but specific strategies are designed to accommodate the identified client population (p. 116).

Effective strategies must consider environmental conditions. Exner and colleagues (1997) voice similar reactions to the context of environmental factors (e.g., socio-economic circumstances). Also, many interventions identified peer educators and community leaders. Mize et al. (2002) concur with McKay's recommendations for culturally specific strategies, which must be defined for each client population being served. Another identifiable theme is the consensus with these reviews that evaluation is needed for longer follow-up periods in order to determine the effectiveness of long-term behavioral changes.

Closer examination is needed when considering the influence of ethnic and gender differences in HIV cognitive-behavioral prevention strategies. Semple, Patterson, and Grant (2002) suggest that behavioral interventions are needed that are responsive to gender issues, and inclusive of relationship concerns (e.g., power disparity, condom negotiations, effective communication skills).

Second, these identified concerns targeting relationship issues are viewed from the mezzo level in the literature. The mezzo level of change is based on the interpersonal ability of couples and families to take action to improve their situations (e.g., couples counseling regarding domestic violence, HIV testing for harm reduction to partner, counseling on the prevention of spreading STDs, credit counseling to enhance financial stability, sessions on disinfecting needles and drug treatment, parenting classes). El-Bassel and colleagues (2005) examine the effectiveness of a relationship-based HIV/STI prevention intervention, involving a total of 217 randomly assigned heterosexual couples to the following three intervention conditions: (1) six sessions involving both partners, (2) the same intervention involving the woman alone, and (3) a one session encounter

serving as the control for the female participant focusing only on health education. Each intervention integrated information from an earlier National Institute Mental Health (NIMH) trial in 1998 involving HIV/STI prevention targeting couples. Results indicated that the intervention was effective in reducing unprotected sex for participants in the sessions involving “both partners,” and the intervention for the “woman alone” compared to those in the control group. However, when comparing couples who attended together versus the woman attending alone, no significant difference was indicated. While El-Bassel and colleagues (2005) are concerned with the effectiveness of relationship-based HIV/STI interventions, Wenger, Kusseling, and Shapiro (1995) focus on the significance of understanding the construct of “safer sex” among heterosexual adults, which is a key factor in determining the effectiveness of relationship-based interventions.

Wenger and colleagues (1995) surveyed 646 sexually active persons enrolled in an educational trial for HIV at a STD clinic and university student health center. The aim was to give an account of sexual behavior with their latest reported partner. As a result of this survey, 233 (36%) reported having safer sex with their latest partner out of the total 646. Interestingly, 124 (53%) of the 233 safer sex cluster, also reported having vaginal or anal intercourse without a condom during that sexual encounter, and only 23% reported asking partners about their HIV status, while 46% inquired about intravenous drug use, and 47% asked about the number of prior sexual partners. The length of the sexual relationship for 34% of those surveyed was 1 month or less with their latest sexual partner, and 18% estimated that this latest partner had approximately 11 or more sexual partners. STD clinic participants characterized intercourse without a condom as safer sex more frequently than student health enrollees [76% versus 39%, $p < 0.001$]. This survey

alerts researchers and professionals to the misconceptions and myths still affecting sexual decision-making among heterosexual couples.

While the need for effective relationship-based HIV prevention strategies for heterosexual couples is paramount, it is essential to address the myths and misconceptions still causing barriers to safer sex practices. This concern is illustrated through the need for greater attention in the examination of HIV exposure among female partners of substance-abusing men. Peterson (1995) claims that transmission of HIV through IV drug use must be understood within a broader sociocultural context including the sharing of needles between couples as a sign of trust, friendship and loyalty, and denial of partners' addiction (p. 1328). Fals-Stewart and colleagues (2003) examine HIV risk and preventive behaviors among 362 married couples during outpatient service interventions where drug-abusing husbands were treated. The premise of Peterson's argument for the inclusion of the sociocultural context of HIV transmission among drug abusers is evident by wives experiencing HIV risk in relation to partners' drug use and sharing needles without women being aware of their risky behaviors.

Fals-Stewart et al. (2003) acknowledged that during the year prior to entering treatment, 144 (40%) out of the 362 husbands reported engaging in sexual or drug use behaviors that placed them in a category for high risk of HIV exposure. Most of the wives (138 or 96%) reported having sexual intercourse with their drug-abusing husbands during this same time period. Among the sexually active couples, 108 of the wives (78%) disclosed that condoms were not regularly used during sexual intercourse, and 77 (71%) of these 108 wives reported that they were not aware of their husbands' high-risk behaviors. The survey of Wenger and associates (1995), along with the study of Fals-

Stewart et al. (2003) involving wives of substance-abusing spouses, reinforce the notion that lack of awareness, or knowledge of unsafe sexual behaviors places unsuspecting mates at high risk for indirect exposure to HIV. Wolitski and colleagues (1997) include women and heterosexual couples as a subgroup identified in their study concerning risk-related behaviors.

Wolitski and colleagues (1997) identify four subgroups: (1) men who have sex with men [MSM], (2) injection and other drug users, (3) women and heterosexual couples, and (4) mixed samples recruited from STD clinics in regards to the effects of HIV counseling and testing (HIV CT) on risk-related behaviors. Literature searched by Wolitski et al. (1997) included Medline and PsycLIT in August 1996. The inclusive category included studies that examined the influence of HIV CT on “risk-related practices and help-seeking behavior” (p. 54). Studies exploring HIV CT among women and heterosexual couples focus primarily on pregnancy rates and termination, along with sexual practices. The settings and findings varied, depending on the focus of the research under investigation. For example, five studies examined condom use after HIV CT among women and the findings were mixed regarding condom use by partners between HIV seropositive versus seronegative women. HIV CT for drug-using women also focuses on pregnancy-related decisions, but most of these findings indicate some beneficial behavioral changes among IVDUs and other drug users who receive HIV CT (Wolitski et al., 1997, p. 59).

According to Wolitski and associates (1997), substance abusers who enter treatment and continue to receive comprehensive services, “are more likely than those who remain out of treatment to reduce risky activities” (e.g., engaging in unprotected sex,

sharing needles). Also, staff members are trained to help individuals who test positive for HIV to inform their drug-using associates and sex partners of their potential risk for HIV infection.

Cultural expectations and social norms influence HIV-related risks involving relationships. Primarily, HIV/AIDS-related behaviors are interpersonal, involving both partners, whether risky behaviors are sexual or associated with drug-use.

Third, the macro level of change is based on the ability of communities and organizations to develop a collective effort toward change in order to distribute a fair share of resources, reach solutions to problems, and resolve conflict (e.g., negotiations of policies, group discussions, cultural norms regarding sexual practices, informational exchanges about HIV and IV-drug use) (Gutierrez, 1992; Lee, 2001). Freire (1970) advocates for collective reflection and action through individuals, organizations, and communities creating social change, along with Gutierrez (1992) supporting the conviction of community empowerment.

This level of change requires a method of organizing people to take action on a social problem (e.g., HIV infection, substance abuse, domestic violence). In connection to sexual decision-making and exposure to HIV transmission, postmodern views offer multiple “ways of knowing” through processes that are critical for women. Shriver (1998) speaks to creative developments that are “non-hierarchal, feminist influenced, and participatory...” (p. 13). However, in order for women to transition from the “invisible” posture of the AIDS pandemic identified by Peterson (1995), social constructs defining gender roles and cultural influences of women must be challenged on a broader level as

suggested by Lee (2001), who offers an explanation as to the critical role of community planning as a change agent.

According to Lee (2001), problem-solving processes are critical components of social change in the community with a strong emphasis on initially identifying the problem and analysis, along with developing and implementing a plan of action, and then evaluating the outcome. Schriver's (1998) mention of participatory developments as an alternative means of discovering new knowledge is reiterated by Lee (2001):

In order for participatory action outcomes to be most advantageous, the combination of qualitative and quantitative data is optimal in utilizing research toward the ends of empowering those who usually do not speak for themselves...where few resources are directed toward the poor.
(p. 419)

O' Conner (2002) advocates for a postmodern approach with non-traditional methodologies, when the goal is a system level of change in the group or community. O' Conner (2002) states, "Many of the communication, data collection, data analysis, and change-planning techniques used can be seen with qualitative research" (p. 779).

However, while numerous studies have addressed evidence-based strategies predicting effective HIV preventive strategies within the traditional positivist paradigm, and suggesting the need for cognitive behavioral skills-building to reduce the frequency of HIV/AIDS among women on multilevels, few studies have focused on the effectiveness of qualitative methodologies capturing the real life experiences of "invisible women" facing the pandemic. This paucity of studies in the literature is more evident when targeting the perceptions of HIV/AIDS risk among African-American heterosexual women.

From numerous studies reported in the literature regarding the progression of the spread of HIV/AIDS in the United States, it is clear that African-Americans are the largest recognized racial group disproportionately represented, with African-American women identified as “triple burdened” by this disease (Gilbert, 2003; Icard & Schilling, 1995; Quinn, 1993; Wyatt, 1997). The discourse in the literature deals with arguments regarding the structural barriers existing for African-American women faced with racial inequality, gender inequity, and economic disparity, while simultaneously facing the daily existence of the HIV/AIDS pandemic (Gilbert, 2003; Icard & Schilling, 1995; Quinn, 1993; Wyatt, 1997).

Leashore (1995) convincingly defends the worldviews of African-American women, influenced by strengths revealed through strong kinship ties to family and community, spiritual beliefs, religious orientation, egalitarian sharing of roles, desire to promote careers, and the need to pursue higher education. However, Gilbert (2003) argues that despite the legacy of survivorship of this population of women, HIV/AIDS continues to impact African-American females disproportionately. Furthermore, Gilbert (2003) contends that health care policies and resources are needed in order to develop effective culturally-competent and gender-sensitive interventions to reduce the rate of HIV/AIDS for these at-risk women. This scholar adheres to the sociocultural construction of HIV/AIDS, in regards to the influence this disease has on African-American women:

Although the literature has acknowledged the vicissitudes of poverty and gender inequality as risk factors, rather than inherent racial or ethnic factors, there is still a need to examine the complexity and inextricably intertwined sociocultural factors that place African Americans, particularly African American women, at increased risk for HIV-infection. (p. 6)

Thus, the social context of African-American women's plight with HIV/AIDS is acknowledged in more contemporary studies, but the interrelatedness of structural impediments must continue to be examined. Researchers and policy makers only recently recognized that early preventive messages, while successful among urban gay males, did not impact African-American communities effectively (Gilbert, 2003). Quinn (2003) relates failure [disproportionate rates of HIV/AIDS among African-Americans] of these early HIV prevention strategies in some measure to mistrust and myths, which is substantiated in the literature (Gilbert, 2003; McBarnette, 1996; McBride, 1991; Quinn, 1993; Wyatt, 1997).

Bassey, Ekundayo, Udezulu, and Omisbakin (2003) investigated a tool used to assess African-American women regarding their knowledge of HIV/AIDS. The participants were examined through a modified 50-item ethnically-sensitive and gender-specific HIV/AIDS survey instrument (AKFBQ) in a comparison study between 449 urban and 300 rural African-American women. According to Bassey and associates (2003), one of the most surprising findings was “the high level of negative attitude/feelings, mistrust, and misconceptions by the subjects about HIV/AIDS among African-Americans” (p. 121). Many of the participants believe that the government is involved in a genocidal plot against the black race as indicated by 81.6% of the rural women. In fact, out of the following eight states reported to have the highest prevalence of AIDS cases among women, the top three are southern rural states: (1) Florida, (2) Georgia, (3) South Carolina, (4) Maryland, (5) Delaware, (6) New Jersey, (7) New York, and (8) Connecticut (Centers for Disease Control and Prevention [CDC], 2003). A convenience sample was used in this inquiry, and the lack of randomization and the

problem of generalizability limited this study. However, the need to address issues of mistrust and fears regarding the prevalence of HIV/AIDS among African-Americans, especially with rural women, must be recognized. Fears of genocide, and mistrust of public health organizations, even though historically relevant, create yet another barrier to HIV educational efforts among many African-Americans (Quinn, 1993).

While some scholars speak of mistrust and misconceptions of HIV/AIDS as a factor in the disproportionate rate of this disease among African-American women, many researchers consider poverty among women-of-color as the primary barrier. Just as HIV/AIDS has ravaged poverty-stricken countries globally, this same trend is evidenced among economically-disadvantaged populations in the United States. This variation is supported through the disproportionate numbers of single-headed households among African-American women rearing children (Gilbert, 2003; Icard & Schilling, 1995; Quinn, 1993; Wyatt, 1997). The threat of AIDS frequently is not the most urgent issue to address when financial and social issues are more pressing matters among the daily lives of poor women (Quinn, 1993).

Moreover, many scholars perceive the lack of power in relationships (i.e., financial dependency on male partners) as a primary obstacle for many African-American women. HIV strategies must emphasize negotiation skills regarding condom use and encourage the discussion of birth control among intimate partners, while customizing prevention according to ethnicity and social context (Soler et al., 2000). Many studies have shown that even though African-American and Latina women have reduced the risk of HIV exposure in casual relationships, they continue to practice unsafe sex with regular intimate male partners (El-bassel, 2000). However, there appears to be a

failure in the literature to account for the significance of the shortage of suitable and available men in many African-American communities where some women perceive sexual relationships as an economic advantage, or social status [slang expression is *sugar daddy*- a man providing financially for his women] influencing sexual decision-making (Quinn, 1993).

Many studies focus on the risk of African-American women engaging in sex with multiple male partners in social networks known for high HIV prevalence, rather than emphasizing the HIV risk of African-American women encountering the shortage of suitable male partners. One such investigation revealed that the number of sex partners was the most predictive risk factor in a self-administered survey examining the transmission of sexually transmitted diseases involving 535 white men, 694 white women, 262 black men, and 472 black women between the ages of 21-40 recruited from a multicenter cardiovascular clinic between the years 1987-1988 (Melnick et al., 1993). The relevance of the findings in this early study is found in the recent awareness that sexual decision-making is “shaped by a complex web of gender and social class dynamics” not adequately examined in the literature regarding African-American heterosexual women (Quinn, 1993).

Even though sex with multiple partners was considered an HIV risk factor during the early onset of this disease, few studies correlate this risk factor within the sociocultural context that decision-making is occurring in the daily lives of African-American women at-risk. For instance, Dolcini and colleagues (1993) disclose that gender differences influenced by culture and marital status place men and women at risk for HIV and STDs for different reasons. Men, for example, are likely to be at risk due to

multiple sexual contacts, while women are likely placed at risk because of male partners' behaviors (e.g., drug-using behaviors, men having sex with men [MSM], cultural sex norms in social networks). Therefore, the investigation of the effects of interrelated prevention strategies targeting health risks for couples, beyond just individual interventions for women, and HIV interventions targeting social networks in high-risk communities, are deemed advantageous in attacking this disease on multiple levels. The differences in HIV risk for men and women have created obstacles to better understanding aspects of widespread HIV infection reported among African-Americans, specifically with at-risk heterosexual women.

Significance of the Problem

In the United States, by the time action was taken in 1990 through the Ryan White Comprehensive AIDS Resources Emergency Act, an estimated one million people were diagnosed with HIV, and approximately 140,000 were already diagnosed with AIDS (Perry, 2003). Recent trends of HIV cases newly reported to the Centers for Disease Control and Prevention (CDC) stayed at the 40,000 level in 2005, with *Morbidity and Mortality Weekly Report* [MMWR] citing an increase of 19.5 to 19.7 per 100,000 new HIV cases in this country, which places the estimated total of HIV cases at 950,000 in the U.S.

It is estimated that there are as many as 280,000 undiagnosed cases of HIV in this country (Positive Populations Newsletter, 2005). However, routine testing is still not occurring among all high risk groups, although the CDC (2003) encouraged healthcare providers to make testing for HIV as routine as screening [universal] for other chronic conditions (e.g., hepatitis B, diabetes) in areas where HIV is prevalent [above 1% of the

population]. Barriers to universal screening for HIV include problems for reimbursement, the time needed to implement counseling and testing in busy health-care settings, and the lack of explicit information regarding the prevalence of HIV among certain at-risk populations needed to inform health care providers (CDC, 2003; Positive Populations Newsletter, 2005).

Earlier identification of HIV on a routine basis would increase life-expectancy of an individual by 18 months generally, and reduce annual HIV transmission by 21% (CDC, 2003). HIV screening would be cost effective at \$57,100 every five years per quality-adjusted life year gained [determining the level of health and the effectiveness of a particular intervention by calculating on a continuum of 0-(death) to 1-(perfect health)]. This compares exceptionally well with the costs of routine screening for hypertension, colon cancer and diabetes, which cost approximately \$48,000-\$57,000 per quality-adjusted life year gained (CDC, 2003). Therefore, routine HIV testing appears clinically and economically justified and would reduce the spread of HIV infection notably among populations most at risk of contracting this disease. On the other hand, policy makers might argue that routine HIV screening is a level of health just too costly to be effective. In regards to calculating the effectiveness of routine HIV screening, how do scholars define perfect health? This is a question open to debate.

Early HIV/AIDS interventions followed a traditional medical model, focusing on the “gay-related immunodeficiency disorder [gay plague]. This new and mysterious disease was primarily killing young gay men” (Taylor-Brown, 1995, p. 1291). Presently, researchers and professionals are beginning to examine the psychosocial aspects of culture and health beliefs as they relate to HIV/AIDS prevention and the disease process

among other vulnerable groups, besides the gay male population (e.g., women-of-color, adolescents, older adults). This concept of vulnerable populations is described in Gilbert (2003): “structural impediments refer to social, political, and economic forces in our society that establish and define the reality of certain populations and restrict the options that people can choose as a means of survival” (p. 6). Potential risks for women were not equally investigated and mandated during the early phases of the reporting of HIV/AIDS (Peterson, 1995), rendering them vulnerable to this disease.

The number of AIDS cases reported to the Centers for Disease Control and Prevention (CDC) (2001) among women in this nation has increased progressively since 1981 when only 3% of all reported cases of this disease were women. By 1994 the percentage escalated to 12.9%. It has been reported that since 1995, an average of approximately 11,600 new cases of AIDS in U. S. have been diagnosed in women annually (Lansky, Fleming, Byers, Karon, & Wortley, 2001). More recent statistics indicate that in 2005, 9,708 new cases of HIV/AIDS reported among women, with an estimated 126,964 women presently living with HIV/AIDS (CDC, 2005). The overall new cases of HIV/AIDS dropped from 11,941 in 2001 to 9,708 in 2005 among women. Out of the 126,964 women estimated to be living with this disease, 64% are African-American women, 19% white, and 15% Latina (CDC, 2005).

According to Peterson (1995), these statistics denote a trend in the United States that mirrors the universal pandemic. For example, heterosexual intercourse is the dominant mode of transmission of HIV globally, with women’s rate of HIV infection fast approaching that of men worldwide (Peterson, 1995). According to recent trends of transmission per CDC reporting, generally female adults and adolescents diagnosed with

AIDS were exposed through intravenous drug use (IDU) and heterosexual contact with an HIV-infected partner. By 2002, more than 146,000 AIDS cases among this target population had been attributed to IDU and heterosexual contact. Also, most of these cases have been among female adults and adolescents in the Northeast [attributed to IDU], and in the South [attributed to heterosexual contact rather than IDU] (CDC, 2000).

Lansky and colleagues (2001) classified HIV-infected women [with no previous risk data reported] into exposure risk categories. Their findings supported Peterson's observation regarding the primary mode of HIV infection. All states and territories in this country report cases of AIDS to CDC through the HIV/AIDS Reporting System (HARS) [since December 1999, 33 states and territories also report cases of HIV infection without AIDS]. The Supplement to HIV/AIDS Surveillance (SHAS) is a project using a standardized and confidential questionnaire. The analysis of data in this study was restricted to women from January 1993 to December 1996 with a diagnosis of HIV infection [not AIDS], 12 months prior to the interview. Questions on the instrument included "sociodemographics, sexual behaviors during the previous year, and substance abuse during the previous 5 years" (p. 34).

Based on their interviews of 1,297 women [HIV-infected] from 12 states during 1993-1996, 81% of HIV-exposure risk came from heterosexual contact and 16% from injection-drug use. Other risk categories included "crack use, noninjection-drug use, including crack but excluding marijuana, sexually transmitted disease, alcohol abuse, exchange of sex for money or drugs, and number of male sex partners" (Lansky et al., 2001, p. 35). This classification model designed by Lansky et al., (2001) used discriminant function analysis to estimate women's exposure to HIV/AIDS risk

categories. This approach was influenced by the increasing number of reported cases of HIV/AIDS not including exposure risk information needed for surveillance data. This study heightened the awareness of the difficulties of quoting or estimating exposure risk for women without an appropriate method for comparison. This is especially problematic for public health departments attempting to establish HIV and other sexually transmitted diseases (STDs) risk information and follow-up on vital cases. Also, risk exposure data are critical components of research aiming to better comprehend the biology of HIV/AIDS, successful strategies to treat it, and effective interventions to prevent the further spread of the disease (U.S. Department of Health and Human Services [HHS], 2000).

The National Institutes of Health (NIH) reflects the largest single public investment in AIDS research in the world. The NIH supports the Women's Interagency HIV study (WIHS), intended to identify the nature and rate of HIV progression in females. Women experience certain "clinical manifestations" of HIV infection (e.g., cervical dysplasia, persistent yeast infections) that are unique to females (Health and Human Services [HHS], 2000). Therefore, women's exposure risk categories must be accurately reported in order to advance empirical evidence of the disease process, including sociocultural and other significant factors that have an impact on women.

Research based on well-designed studies is needed for effective strategies to reduce the risk of HIV/AIDS among at-risk African-American women. The primary assumption underlying the necessity for this research is the conviction that women have the non-discriminatory right to be involved in the process of sexual decision-making with intimate partners. Despite the reporting of the prevalence of HIV/AIDS among African-

American women, this population has remained primarily on the margins of society [lack of federal response and public policy] in regards to effective HIV/AIDS prevention (Anastos, Denenberg, & Solomon, 1996; Bassey, 2003; Doyle, 2001; Gilbert, 2003; Grant, Green, Stewart, Wheeler, & Wright, 1998; McBarnette, 1996; McBride, 1991). According to Perry (2003), African-American women have been characterized as “invisible, triple burdened, and falling through the cracks,” in accordance to the HIV/AIDS crisis in the United States (p. 225). By and large, HIV/AIDS-related policies and advocacy efforts have been deficient in addressing social, economic, and cultural [triple burdened] aspects of this disease regarding African-American women.

Conceptualizing Factors Related to the Problem

Socialization is a process that begins in infancy, and changes throughout life. According to Payne (1997), socialization and perceptions of life's realities are taught through cultural and social networks. However, “there has been controversy about whether social work and ‘theories’ of it [social work] may be considered global or restricted in its use. They arose, historically, in Western democratic countries, and their value base has Jewish/Christian origins” (p. 7). In other words, social factors [shared cultural norms among groups], and contextual factors [aspects which define realities of life for a person] are critical aspects of the socialization process, and these essential factors must be integrated as part of HIV/AIDS risk and intervention for women of all ethnicities.

This type of integration involves a multicultural approach defined in the *Social Work Dictionary* as “an orientation that recognizes, supports, and accommodates a variety of sociocultural practices and traditions; also a sociointellectual movement that

promotes the value of diversity as a core principle and insists that all cultural groups be treated as equal” (Barker, 2003, p. 280). Social and contextual factors, along with psychological dynamics, are vital aspects of HIV/AIDS prevention involving African-American heterosexual women.

In order to clarify this viewpoint, the argument is not related to the historical influences of Western socialization, including religious and cultural norms, or the restriction of awareness regarding the need for a multicultural approach to HIV/AIDS prevention. The issue is the lack of effective HIV/AIDS intervention strategies to address the multidimensional needs of African-American women socialized in a nation where they are facing the “triple burdens” of their lives on a daily basis. A multicultural approach implies the equal treatment of all cultural groups, but the evidence of the disproportionate rate of HIV infection among this population of women give rise to the existence of unbalanced HIV prevention outcomes for at-risk groups.

There are numerous risk factors affecting this subgroup (e.g., men who have sex with men and women [MSM/W], domestic violence, childhood sexual abuse, abandonment issues, incarceration, depression, anxiety). The following section investigates three critical issues related to the scope of the problem when examining HIV-related co-factors among this client population: (1) social and economic barriers, (2) health disparity and access to care, and (3) substance abuse.

Social and Economic Barriers

The day-to-day hardships many African-American women face regarding race/ethnicity issues, the pervasive impact of poverty, and availability of food, housing, and health care, along with gender-related factors (e.g., sexual communication with

partners, condom negotiations, power disparity in relationships) places poverty-stricken, inner-city African-American women at higher risk for contracting HIV/AIDS due to trading sex for money [prostitution], trading sex for drugs, and using drugs intravenously [sharing needles] with male drug users (Gilbert, 2003; Icard & Schilling, 1995; Wyatt, 1997). Consequently, for many African-American women living in poverty, the daily struggle for survival often overshadows concerns about contracting HIV (Wyatt, 1997).

Higher rates of poverty and homelessness among single-parent households have negatively affected African-American women (Galaif, Stein, & Nyamathi, 1991). This evidence is supported by the 1995 Census Report, where African-American women [heads of household] with children had median earnings of \$13,608 or 28% of the median for married-couple African-American families with children. Therefore, a focus on economic survival for many African-American women makes it difficult to practice healthy behaviors (Gilbert, 2003). Stein (1998) says much the same as the 1995 Census Report about the fiscal vulnerability of poor, single women. He further comments on the susceptibility of poor women to contracting HIV. Approximately 75% of women with HIV have children [50% have more than one child], and most are single women. Roughly 70% of single women who are rearing children are poor (Stein, 1998). African-American women with children are over-represented in regards to reported poor populations in this country (Gilbert, 2003; Stein, 1998). Therefore, the trends related to HIV/AIDS are likely to have a bearing on the many African-American women disproportionately living in poverty (Bassey, 2003; Gilbert, 2003; O'Leary, 2000; Quinn, 1993).

Quinn (1993) refers to the plight of low socioeconomic African-American women as the “triple burden” when examining the prevalence rates of HIV/AIDS among this population. Structural issues (e.g., institutional racism, poverty, gender inequalities) that sustain the disproportionate rate of infection among African- American women seldom are incorporated into HIV/AIDS prevention programs targeted at this client population. For example, gender plays a vital role when women are more vulnerable due to sexism, gender inequality, or financial dependency in personal and sexual relationships (Quinn, 1993).

According to Gilbert (2003) “poor African-American women tend to be overwhelmed by life’s circumstances, even before HIV became a threat to them” (p. 8). Primarily, the most vulnerable women susceptible to HIV/AIDS tend to be poor (Gilbert, 2003; Stein, 1998). This assertion is not meant to negate the strength and determination revealed among many low-income, single-parent, African-American women, but to highlight the disproportionate rate of HIV/AIDS infection among poor, single-headed female households in this country. Poverty, risky sexual behavior, and drug use is not restricted to inner-city, impoverished African-American women (Gilbert, 2003). However, if HIV prevention efforts are to result in positive outcomes for African-American women, then the existence and consequences of racism, sexism, and classism must be realized in this society.

Health Disparity and Access to Care

Hellinger (1993 as cited in Peterson, 1995) conducted the AIDS Cost and Service Utilization Survey (ACSUS) in order to examine the use of health services by women with HIV in the United States. This study revealed that 55% of the women in the

ACSUS sample had incomes of less than \$5,000 in 1990, in comparison to 31% of the men participating in the study. Women were more likely than men to depend on, and be eligible for public welfare support, and less likely to have private insurance. Generally speaking, for women to have access to medical services (e.g., hospitals, emergency rooms, clinics, physicians' offices) payment for these indispensable services must be available, regardless if the source of payment is private insurance or public health aid. Even for those individuals who have the means to pay for private insurance, the positive results of an HIV-test might be the basis for insurance companies to deny coverage, forcing the cost of the epidemic into the public arena (Stein, 1998). Lloyd (1995) reports that "the monetary cost of treating a person with HIV in the United States from the time of infection to death was estimated in 1993 to be \$119, 000" (p. 1268) [recent lifetime HIV treatments have skyrocketed in 2006 to approximately \$600,000 for a 24 year span or \$2,100. monthly...CBSNews.com].

Under the Clinton Administration, \$9.2 million was budgeted in 2000 for total HIV/AIDS funding in the following fiscal year [2001] (HHS, 2000). Recently, President Bush in his 2006 budget requested \$206 million for abstinence-only sex education programs, a \$38 million increase over the FY 2005 level (Kaiser Daily Health Reports, 2005). However, according to the 2007 budget proposal, the Health Resources and Services Administration (HRSA) would receive a \$181 million funding increase to fund 300 new or expanded community health centers, as well as \$188 million to fund new HIV/AIDS initiatives. This includes funds to test three million additional citizens for HIV, and provide HIV/AIDS drugs to low-income individuals currently on state waiting lists. However, with an overall \$25 million reduction proposed in funding for the HRSA

in 2007, major cuts are expected in CDC operations over the next several years (Kaiser Daily Health Reports, 2006). The influence this will have on policies and available resources affecting African-American women and HIV/AIDS prevention is uncertain. The vital investment needed for effective disease prevention interventions for at-risk populations is critical. African-American women can no longer risk the negative consequences of HIV infection by remaining undetectable regarding the HIV/AIDS pandemic.

Women and clinical trials. Stein (1998) reports that “throughout the early 1990s, men [initially believed to be a white male gay disease] were the primary focus of AIDS research, treatment, and prevention programs. Women were either excluded from or underrepresented in trials of drugs to treat HIV and AIDS” (p. 47). Gant (1995) states that prior to this focus of attention on white gay males, government officials primarily held a stance of “near-nonexistent response” to AIDS in the 1980s, and volunteers and private organizations provided support to the gay population in community-based programs (p. 1308). Early clinical trials using azidothymidine (AZT) initiated both feelings of hope and frustration due to severe side effects, but this drug was thought to be the first step toward a cure for patients with advanced symptoms of HIV (Lloyd, 1995).

Additionally, the focus of research has been on “vectors of transmission” with more attention given to prostitutes infecting heterosexual men and mother-to-child-transmission (Peterson, 1995). The infections specific to women that originally defined AIDS (e.g., atypical inflammatory disease, vaginal yeast infections, cervical cancer) were not included in the CDC reports, since HIV transmission among women was not the

focus of attention. In 1993 the CDC finally revised the definition of AIDS to include these opportunistic infections affecting women (Lashley, 2000; Peterson, 1995).

African-American women and disparity in health outcomes. African-Americans have a higher frequency of and inferior survival rate for many diseases (e.g., lung cancer, cervical cancer, cancer of the esophagus). Additionally, the excessive use of alcohol, tobacco, and illegal drugs result in health problems for many African-Americans (Leashore, 1995). Improvements in health status for disadvantaged African-American women are hindered by poverty and socioeconomic status, resulting in significant differences in health outcomes (Bassey, 2003; Edlin et al., 1994; Gilbert, 2003; McBarnette, 1996; McBride, 1991; Quinn, 1993). For example, “the life expectancy at birth for Americans was at an all-time high of 75.5 years in 1991. The highest life expectancy at birth, 79.6 years, was for white women followed by African-American women (at 73.8 years)” (Leashore, 1995, p. 111). Further examination is required to evaluate the influence of socioeconomic status on the life expectancy of women of all races. Regarding HIV diagnosis, a gynecological problem can be one of the first indicators of HIV in women. Lack of accessible health care and insurance impede the possibility of early diagnosis and treatment for impoverished women (Stein, 1998).

Moore and Collins (2002) expound upon the fear and distrust of the government and medical system. According to these scholars, many African-American women believe in conspiracy theories related to AIDS, which could delay proper diagnosis and treatment. Some African-Americans believe that the government promoted drug use in African-American communities creating the spread of HIV/AIDS among African-Americans. This fear of becoming “human guinea pigs” resulted from the Tuskegee

Syphilis Study conducted for 40 years until the early 1970s when 107 out of the 400 African-American men involved in the study died from not being properly treated for syphilis (Leashore, 1995; Moore & Collins, 2002).

Further examination is required to better understand how AIDS conspiracy theories interact with risky sexual behaviors among African-Americans. What is the perceived correlation between these conspiracy beliefs and condom use? Some African-Americans fear that condom use based on HIV-infection threats could result in fewer births and eventually annihilate the African-American race (Moore & Collins, 2002). It is vital for social workers and researchers to understand how myths related to AIDS conspiracy perceptions, socioeconomic, racial, and gender issues interrelate with health outcomes for African-American women.

Substance Abuse

Pure cocaine is one of the oldest known drugs, and coca leaves [source of cocaine] have been ingested for thousands of years. Crack is the processed form of powdered cocaine hydrochloride transformed to a smokable substance. The street name crack refers to the crackling noise heard when being smoked, and it is processed with ammonia or baking soda and water to remove the hydrochloride. Users are vulnerable to this drug due to the immediate euphoric effect [high in less than 10 seconds], and the inexpensive cost (National Institute on Drug Abuse [NIDA], 2002).

In the report issued by NIDA (2002), an estimated 1.5 million Americans were current cocaine users based on the 1997 National Household Survey on Drug Abuse (NHSDA). However, the Office of National Drug Control estimates the number of chronic cocaine users in this country to be at 3.6 million (NIDA, 2002). Beginning in

1994, the Center for Substance Abuse Treatment (CSAT) has been influential in targeting community-based programs identifying high risk injecting drug users in racial and ethnic communities with a total investment of \$32 million in 2000 (HHS, 2000).

Intravenous drug use (IDU) and crack-cocaine abuse have been instrumental in spreading HIV infection among African American women, especially if they are exchanging sex for drugs or money (Gilbert, 2003; Peterson, 1995). However, this client population experiences differential levels of HIV risk, because not all crack users are exchanging sex for drugs (Logan, Leukefeld, & Farabee, 1998). Also, even when African-American women do not use drugs or do not engage in risky sexual behaviors, they are still at higher risk than their female counterparts in society because of the disproportionate number of their male counterparts who are drug users, and have primary sexual relationships with women (Gilbert, 2003). When women are not aware of their male partners' drug use [men involved with IDU, crack-cocaine, or other substances frequently conceal drug habits], they are found to be at risk for HIV/AIDS unknowingly, because of having sex with drug-using spouses or intimate partners (Gilbert, 2003). Even though an individual might attempt to obtain information about his/her partner's sexual, medical, and/or drug history, intimate partners are not always factual in disclosing information related to these issues; therefore, African-American females involved with drug-using male partners are disproportionately vulnerable to HIV/AIDS.

These gender and ethnic group disparities are associated with the overall risks of HIV/AIDS correlated with poverty and IDU. This method of drug use represents the greatest factor influencing African-American women's exposure to HIV-infection, described as the “intersecting” or “twin” epidemic, which results in a disproportionate

exposure to heterosexual transmission due to social networks [e.g., drug-abusing, impoverished male partners].

Women are underrepresented in traditional drug treatment programs, and usually experience high levels of stress due to child-rearing responsibilities, financial difficulties, and low self-esteem. Additionally, African-American women with drug-related influences in their lives experience higher degrees of depression and anxiety, medical problems, and family-of-origin issues in comparison to male counterparts (Gilbert, 2003; Logan et al., 1998; Wyatt, 1997). Therefore, the expectation for this population of women to change both their drug-using behaviors and high-risk sexual practices create many dilemmas for this population. Also, ethnic minorities experience the negative consequences of AIDS, poverty, and IDU disproportionately compared with white populations in society (Gilbert, 2003; Logan et al., 1998; Wyatt, 1997).

Epistemological Interpretation

The Relationship of the Knower to the Known

I must be attentive to my personal biases as I explore the experiences of African-American women and issues related to sexual decision-making. When I initially became disturbed by the overwhelming HIV/AIDS statistics involving women-of-color, I could not help but wonder why women were not insisting on their partners wearing condoms, or taking more aggressive steps to protect themselves. Later, I realized that I was attempting to integrate my values about sexual decision-making as I explored issues related to this topic and imposing them on other women. All African-American women do not share my beliefs concerning intimate matters in relationships. Nevertheless, the diversity observed within this client population further expands the gap of knowledge

pertaining to their risky behaviors. I was attentive to the need to manage my personal biases while conducting this investigation.

When attempting to generate new knowledge in order to grasp what is unknown about the risky sexual behaviors of African-American women, it is necessary to explore the relationship between the researcher [the knower] and the analyzing and theorizing of data [what becomes known]. Simply stated, according to Coffey and Atkinson (1996) this construct, “the relationship of the knower to the known,” can be interpreted as meaning the processes of generalizing and analyzing data. This requires the qualitative researcher to go “beyond the data” and begin to think with the data. In other words, theorizing is not perceived as a separate stage of the data collection and research process, but is aligned with analysis. These scholars argue that “good research is not generated by rigorous data alone” (p. 139). For example, developing new ideas requires going beyond coding and manipulation of data. This involves the “intertwining” or interconnecting of the researcher’s interpretation of what is being observed, along with the views or observations of participants themselves, and possibly feedback from other professionals in the field. Silverman (2004) furthers this notion of interpreting ideas as being central to any research process by suggesting that theory-building is actually giving detail and understanding to data collected from obscure or unknown information gathered by investigators.

Furthermore, “the relationship of the knower to the known” is a concept applicable to this target population. There is a need for researchers and professionals to understand the meaning of sexual decision-making in such a manner that is relevant to African-American women. It is imperative to understand what is known about the

historical and cultural aspects of this population of women. In the sixteenth century African women lived within strict boundaries regarding sexual behaviors (e.g., rituals, family approval, marriage) only to be disrupted by the institution of slavery, which altered the sexuality patterns of stolen Africans and their descendents (Wyatt, 1997). According to Wyatt (1997), sexual behavior was taken out of its cultural and natural context, and sex became something to be dreaded by enslaved black women who no longer had rights over their bodies and frequently were raped. This scholar argues that the historical systematic assault on African-American women's sexuality, which began more than three hundred years ago, continues to affect African-American women by the contemporary societal stereotyping of their sexuality and the generational psychological burden of slavery.

In addition to the relevance of historical and cultural aspects of identified populations, I believe that at-risk groups must feel some sense of vulnerability or threat in order to change risky behaviors. If I view this stance from a “positivist” perspective with the intent of better understanding harmful [unsafe] behaviors, I would provide evidence in support of behavior observed in an objective approach and analyze the data collected in a measurable [quantitative] manner. On the other hand, if I adopt a “postmodern” view, which allows for a broader scope of considering the complexity of risky human behavior, I would include observations, meanings, symbols, and would encourage participation from clients in the [qualitative] process (Payne, 1997; Schriver, 1998; Turner, 1996).

I respect the “pros and cons” of traditional and alternative paradigms in ascertaining new knowledge, with the proclivity to learn from all scholars engaged in the

discourse of new discovery. However, I chose to view this social issue from the perspective of the following four dimensions (Jordan, 1995) as they relate to the qualitative paradigm: (1) perceptions of reality, (2) ways of knowing, (3) value bases, and (4) applications.

Perceptions of Reality

African-American women's perceptions of reality are viewed from the stance as being multiple and holistic in nature if examined from the perspective of the qualitative paradigm (Bell & Opie, 2002; Meloy, 2002; Rudestam & Newton, 2001). According to Rudestam and Newton (2001), contemporary qualitative researchers understand issues from the natural environment in various stages over time with an emphasis on “the socially constructed nature of reality” (p. 36). These scholars further explicate that the holistic position is clarified by attempting to “understand phenomena in their entirety in order to develop a complete understanding of a person, program, or situation” (p. 37). This is in contrast to the quantitative approach, which attempts to isolate and operationalize variables for purposes of measurement and prediction (Bell & Opie, 2002; Rudestam & Newton, 2001). Timmons and Sowell (1999) investigated the concept of multiple and holistic realities.

These researchers examined the perceptions of 19 heterosexual African-American women, ages 18 to 44, regarding perceived HIV-related sexual risks and prevention practices. An exploratory method of inquiry was used involving an informal, but structured focus group discussion, “which is an efficient means of determining the range of experiences among a group of people” (Timmons & Sowell, 1999, p. 582). The following four themes were revealed by the use of content analysis: (1) a man will be a

man, (2) inconsistent and/or no condom use, (3) safe relationships, and (4) racism and discrimination. These participants disclosed that they perceive safety in relationships with primary, monogamous partners, but acknowledged that men will cheat on women. In addition, women felt powerlessness over men's behavior, ranging from inconsistent condom use to infidelity.

An unexpected finding was the importance of racism and discrimination in their perception of risk of HIV infection. Participants perceived themselves as victims in society with limited social and economic options in their lives. Some women spoke of a conspiracy theory suggesting that HIV had been placed in African-American communities by a racist government. However, some women commented that if the government placed something harmful in African-American communities to be damaging, it is more critical to use protection against HIV. Timmons and Sowell (1999) offer further explanation, "It was not that women attributed individual sexual behaviors to racial discrimination, but rather that discrimination resulted in a context of rejection and victimization in which they lived their lives" (p. 587). Women in the study insisted on sharing their views of racism and discrimination and how these injustices were associated with their risk of contracting HIV. It appears that many women related risk of HIV in African-Americans to the racist actions of Caucasians [sic] (Timmons & Sowell, 1999).

This discovery of participants' perceptions of a connection between discrimination and HIV risk is not to imply that racism is linked empirically to HIV/AIDS and/or sexual decision-making, since there is no way to fully explain universally how various risk factors influence the rate of HIV or choices related to sexual

behavior (Timmons & Sowell, 1999). More accurately, the significance of this component of the study is connected to the perceptions held by participants and their willingness to express these views candidly. In order to develop effective models to promote the health of women, it is essential to better understand pertinent issues that need to be addressed with target groups. For instance, genocidal conspiracy theories are based on the notion that the use of condoms to prevent the spread of HIV is another way for the government to annihilate various racial groups by decreasing the birth rate (Ross, Essien, & Torres, 2006). Furthermore, if African-American women perceive themselves to be oppressed based on reported discrimination and structural barriers related to race, gender, or economic status (e.g., disparities in access to health care, treatment outcomes, transportation), then it is vital to examine the influence their perceptions have on prevention efforts. Therefore, it is critical to concentrate on myths and conspiracy theories related to HIV transmission, if prevention efforts are to be advantageous for African-Americans and other at-risk groups.

Timmons and Sowell (1999) encouraged researchers and practitioners to integrate prevention interventions focusing on social and economic factors and to further test for “culturally relevant HIV infection prevention interventions for African-American women” (p. 589). This approach would “define the context of women's lives,” and further explore the meaning of “safe relationships” from the perspective of African-American women (Timmons & Sowell, 1999, p. 589). Power expressed in interpersonal relationships is not clearly defined in terms of how it influences sexual decision-making (Pulerwitz, Gortmaker, & DeJong, 2000). In the case of financial dependence on male

partners, women who fear losing economic support for family members probably will not challenge intimate male partners regarding the negotiation of sexual decision-making.

However, power differences between men and women regarding sexual decision-making seem to require further examination. In the broadest context of the meaning of power, it can imply power-over another person, or power-to someone, giving them personal authority (Rampage, 1994). Some women are willing to give their power to men willingly for the sake of pleasing them, while sacrificing their well-being. For example, if a man complains about not liking the feel of condoms during sexual intercourse, a woman might engage in condomless sex for his pleasure. On the other hand, if women perceive that their male partners have power-over them, the presumption of equality in intimate relationships is no longer realistic, resulting in the feasibility of coercion and abuse, or increased risk of contracting HIV. Of course, there are women not willing to give in to demands of control in intimate relationships, and who will assert themselves with male partners straightforwardly.

In regards to African-American women, HIV risk among poor, uneducated females, along with other societal factors contribute to difficulties making healthy choices, including sexual negotiation (Bunting, 1996; Gilbert, 2003; Logan et al., 1998; Wyatt, 1997). As mentioned previously, African-American women's decision-making in intimate relationships is influenced by the sex-ratio imbalance. This causes perceptions of less power by women in communities where there is a shortage of available males, and an abundance of women (Rampage, 1994). For example, this imbalance creates power differentials in intimate relationships forcing some women to accept such behavior as "man sharing" out of fear of losing their men to other women.

Ways of Knowing

A critical aspect of the qualitative paradigm involves inductive reasoning, which is “the process by which theories and generalizations are evolved from a set of particular observations,” and can establish explanations about more complex phenomenon (Barker, 2003, p. 217). This is in contrast to deductive reasoning, which is “the process by which particular conclusions are reached by starting with general principles believed or shown to be true” (Barker, 2003, p. 111). Therefore, deductive reasoning adheres to a strict principle of logic and reason, whereas, inductive reasoning is flexible and allows for knowledge to be personally constructed and made relevant to contextual aspects (Rudestam & Newton, 2001). Qualitative research entails linked and multiple workings, rather than discrete and linear thinking (Meloy, 2002).

In order to grasp a qualitative perspective of the social issue in this inquiry, one must think about the sexual experiences of African-American women, and how these experiences are made known to others. This is accomplished by capturing the detailed experiences of a few participants, and consequently these experiences are considered only in relation to the larger scheme or dilemma. “Ways of knowing” are exemplified through testimonies, stories, symbols, and shared secrets. African-American women’s life experiences are progressively discovered, and the uniqueness of their sexual practices is critically examined but valued for their cultural relevance.

Value Bases

I believe that in order for African-American women to feel safe in relationships, the construct of power, which has sociopolitical, cultural, and gender relevance, demands more in-depth examination from the views of this population of women. An approach

involving multiple and holistic perceptions of reality is needed in order to advance knowledge concerning this social predicament.

I have faith in one basic value guiding this qualitative inquiry; my life is not separate from the lives of the African-American women facing various challenges regarding sexual decision-making and HIV/AIDS. Therefore, I am simply stating that the process of investigating this private and sensitive topic is “value-bound.” As a qualitative researcher, I acknowledge that I enter into a partnership with participants in order to collect data about participants' lives and sexual experiences. However, while this interconnectedness exists between us, there are also many differences that will not be shared because of the uniqueness that belongs to every individual African-American woman.

For instance, Gilbert (2003) speaks of heightened HIV risk among African-American women due to perceived need for multiple male partners for financial security, restricted marriageable males, and men's multiple relationships (p. 18). Gilbert's stance on this topic instigates a yearning for more in-depth knowledge as to how some African-American women survive on righteous principles and religious-based morality regarding intimate relationships with male partners, whereas, others succumb to desperate means to maintain men in their lives, even if it means engaging in risky behaviors. As researchers, we must be sensitive to the value differences that exist within this population of women and be willing to learn from them.

Applications

Research on populations-at-risk requires an emphasis on the impact of economic deficiency, racism, sexism, and covert oppression on marginalized groups (Gilbert, 2003;

Lee, 2001; Quinn, 1993; Schriver, 1998; Wyatt, 1997). Qualitative applications are not generalized across large populations, but rather are reflective of the participants involved in the inquiry, resulting in a deeper understanding of issues involving these members (Bell & Opie, 2002; Meloy, 2002; Rudestam & Newton, 2001). Undoubtedly, application of results is not intended to predict a pattern of behavior among a large population of African-American women, but rather ascertain insight into sexual decision-making in view of the sweeping HIV/AIDS pandemic.

This inquiry will unveil real-life narratives from participants affected by cultural norms and values. The context of these narratives is vital in unraveling the mystery associated with the meaning of high-risk sexual behaviors from the perspective of participants. The key to collecting and analyzing the data is to understand the stories, symbols, and meanings shared by participants in the study with the intention of applying this knowledge to imminent culturally-competent and effective intervention strategies to prevent HIV/AIDS among this at-risk population.

Research Questions

This investigation will focus on the following salient research question: (1) How are African-American heterosexual women perceiving their risk for contracting HIV/AIDS during sexual decision-making when involved in issues related to power disparity (e.g., condom negotiations) with male partners? This grand tour or primary question is the query that will guide the investigation and rationale for the qualitative research design of this study. From the grand tour question follows these subsequent questions: (2) What does having a safe sexual relationship mean to African-American women? (3) Is there an indication from African-American women that they sense actual

modification in their sexual behaviors, and in what ways, as a result of what they have learned about HIV/AIDS prevention? The aim of this research is to enhance the development of health promotion interventions for African-American women by strengthening effective HIV/AIDS prevention strategies targeted to this population of women. According to Rudestam and Newton (2001), "Research questions in qualitative research can be revised or reformulated as the study proceeds" (p. 44). This approach requires flexibility and the ability to analyze the emerging data in order to obtain valuable information from participants.

A REVIEW OF RELEVANT LITERATURE:

African-American Women And Risky Sexual Behaviors

Researchers have examined existing theories and models of HIV/AIDS prevention and intervention strategies as an attempt to understand what is known about African-American women's sexual behavior and to reduce the frequency of this disease among this population of women. Traditional HIV/AIDS prevention efforts are influenced by existing behavioral theories and models, such as cognitive theory, ego psychology theory, psychoanalytic theory, and social learning theory (Doyle, 2001; Gilbert, 2003; Icard & Schilling, 1995; O'Leary, 2000; Wyatt, 1997). These conceptual frameworks were assumed to be effective in preventing HIV infection among African-American women and other subgroups in the general population (Gilbert, 2003). This review of the literature examines a range of complex issues affecting African-American women's sexual practices related to the grand tour question and subsequent questions.

The focal point of this literature review is on how scholars using distinct theoretical frameworks applied to a number of recent studies have attempted to understand HIV risks among African-American heterosexual women. Risky sexual behaviors among these women are explored in relation to their intimate male partners, along with barriers to behavioral changes. For example, Wyatt and associates (1997) analyze various theoretical frameworks, such as the Health Belief Model, AIDS Risk Reduction Model, and Social Learning Model in an attempt to identify pertinent dimensions influencing sexual decision-making and sexual behaviors among African-American women. These dimensions (e.g., interrelatedness, sexual practices, quality of relationship, economic status) were hypothesized to affect risky sexual behaviors. As a

result, these scholars concluded that the various models examined in the Wyatt et al. (1997) study varied in effectiveness in addressing socio-cultural and gender-related factors that influence sexual decision-making among this population. Furthermore, there was a strong recommendation by Wyatt and Ashing-Giwa (1997) to modify existing models to integrate socio-cultural factors that ultimately will enhance sexual behavioral changes among African-Americans. Likewise, some scholars argue that different theories and models are being applied in contexts that are not within the boundaries for which they were designed (Airhihenbuwa & Obregon, 2000). Additionally, much of the research aimed at HIV prevention targeting African-Americans has not been theory-driven (Beatty, Wheeler, & Gaiter, 2004). Several of the dimensions (e.g., sexual practices, sexual socialization, economic status) affecting sexual decision-making among African-American heterosexual women are examined within the context of three theoretical frameworks in this review. The following theoretical frameworks in the literature are strongly associated with advancing health-related behavioral changes and are applicable to this target population: (1) the Health Belief Model (HBM), (2) the Transtheoretical Change Model, and (3) the Black Feminist perspective.

Existing Intervention Paradigms

The Health Belief Model

Many of the HIV intervention models are influenced by theories originating in social psychology (Airhihenbuwa & Obregon, 2000). For instance, Lantz (1996) asserts that the central premise of the social cognitive approach (e.g., Bandura's Social Cognitive Learning Theory) centers on human personality influenced by physical and social factors, and “a person’s thinking is the principal determinant of emotions and behavior” (p. 94).

The psychosocial paradigm or model is based on the assumption that behavior is learned through experiences of interpersonal relationships (Payne, 1997; Schriver, 1998; Turner, 1996). Even though these psychosocial paradigms integrate constructs of social and environmental influences, the Health Belief Model (HBM) is criticized for excluding these dominant influences (Airhihenbuwa & Obregon, 2000). However, the HBM details the importance of knowledge and beliefs and was developed “to predict individual response to, and utilization of, screening and other preventive health services” (Airhihenbuwa & Obregon, 2000, p. 6). To be precise, the aim of this model is on individual health behavior change and prevention, not the social and environmental factors influencing it.

The HBM originated in the 1950s based on the work of Rosenstock and other behavioral scientists. One of the primary questions during the 1950s for public health educators and researchers focused on prevention of illnesses (Airhihenbuwa & Obregon, 2000). Why were people not involved in preventive health care? The greatest benefit of the HBM was the contribution made by researchers attempting to predict and explain health-related behaviors (Burns, 1992; Rosenstock, Stretcher, & Becker, 1988). Another positive aspect of the HBM is its advancement beyond the traditional medical model, which restricted individuals in the decision-making process and actions regarding their health issues (Payne, 1997).

The following underlying assumptions provide the basis for the HBM and determine whether an individual will take action to prevent illness: (1) belief depending on the amount of perceived threat from the disease or feelings regarding the severity of the disease [e.g., thoughts of leaving a disease untreated], (2) perceived susceptibility or

one's subjective perception of the disease, and (3) perceived seriousness of the consequences or barriers related to the disease (Burns, 1992; Rosenstock et al., 1988). These suppositions are illustrated in the following situation: if a woman perceives the threat of contracting HIV as dangerous or threatening to her well-being, she will likely value the use of condoms because of perceived susceptibility to HIV. The outcome will result in less risk of her contracting HIV due to her perceived seriousness of the consequences of this disease. Simply stated, this woman will feel personally vulnerable to HIV, and as a result she will realize the seriousness of the consequences of HIV if contracted, and then will use condoms [take action] as a means of protection or prevention. It is critical to note that in general, people tend to underrate their own sense of susceptibility to disease, and knowledge does not necessarily mean behavior change (Redding et al., 2000). According to the ideology of the HBM, the chances that African-American women and others will make use of strategies [e.g., condom use] to prevent HIV depends on their perceived risk [susceptibility] of contracting this disease.

Then again, one theoretical approach does not simply fit all situations (Payne, 1997). This is particularly pertinent in situations involving risky sexual behaviors of women, and co-occurring factors (e.g., intravenous drug use (IDU), domestic violence (DV), and men having sex with men and women (MSM/W). The simplicity of the HBM does not consider the effect of co-occurring factors involving the prevention of risky sexual behaviors. These “mediating factors” are believed to indirectly influence perceptions of susceptibility (Redding et al., 2000, p. 183).

Even in situations when a woman is potentially well-informed of the facts regarding HIV/AIDS, and is motivated to change behavior, condom negotiations for safer

sex practices are required, which includes more frequent use of condoms, and fewer sexual partners (Gilbert, 2003; Lam, Mak, Lindsay, & Russell, 2004; Quinn, 1993). Furthermore, in order to initiate condom negotiations, effective communication skills are compulsory in order for her to successfully reduce the risk of contracting HIV/AIDS from her male partner(s) (Lam et al., 2004). Rampage (1994) remarked, “Feminists have argued that continued gender inequality has oppressed women, preventing them from having access to the same opportunities, challenges, and rewards as men” (p. 125). Specifically, individual [micro] models of behavior change, such as the HBM, undoubtedly do not explain the complexity of risky sexual behaviors, especially when it involves power disparities in intimate relationships with sexual partners. The HBM assumes that individuals will change behaviors based on knowledge and attitudes, if there is a perceived susceptibility to a particular disease (Airhihenbuwa & Obregon, 2000; Payne, 1997). However, what if behavior change (i.e., condom use) is beyond the control of an individual?

Another critical factor to consider regarding the HBM pertains to cultural issues. Airhihenbuwa and Obregon (2000) argue that health behaviors frequently are influenced by culture, and at times, researchers and practitioners mistakenly attempt to apply traditional models in contexts in which they were not designed. Misconceptions about HIV/AIDS are often learned through social and cultural experiences, and HIV prevention strategies would be significantly improved by awareness of how these cultural beliefs or myths influence sexual decision-making. Furthermore, Airhihenbuwa and Obregon (2000) assert that the HIV/AIDS pandemic heightened the awareness of the need to

consider cultural aspects in prevention efforts. Lam and colleagues (2004) exemplify this premise in their examination of condom negotiation strategies.

Many existing HIV/AIDS intervention models teach individuals verbal-direct condom negotiation strategies (i.e., asking a partner candidly to use a condom with the possibility of an angry response), but Lam and colleagues (2004) developed an exploratory scale that examined four distinct strategies verbal-direct, nonverbal-direct, verbal-indirect, and nonverbal-indirect. The relevance of this study is based on the notion that in order to prevent the spread of HIV/AIDS, sexual partners must be able to effectively convince their counterparts to use condoms, which involves safer sex communication. This study was a supplemental survey to the National College Health Assessment Survey (NCHAS), which involved sending health-related questionnaires to 2,000 randomly selected undergraduate students at a northern California university.

As a result of the recruitment procedure, 508 students responded, primarily female, with Asian and white American students predominately represented in the sample. Although direct [verbal and non-verbal] strategies were used more frequently, participants also used indirect strategies (e.g., dropping hints, placing condoms in view of partners, placing condoms on partners). Lam and associates (2004) contend that not only are indirect condom strategies more significant than indicated in earlier HIV/AIDS prevention studies, but gender and cultural differences in communication styles are critical factors in prevention approaches. Women used nonverbal-indirect strategies more than men, and Asians used verbal-indirect strategies more than whites. Unquestionably, gender and culturally-based aspects of condom negotiations are relevant to power issues

in relationships, which are critical components of safer sex decision-making (Pulerwitz et al., 2000).

In Asian culture, sex is not openly discussed because it is considered a private matter, and these taboos encourage the use of nonverbal and indirect forms of condom negotiations (Lam et al., 2004). According to Airhihenbuwa and Obregon (2000), advocating HIV prevention efforts involving verbal-direct approaches are culturally inappropriate in the context of intervening with Asian-American females. Likewise, gender and cultural issues are critical factors to be examined when exploring risky sexual behaviors among African-American women.

Essien and associates (2005) investigated strategies for prevention among twenty-five African-American women, aged 18-29, recruited from a low-income housing project in Houston, Texas. In this qualitative study, drugs and alcohol were reported as barriers to practicing safer sex, along with the need for money to purchase food or drugs. Even though participants were aware of consequences of HIV/AIDS, about one-third of participants perceived no personal risk due to involvement in monogamous relationships with male partners. Other reasons given for not using condoms included no money to purchase them, partner's refusal to wear one, and being unprepared at the time of the sexual act.

Self-efficacy [desire or capability to produce change in one's behavior] was indicated as one of the most positive aspects of the Essien et al. (2005) study. This was evident by the motivation of participants to practice safer sex due to fear of contracting HIV and other STDs, desire not to become pregnant, and personal experience with someone who had contracted HIV/AIDS. Women valued their lives enough to

contemplate the significance of changing risky sexual practices, even if changes were based on perceived fear. In contrast to the inner-city location of the study by Essien et al. (2005), the construct of self-efficacy among sexually-active African-American female college students also proved to be the strongest predictor of condom use in a study by Southerland (2004). The primary purpose of this dissertation was to assess the factors that were correlated with male condom use among African-American college women, ages 18-24, at the University of Tennessee, based on the HBM. A convenience sample of 196 sexually-active participants was recruited from the Black Cultural Center. Since self-efficacy was the strongest predictor of condom use for both of these above-mentioned studies targeting African-American women, this construct will be examined as it relates to the HBM.

If the primary assumption driving the HBM involves the individual taking action to prevent illness based on perceived susceptibility, then the model [or any health behavior model for that matter] must theoretically indicate a significant degree of usefulness (Rothman, 2004). Scholars continue to debate those factors constituting value-driven theories, but that is not the purpose for this review. The aim is to examine how health behavior models can accurately account for risky sexual behaviors among African-American women during the HIV/AIDS pandemic. Consequently, how can college-educated African-American women living on campuses across the country be at risk for contracting HIV/AIDS, along with poverty-stricken inner-city African-American women? Further research is needed in this area. In order to ascertain adequate statistics on the rate of HIV infection among African-American college females, the CDC will need to allocate additional funding. Researchers at CDC conducted a blind study at 19

American universities using anonymous blood samples, and CDC researchers estimate that 1 in 500 American college students (not specified by ethnicity or gender) probably has the HIV virus (Kaiser Daily HIV/AIDS report, 2004). In reality, even though poverty and insufficient education are some of the contributing factors to be considered in the frequency of HIV among more vulnerable women, these variables do not adequately account for the disproportionate rate of HIV/AIDS among the population of African-American women at large.

Rothman (2004) argues that interventions should be more receptive to theory-building. In fact, according to this scholar, interventions can be used to test and refine theory. Therefore, if the construct of self-efficacy is to be used to build and re-conceptualize the HBM in order to promote health behavior changes among African-American women at risk for HIV, then a workable definition of self-efficacy is needed. Self-efficacy must be defined in such a feasible and practical way as to link effective culturally-competent interventions to theory-based models (Rothman, 2004). Then, interventions actually will be more receptive to theory-building. This necessity for the re-conceptualization of the HBM, in order to be more advantageous in promoting health behavior changes, is exemplified in a study by Tross and colleagues (1992).

Tross et al. (1992) examined determinants of condom use in female sexual partners of IV drug users in New York City. In a random sample of 346 women, primarily Latina [80%], Tross and colleagues (1992) recruited participants from a housing project in the Lower East Side of Manhattan. This study was based on similar constructs of the HBM in the Southerland (2004) investigation. As a result, self-efficacy concerning condom use was once again a strong indicator of whether participants were

inclined to use condoms. Tross and colleagues (1992) interpret the findings of their study [self-efficacy] as an indication that culturally-specific programs should be targeted at Latina and African-American women who are less likely to be involved in current condom use or unlikely to use condoms in the future. However, similar to other studies based on the HBM, Tross et al. (1992) used different questions to determine the meaning of the constructs defining self-efficacy. Therefore, it is extremely difficult to compare how the meaning of self-efficacy is being used across studies in order to be “useful” in the prevention of HIV/AIDS concerning vulnerable populations. The implementation of HIV prevention strategies must be examined in order to determine their effectiveness with a diverse population of African-Americans, regardless of the mediating factors involved.

Even though gender, race, nor poverty, inescapably place African-American women at risk for HIV/AIDS, many studies link low socioeconomic status among this population of women to exchange of sex for food, alcohol and drug use, domestic violence, and power disparity in relationships (Gilbert, 2003; McBarnette, 1996; McBride, 1991; Quinn, 1993). However, the results of the Southerland (2004) investigation strengthen the premise that self-efficacy is highly relevant to at-risk African-American women, whether they are surviving in the daily existence of inner-cities, or on college campuses. Moving beyond the stereotypes of sexual practices, and understanding the role of self-efficacy, has significant implications for HIV/AIDS prevention among African-American women.

Although the Health Belief Model (HBM) has functioned as the primary theoretical framework for numerous studies examining preventive health strategies,

Burns (1992) argues for an expanded model with reconstructions designed to better comprehend and manage social and cultural factors interrelated to complex risky behaviors. Even though Redding et al. (2000) claim that the HBM has been modified since its original formulation, further testing is needed regarding the effectiveness of preventing HIV/AIDS among vulnerable populations. Also, these scholars argue that self-efficacy is a key factor in more recent modifications of the model.

This current study provided another means of expression for African-American women to “voice” their perceptions of HIV risk, and in future studies further enhance culturally-competent interventions needed to construct a “useful” health behavior model for this population of women. The construct of self-efficacy will have greater significance concerning HIV prevention, if the meaning of the construct is defined by the population it is intended to target. The aim is the achievement of long-term compliance with prevention recommendations (Rothman, 2004). Furthermore, reconstruction of the HBM will allow for external factors (e.g., poverty, education, trauma) influencing perceived susceptibility of diseases to be examined without placing blame on the individual in regards to behavioral change. For example, stigmatization of individuals with HIV/AIDS is to some degree still supported by the perception that this disease is a curse from God for immoral behavior (Solomon, 1996).

In summary, there is a need for scholars to better understand African-American women's perceptions of perceived HIV-related risks, which was the goal of this current investigation. The HBM is one traditional theoretical framework providing the foundation for theory-based research in this area. The early focus in the 1950s on the prevention of diseases is still applicable during the current HIV/AIDS pandemic. In my

opinion, the lack of consideration of mediating factors influencing health practices, including risky sexual behaviors, and ambiguity concerning the meaning of self-efficacy across studies, seriously limits the usefulness of this Health Belief Model regarding African-American women and HIV prevention.

The Transtheoretical Change Model

The majority of new HIV cases in women result from risky sexual behaviors through heterosexual transmission (Centers for Disease Control and Prevention [CDC], 2003). In order to conceptualize how women can change their behaviors, the Transtheoretical Change Model [Stages of Change Model] is explored. Psychologists James Prochaska, Carlo DiClemente, and John Norcross developed this model in 1982 with the underlying premise that therapy should be tailored to the needs of a person and reflect a stage of change. The underlying assumptions of this approach are based on the belief that behavioral change is a series of incremental steps, and the movement between stages has a spiral effect, resulting in flexibility for clients to move between various stages of behavior (Prochaska, DiClemente, & Norcross, 1992). The emphasis is on “intentional” behavioral changes [e.g., clinical issues such as condom use, mammography, medication compliance]. The examination and attempted modification of different health-related behaviors have resulted in countless studies based on this theoretical framework. One of the primary advantages of this model includes the definition of behavior change as a process instead of an event (Prochaska et al., 1992). To be precise, this approach is in contrast to the direct linear and individualized behavioral changes theorized in classical health prevention models such as the HBM. Also, there is a belief that individuals facing a specific problem will encounter the same stages of change

as they are working through the situation, regardless of the identified problem. The Transtheoretical Change Model provides tools for research advancement and intervention development, along with attempts to measure and define constructs as they relate to each stage of change involving various behaviors (Redding et al., 2000).

Many factors are interwoven in participants' lives, which influence intentions, behaviors and readiness to initiate changes in behaviors (Prochaska et al., 1992). For instance, a woman's perception of susceptibility to contracting HIV, or her attitude and beliefs about this disease will influence her "readiness" to change risky sexual behaviors. This continuum provides a series of steps or stages on a behavior-change continuum: (1) *precontemplation* [an at-risk woman may have no serious thought of changing risky sexual behaviors], (2) *contemplation* [a woman may now consider changing risky behaviors in the distant future], (3) *preparation* [now the woman is ready to adopt behavior in the immediate or foreseeable future, possibly may attempt to initiate change in behavior], (4) *action* [the woman has adopted new behavior], (5) *maintenance* [changes are becoming a routine part of the woman's life], and this next stage has the potential to occur (6) *relapse* [movement through changes in a woman's life become more predictable with possibility of relapses in the altered behavior]. Relapse throughout the various stages occur frequently as individuals attempt to modify or eradicate addictive or risky behaviors, and "stabilizing behavior change and avoiding relapse is the hallmark of maintenance" (Prochaska et al., 1992, p. 1105).

The Transtheoretical Change Model allows for consideration of a wide range of sexual behaviors and addictive disorders (e.g., pornography, smoking, compulsive eating, crack-cocaine use). However, the contextual factors involving stages of behavioral

change in relation to African-American women are not consistently recognized in HIV prevention models. Traditional assumptions of sexuality define sexual behavior as primarily heterosexual or homosexual (straight/gay dichotomy). Many researchers do not acknowledge the affect of homophobia in African-American communities and the role of homophobia regarding HIV risk among African-American heterosexual women. This is not to suggest that staging models, such as the Transtheoretical Change Model, do not successfully promote health behavior changes among diverse populations. However, key concepts from other models or theoretical frameworks in conjunction with staging models, enhance the opportunity to “tailor” effective strategies (Oldenburg, Ffrench, & Glanz, 1999). Fullilove (2001) speaks of the “elephant in the room” regarding bisexual behavior among African-American males. According to this scholar, some African-American men will have sex with other men in prison, but once released, will return to wives and girlfriends. These men will possibly maintain heterosexual relationships outside of prison. However, many African-American women attribute their men being in and out of prison as the reason for bisexual behavior among African-American men (Fullilove, 2001). This cycling conduct regarding incarcerated men might be interpreted as staging or readiness to change behavior with the possibility of intervention development through staging models. Therefore, the application of the Transtheoretical Change Model, along with knowledge of Afrocentric-based community strategies, potentially can eradicate the “elephant in the room” barriers by promoting culturally-competent stages of change interventions among African-American individuals, couples, and surrounding communities.

African-American men who hide having sex with men and women [MSM/W] identify primarily as heterosexual, and frequently are referred to as being “on the down low” [DL]. Therefore, safe-sex messages targeting gay or bisexual men do not apply to them (Wohl et al., 2002). As a result, an African-American woman going through stages of change regarding her own risky sexual behaviors may not have knowledge of her partner(s) living a dual sex life, placing her at higher risk for contracting HIV (Gilbert, 2003; Stokes & Peterson, 1998; Wohl et al., 2002). Homosexuality is a cultural taboo, similar to sex not being discussed openly in Asian culture, which creates secrecy among African-American women and their intimate male partners (Stokes & Peterson, 1998; Wohl et al., 2002).

Wohl and associates (2002) examined risky behaviors of 90 HIV infected and 272 uninfected African-American men in Los Angeles county who self-identified as heterosexual. In this study, 31% of the HIV infected men reported inconsistent condom use when engaging in anal sex with men. Of the uninfected HIV men [HIV negative men], 16% reported having anal sex with men, and of these males, 67% reported inconsistent condom use. What is most striking is that 46% of the HIV positive men, and 37% of the HIV negative men, who had anal sex with men and identified as heterosexual, also reported having anal sex with women with infrequent use of condoms. Consequently, female partners of the men in this study are at-risk for HIV transmission due to lack of awareness of their men's risky behavior or their HIV status. Along with the high risk of HIV transmission due to MSM/W related to inconsistent condom use, this study reveals another vital discovery. Self-homophobia, personal fear and/or revulsion related to one's identification with homosexuality, is a factor in high-risk behavior among

MSM (Wohl et al., 2002). To be truthful, this means that MSM/W do not want to admit their homosexual behavior to women, leaving women unknowingly vulnerable to contracting HIV/AIDS. Stokes and Peterson (1998) have the same opinion regarding the influence of homophobia on the risk of HIV transmission among African-Americans.

Stokes and Peterson (1998) explore the relationship of negative attitudes toward homosexuality, self-esteem, and risk for HIV in a qualitative study involving 76 individual interviews of African-American men who identify as MSM, 18-29 years old. Overall, participants perceived African-American communities less accepting of homosexuality than white communities, and these negative feelings were internalized by signs of low self-esteem and psychological distress.

Furthermore, African-American and Latino MSM are less likely than white MSM to live in gay neighborhoods. Therefore, prevention programs may not adequately reach them, as opposed to white MSM living in gay communities (Centers for Disease Control and Prevention [CDC], 2004; Mills, Stall, & Pollack, 2001). Also, African-American MSM are two to three times higher for risk of HIV infection than white MSM. Additionally, 32% of African-American men who identify as MSM were found to be infected with HIV in a six-city study of men ages 23-39, compared to 14% of Latinos, and 7% of whites (Centers for Disease Control and Prevention [CDC], 2004). Lewis (2003) argues that evidence is limited to suggest that blacks are more homophobic than whites. However, this scholar claims that religious and educational differences contribute significantly to attitudinal discrepancies between these two races concerning homophobia. Battle and Lemelle (2002) contend that the issue of gender heightens the complexity of the role of homophobia in African-American communities.

These results are reflective of the view of homophobia connected to the disproportionate number of African-American men resisting self-identifying as gay or bisexual, and therefore heightening the risk of HIV infection among African-American heterosexual women. Public views of homosexuality, and cultural taboos among African-Americans, are vital issues to be examined when considering readiness to change risky sexual behaviors among African-American women. Although this target group theoretically is capable of modifying their risky sexual behaviors along the continuum of behavioral changes, they have no control over whether their sexual partners unknowingly are living a dual sex life.

Overall, the Transtheoretical Change Model has advanced research by recognizing that people do not change behavior all at once in a linear fashion, but that change is expected to occur in various stages. As a result, predictable behavior becomes apparent from the various stages of the model (Redding et al., 2000). However, the lack of acknowledgment regarding culturally-related factors and the effect this has on behavior change hinders its usefulness among some populations. For example, cultural taboos create barriers for many individuals attempting to change health-related behaviors. Even though the model has proven advantageous in awareness of self-efficacy as a construct necessary for health-related behavior changes, more knowledge is needed regarding intervention development among ethnic groups. This current study explored participants' perceptions of their views related to the cultural influences on readiness to change risky sexual behavior. Knowing more about cultural taboos and myths among African-American women can lead to a better understanding of how this population of women makes decisions about sexual encounters.

The Black Feminist Perspective

Black feminism is a conceptual framework that examines the status of African-American women in society (Simien, 2004). Conventional health prevention models often negate the significance of gender, race, and class, leaving a gap in our understanding of the effectiveness of these traditional models. Black feminist consciousness “arises from an understanding of the intersecting patterns of discrimination” (Simien, 2004, p. 81). The tradition of feminism offers many “meanings to different people,” which underscores its greatest strength as an ideology. This approach has a “multidimensional perspective” involving a world view based on political theory, spiritualism, and activism, encompassing various theories and principles (Schrivver, 1998, p. 85). In Black feminist theory, patriarchal social systems [structuring of society in which the father or male rules] are tied to negative connotations related to racial, sexual, and class oppression (Schrivver, 1998; Simien, 2004).

In regards to sexual health promotion, the feminist perspective is advantageous in examining the influences of gender relations and power issues in sexual decision-making. In a similar fashion, Wight, Abraham, and Scott (1998) emphasize this premise based on the following assumptions found in their psycho-social theoretical framework: (1) primarily, the understanding of sexuality is learned behavior based on an individual's gender, and this learning is centered on thinking or ideas open to change; (2) sexual relationships based on heterosexual involvement are influenced by power differentials/gender roles; and (3) the interpretation of health risks is affected by culturally-specific variables (e.g., age, gender, social class, cultural taboos). These scholars argue that sexual decision-making and sexual encounters are influenced by what

happens during sexual interactions and the context within which these encounters take place. Therefore, if one partner directly communicates his/her desire to have sex, then “it transforms the interaction and allows for discussion of precautions” (Wight et al., 1998, p. 327). The emphasis is on not only what is actually discussed between partners, but the environment in which sexual decision-making occurs. Specifically, cultural influences often dictate or validate the ability to exert power or condom negotiations in the relationship. However, in some situations or cultures, if a woman asserts herself and appears knowledgeable of sexual matters, she might possibly be perceived as promiscuous [slang expression often used is *whore* or *ho*]. Within this social context, women must have skills to negotiate safe sex and learn that “passivity” does not have to be the social norm on which to base sexual decisions. On the other hand, men often feel pressured to behave in a manner of having sexual knowledge or power, because sexual ignorance frequently is perceived as a lack of masculinity (Wight et al., 1998).

Feminist discourse appears divided between normative claims of rhetoric, emphasizing that men and women are entitled to equal rights and respect, and descriptive claims, arguing that women are currently disadvantaged in regards to rights and respect in comparison to men. This “ought to have” versus “denied” equal rights dichotomy have influenced three waves of the feminist paradigm. The first wave began in the 19th century with the right to vote and the passing of the 19th amendment. The second wave involved the fight for political freedom in the late 1960s and early 1970s with equal rights marches and burning of bras. The present-day battle, the third wave, entails the fight for equal opportunities in the labor market and the recognition of diversity among oppressed groups (Connell, 1987; Payne, 1997; Schriver, 1998; Turner, 1996). However,

the Black feminist perspective emerged out of response to feminist theories historically excluding the plight of racism and general issues related to black women and other women-of-color (Hamer & Neville, 1998). Feminist writer and cultural critic Gloria Watkins [pen name bell hooks], Barbara Smith, and Deborah King are among the black feminists confronting multiple forms of oppression (e.g., race, class, gender) affecting African-American women.

In 1983 Alice Walker popularized the term “womanist,” which is often used interchangeably with identifying as a Black feminist, reflecting on the unique experiences of African-American women (Taylor, 1998). Convincingly, Walker and other scholars in the literature argue that African-American women require a conceptual identity of oppression separate from traditional feminism, which historically is associated with the plight of privileged white women seeking equal opportunities in the dominant culture, along with other disempowered groups (Hamer & Neville, 1998; Leatherman, 1995; Schriver, 1998; Taylor, 1998). A Black feminist perspective is summarized by Taylor (1998):

The absence and invisibility of African American women prompted Black feminist scholars to develop theoretical discourses that considered the complexities of African American women's lives. The basis for theory development is the everyday lives of African American women. Black feminist scholars develop theory that is situated in the African American experience and link such experiences to larger structural constraints. (p. 54)

This scholar further illuminates this underlying principle of the Black feminist perspective by identifying the interactive relatedness of the social constructs of race, class, and gender as interdependent control systems producing “a unique multiple jeopardy situation for African American women” (Taylor, 1998, p. 54). This population

of women experiences unique circumstances, unlike white women, causing vulnerable situations in life based on multifaceted societal oppression (e.g., race, class, gender) (Gentry, Elifson, & Sterk, 2005; Gilbert, 2003; Wyatt, 1997). Traditional HIV prevention strategies tend to focus on safer sex and drug use; whereas, more contemporary approaches emphasize the significance of basic survival needs of high-risk populations, which include securing a steady income, eating meals routinely, and obtaining affordable housing (Gentry et al., 2005). According to Black feminist principles, social and economic factors that place low-income African-American women at-risk for HIV differ disproportionately from other populations in society (Genty et al., 2005; Hamer & Neville, 1998; Taylor, 1998). Thus, attempting to maintain sexual relationships with intimate male partners in a persistent and rigid environment of oppression heightens the risk of HIV/AIDS among African-American women.

According to Taylor (1998), an Afrocentric perspective, introduced by Woodson in 1933, “incorporates key African traditions and values” as significant parts of African-American culture (p. 58). Both the Black feminist and/or Womanist theoretical frameworks use an Afrocentric perspective based on collective responsibility, spiritualism, corporateness, harmony with nature, and inclusiveness (Taylor, 1998). Intriguingly, Wyatt (1997) argues that the same underlying principles and values outlined in the above-mentioned theoretical frameworks were “stolen” from descendants of Africans sold into slavery centuries ago. The Black feminist perspective, along with other Afrocentric-based theoretical frameworks, are ideologies more recently used by Black feminist scholars in the advancement of intervention development and theory-building to reduce risky sexual behaviors among African-American women (Taylor, 1998).

Traditional psychological theories, often guiding the foundation for HIV prevention and intervention, have successfully reduced the rate of HIV infection among white gay males but are restricted in “addressing cultural and structural factors within at-risk populations” (Gentry et al., 2005, p. 239). Hill Collins (2000) advocates for an interpretive theoretical framework within the Black feminist perspective that stresses the interlocking elements of oppression on multiple levels (e.g., social, political, and economic issues), and how these elements potentially influence black women's risk for HIV/AIDS. For instance, Gentry, Elifson, and Sterk (2005) examine how various living conditions affect HIV-risk behaviors among 45 vulnerable low-income African-American women in Atlanta, Georgia. A Black feminist perspective was the theoretical framework used to guide the inquiry over two years of ethnographic fieldwork. The eligible participants for this study included women currently injecting drugs or using crack-cocaine, with no drug treatment within 30 days, at least 18-years-of-age, and engaging in sexual intercourse. All women completing a six-month follow-up from a larger project, the Health Intervention Project (HIP), were eligible for the ethnographic study.

The Gentry et al. (2005) inquiry was conducted in a high-risk African-American community known as “The Rough,” where 40% of its residents lived below the poverty level based on the U.S. Bureau of the Census report [2000], as cited in this study. Furthermore, only 49 occupants owned their homes, with another 819 residents renting homes owned by others [31.5% of household income spent on rent] (p. 239). A salient characteristic of the Rough is its extremely high concentrated HIV infection occurrence. The infection rate is 155.2 per 100,000 in Fulton County [location of the Rough], one of the highest rates in the country (Gentry et al., 2005, p. 240).

Gentry and colleagues (2005) identify Hill Collins's five-theme theoretical framework as a way to understand the lives of impoverished African-American women in relation to HIV/AIDS intervention. The five themes that emerged are the following: (1) self-determination and self-evaluation; (2) the interconnectedness of race, class, and gender; (3) the unique experiences of African-American women in America; (4) controlling images as constructed for poor African-American women; and (5) structure and agency as a platform for social change (p. 239). The study revealed that this high-risk group of participants was not homogenous. In fact, unique “within group” differences were found. For instance, using Black feminist theory and constant comparative analysis the theme of “street” women and “house” women was identified. Street women were described as “the absolute homeless, the rooming housed, and the hustling homeless,” whereas, the house women were “family housed, the heads of household, and the steady-partner housed” (Gentry et al., 2005, p. 238). Therefore, different HIV-prevention programs need to exist for “street” vs. “house” women. Overall, the focal point of this investigation resulted in the importance of African-American women to “define their own realities” in relation to HIV prevention strategies and to recognize the “within-group” differences in defining this population of women.

According to Gentry et al. (2005), this study was restricted by the potential bias presented by one of the interviewers interacting with 12 of the 45 women in an environmental context outside of the parameters of the study, allowing for the possibility of women responding in a manner to please the interviewer. Also, generalizing of the study findings is restricted due to the size of the sample (Gentry et al., 2005). However, the limitations are minimal in comparison to the critical outcome of the study regarding

the need for professionals to examine the unique living conditions and environments that place some, not all, African-American women in vulnerable positions for contracting HIV/AIDS. Economic disparities, along with other structural hindrances, must be observed in the exploration of risky sexual behaviors among this “within-group differences” population. For example, “street” women are more vulnerable to many societal conditions regarding economic barriers, which result in numerous negative outcomes, including HIV/AIDS potential.

It is reasonable to presume that Black feminists generally base their core argument on the descriptive belief that women-of-color are not being treated justly in society. Sexual reform is not a normative claim of deciding whether women “ought to be” entitled to equal rights and respect, but a movement based on political reform and economic equality for women-of-color. hooks (1994) and Hill Collins (2000) are Black feminists advocating for a meaningful definition of feminism, eradicating not only sexism, but racism and other forms of oppression in society. This common goal has the potential to unite the fragmented feminist movement along the philosophical challenges of reform, which has historically restricted the utility of this theoretical approach as a guide for behavioral changes and practice. That is, what exactly is feminism as an operational definition for reform and theory-building? According to some scholars engaged in the discourse for sexual reform, the solution is unmasked in recognition of the “interlocking force” of multiple systems of oppression that affect “subordinate” groups in this society (Hill Collins, 2000). Feminism is recognized for advances in health behavior research and prevention efforts. However, within the agenda of health-related changes in behavior, this theoretical framework is founded on political reform and advocacy for

oppressed groups in society. These basic principles of feminism must be integrated into the difficult task of strengthening this perspective as a valuable theory-driven approach for behavioral change.

Yet, Butler (1993) is not convinced that universalism is a feasible social alternative based on the notion that challenges to sexual norms in society will take place over many years of duplication of efforts to change the current paradigm of oppression. However, Ebert (1996) contends that political action is mandatory and criticizes feminists not advocating for a global feminist movement against oppression. The discourse regarding global feminism is further debated by Friedman (1995) who believes that a paradigm shift will only occur when “white middle class agendas” are expanded to include objectives aimed at institutional oppression influencing the lives of both genders along the lines of racial, sexual, and economic disparities in society. Brown (1989 as cited in Taylor, 1998) suggests that in order to acquire knowledge of African-American women’s lives, the researcher has to “pivot the center.” Brown (1989 as cited in Taylor, 1998) concurs with Friedman (1995) concerning the need to abandon the Eurocentric lens as a tool to understand the needs of oppressed groups. Taylor (1998) explains that “pivoting the center means to challenge the Eurocentric idea of White [sic], middle class, Western women and men as the normative experience and legitimate perspective of the world” (p. 55). Regardless of the views among scholars debating the need for globalization of the feminist movement, the escalating rate of HIV infection among women, particularly at-risk African-American women, demands the united efforts of researchers and professionals in order to curtail the spread of this disease.

In general, health behavior changes are advanced by the feminist discourse. This approach is multidimensional and beneficial in its evolution of becoming a political catalyst for perpetual social reform, including health-related issues (Gentry et al., 2005; Hill Collins, 2000). The ability to link self-efficacy to health behavior changes within a theoretical perspective designed to be universal and multidimensional creates many challenges for feminists. Many scholars analyzing the theoretical perspectives of feminism perceive the feminist ideology to be limited in practicality concerning intervention development (Hamer & Neville, 1998; Leatherman, 1995; Schriver, 1998; Taylor, 1998). However, the Black feminist perspective offers the foundation for developing effective strategies relevant to African-American women struggling with the daily existence of the “triple burden” in this society. Clearly, this burden refers to the interlocking oppressive forces of racism, sexism, and classism affecting this population of women uniquely from other groups.

This current investigation gave participants the opportunity to voice how issues related to the “triple burden” influenced sexual decision-making regarding power disparities and barriers to behavioral changes. These women had the chance to identify hindrances to HIV/AIDS prevention in the natural environment in which they were expected to live and survive daily. It is well-established in the literature that culturally-competent HIV prevention strategies are most important in effectively intervening with this population of women. This current study is part of the discourse focused on the enhancement of interventions needed to deal with this gap of knowledge regarding mediating factors influencing sexual decision-making among participants in their commonplace surroundings.

Summary of Studies Reviewed

In conclusion, health behavior changes are evolving in the face of the HIV/AIDS pandemic in this society at large. However, behavioral patterns that place African-Americans at risk disproportionately for HIV/AIDS are in need of closer examination. There is an escalating rate of HIV infection occurring among African-American heterosexual women. It is clear that the research to date has been limited in investigating the structural impediments of the “triple burden” affecting African-American women in regards to the interrelatedness of factors associated with HIV/AIDS.

For instance, most studies have focused on the lack of condom use with male partners, or risk factors associated with urban sex workers among this population of women. Traditional health models operate under the basic assumption that women have the control to decide safer sex options. For example, the Health Belief Model (HBM) provides a comprehensive framework suggesting that women can change health behavior if they (1) feel susceptible to contracting HIV/AIDS, (2) are convinced that HIV/AIDS could have serious consequences [stigma, prolonged suffering, death], and (3) decide that behavior changes will modify negative outcomes. The advantage to this approach empowers individuals to participate in changing risky sexual behaviors, and engage in condom negotiations (Airhihenbuwa & Obregon, 2000). However, condom use involves skillful communication between intimate partners. Furthermore, Lam and colleagues (2004) argue that safer sex communication involves distinct strategies based on social and cultural norms. Essien and associates (2005) and the Southerland (2004) studies targeted African-American women from dissimilar socioeconomic and educational backgrounds, but still self-efficacy was the strongest indicator of condom use for

participants in both studies. How can this construct be defined to implement effective intervention strategies among a diverse population of women? If self-efficacy is assumed to be a necessary element of behavior change, then the inability to define self-efficacy across studies has hindered the usefulness of health models targeting ethnic and vulnerable populations (Essien et al., 2005; Gentry et al., 2005; Lam et al., 2004; Redding et al., 2000). This failure to achieve an understanding of self-efficacy across diverse groups of African-American women is a significant limitation of existing models of sexual risk behavior.

Many scholars using traditional health models and quantitative methodologies attempt to predict effective HIV prevention outcomes without adequately understanding the cross-cultural perspectives related to sexual decision-making. Hatfield and Rapson (1996) describe the passionate aspects of people meeting, mating, and falling in love, only to risk it all over again. These authors challenge audiences to enhance their knowledge of the socially constructed aspects of intimate relationships, and “the different ways cultures love and make love,” but what about the risk of HIV/AIDS? One traditional theoretical framework, the Transtheoretical Change Model, has been used for the examination of numerous health-related behaviors. The underlying assumption of this approach theorizes that behavior change occurs through a progression of distinct stages (Prochaska et al., 1992). Yet, individuals faced with social norms and cultural taboos hindering their progression through these stages need culturally-relevant interventions to achieve and maintain desired behavioral change and prevent the chance of relapse. However, some staging models are limited in addressing mediating factors that influence altered behavior (Oldenburg et al., 1999).

In order to promote and develop healthy sexual behaviors, further examination is needed to better understand how racial, ethnic, gender, and socioeconomic factors influence sexual decision-making among diverse populations. In attempting to maintain desired changes in behavior, individuals frequently relapse and regress to previous stages of change. These changes are not perceived as negative, but expected with many addictive behaviors, such as alcohol use, uncontrollable eating, and compulsive gambling. However, societal norms and cultural myths create enormous pressure on individuals to maintain preferred health behavior changes. Wohl and associates (2002), Stokes and Peterson (1998), and Lewis (2003) are some of the scholars engaged in the discourse of how homosexuality and homophobia influence cultural taboos and myths in African-American communities. Even though many scholars do not agree on the extent of negative influences homophobia creates within African-American communities, there appears to be an understanding that African-American males are reluctant to self-identify as gay or bisexual due to fear of adverse reactions from others. This fear or secrecy places African-American heterosexual women at a disproportionate risk of HIV/AIDS due to partners potentially living dual sex lives [living on the down low]. The roles of cultural taboos and myths must be further examined in order to determine the extent that these views create barriers to safer sex practices in African-American communities.

Additionally, few qualitative exploratory inquiries, in comparison to the myriad of evidence-based cognitive-behavioral approaches, have focused on perceptions of HIV risk among this target population in relation to their daily survival needs. Investigators examining meaningful perceptions of HIV risk in the every day lives of African-American heterosexual women have proven advantageous to HIV prevention

interventions. The Black feminist perspective provides the foundation for the recognition of how racism, sexism, and classism have created structural barriers unique to African-American women. Black feminist scholars develop theory based on oppressive forces operating in the daily lives of African-American women, unlike many of the traditional paradigms. Gloria Watkins [bell hooks], Hill Collins, and Barbara Smith are several of the well-known black feminists engaged in the discourse of promoting the eradication of these oppressive forces.

Gentry, Elifson, and Sterk (2005), Hammer and Neville (1998), and Taylor (1998) examine mediating factors such as economic status, housing conditions, and other social circumstances which heighten the risk of HIV/AIDS among African-American women. Gentry and colleagues (2005) based their study on the Black Feminist perspective, which advocates for a paradigm shift to abolish oppressive forces in this country (Hill Collins, 2000; hooks, 1994). This type of paradigm swing demands “pivoting the center.” To be exact, the Eurocentric worldview should no longer be the standard for normative behavior and lifestyle. Therefore, based on the philosophy of the Black feminist perspective, there is a need for African-American women to construct their own meaningful HIV prevention strategies.

This current study was based on the premise that ideas gathered from participants will be used to generate hypotheses that will enhance sexual decision-making with their intimate male partners. This exploratory design was advantageous in an effort to find out “what is going on” in the ways that African-American women allow themselves to think and behave sexually in the face of the HIV/AIDS pandemic. Additional research is needed to determine how this population of women will protect themselves when they are

not in control of decision-making with male partners. For example, when their male partners are living a secretive dual life, having sex with both men and women [MSM/W], sexual decision-making is no longer based on open and honest communication. The meaning of safer sex and protection was investigated among participants in this current study with the aim of addressing this gap in knowledge.

METHODS:

Closing The Gap: Discovery Of New Knowledge

I felt an impassioned need to better understand how African-American women acquire the knowledge to make sexual decisions and the critical factors involved in this process from their perspectives. I aspired to comprehend sexual decision-making among this population, including examination of their attitudes, perceptions, and thoughts of sexual behaviors with male partners. This drive for resourceful and original knowledge, “the real McCoy,” has been an evolutionary journey involving personal growth and scholarly maturity since entering doctoral studies.

I selected the qualitative research approach as the philosophical paradigm associated with this study. The complexity of this social issue, sexual decision-making among at-risk African American heterosexual women in an era of HIV/AIDS, warranted a “ways of knowing” process in order to diminish the gap of knowledge regarding this target population. Even though the aim of this study was not to establish a causal explanation of theory-building by the manipulation of identified variables concerning this social issue, there seemed to be innumerable studies of this description in the literature. Based on the results of these studies there appeared to be an underlying assumption that these women in fact experience power disparity regarding sexual decision-making. Another assumption was that behaviors from different cultures have different meanings, including sexual behaviors. Also, it was understood that women have the right to engage in sexual decision-making with their male partners without fear or personal threat. My desire to learn vicariously about this social problem from participants’ experiences

seemed to be shared among qualitative researchers. Meloy (2002) expounds upon this issue in the following manner:

Qualitative research is inexorably linked to the human being as researcher. I am curious to know whether quantitative researchers feel as possessive about their work as 'my' correspondents and I do. If they do, what is the essence of that linkage-[sic] example, person to topic? Person to results? Are any of our experiences of meaning making the same? (p. 108)

The qualitative focus of my study did not negate the relevance of a quantitative research approach based on statistical procedures and testing the predictive nature of hypotheses. On the contrary, my review of the literature included both qualitative and quantitative research studies resulting in valuable findings regarding this topic. However, the assumptions of the qualitative paradigm (e.g., subjective reality, inductive process, informal structure, personal voice) provided a means for participants to construct reality founded on their personal experiences and testimonies (Coffey & Atkinson, 1996; Meloy, 2002; Schriver, 1998). I believed it was critical for African- American women to be given the opportunity to “voice” the relevance of sexual decision-making and HIV/AIDS based on their real-life encounters. It was my responsibility to adequately report these realities based on the data collected in this study and trustworthiness [truthfulness] of the content analyses.

My role as novice researcher and participants’ role as teachers were clarified within the context of my attitude and behavior as I observed and interacted with respondents. In other words, the use of the first person “I” allowed my role of researcher to move beyond the conventional strict adherence to the logic of deductive reasoning in the discovery of new knowledge. I took the stance of engaging in the exploration of new knowledge by generating new ideas with participants as equal shareholders in the

research process. Coffey and Atkinson (1996) state this view by emphasizing the necessity of inductive reasoning in qualitative research “Inductivism is based on the presumption that laws or generalizations can be developed from the accumulation of observations and cases” (p. 155). However, these scholars warn that the collection of “more and more observations and recordings” in the pursuit of establishing trustworthiness in qualitative research can result in “unremarkable and undistinguished descriptions of social worlds” (p. 155). Therefore, the focus of this study was not to establish truthfulness by the number of participants involved; that is, the belief that the power of empirical research is established by generalizing to the larger population with a large sample. In contrast, the purpose of this investigation was to “close the gap” of what is known about this social problem by attempting to account for the disproportionate rate of HIV/AIDS among African-American heterosexual women based on their perceptions of sexual decision-making.

Purpose Statement and Research Questions

The primary purpose of this research was to conduct an inquiry involving African-American heterosexual women regarding their perceptions of risk for contracting HIV/AIDS when involved in issues related to power disparity, such as condom negotiation, with their male partners. I wanted to examine the meaning of sexual decision-making, and how it influenced the potential for at-risk sexual behaviors. Furthermore, I was interested in whether participants attempted to change these behaviors as a result of knowledge acquired through HIV/AIDS prevention. The rationale for this approach was related to the empowerment of African-American women, and actively seeking their input in the research process. Therefore, the following grand tour or primary

question guided this study: “How were African-American heterosexual women perceiving their risks for contracting HIV/AIDS during sexual decision-making when involved in issues related to power disparity (e.g., condom negotiations) with male partners?” From the grand tour question there were two subsequent questions: “What did having a safe sexual relationship mean to African-American women?” “Was there an indication from African-American women that they sensed actual modification in their sexual behaviors, and in what ways, as a result of what they had learned about HIV/AIDS prevention?”

Developing a Qualitative Inquiry

This qualitative inquiry evolved out of the need to address the research questions guiding this investigation. This approach is among the holistic and inductive methods (e.g., ethnography, narrative inquiry, phenomenology) seeking to understand phenomenon in the natural environment (Glaser & Strauss, 1967; Schreiber & Stern, 2001; Stern, 1980). Clearly, the basis for using this approach was to examine what is unknown about risky sexual behaviors in relation to African-American women’s perceptions of sexual decision-making with intimate male partners. These women are disproportionately affected by HIV/AIDS in the social context in which they are expected to survive on a daily basis. This qualitative method moved the data toward the development of general patterns that emerged from the stories shared by African-American women (Rudestam & Newton, 2001). This process is based on the work of Glaser and Strauss (1967). Glaser focuses on the emergence of categories or conceptual codes out of the data, whereas, Strauss and Corbin apply a more evaluative strategy to identifying categories (e.g., axial coding when categories are in more advanced stages of

development) with the same basic principles of the early endeavors of Glaser and Strauss. For Glaser, this emphasis on evaluative method “pre-empts the data” (Creswell, 1998; Dick, 2005; Haig, 1995). This implies that more structured coding forces the outcome of data analysis, rather than allowing the data to emerge without risking the manipulation of the outcome. The debate between “emergence vs. forcing” of data is essential to the process of qualitative inquiries (Haig, 1995; Rudestam & Newton, 2001; Stern, 1980). I selected the early approach of Glaser and Strauss in terms of open coding as data emerged.

When applying this method, data are used to develop a conceptual framework, rather than proposing one for testing (Stern, 1980). This approach allows for the examination of complex human behavior by using open-ended questions during interviewing and skilled observations (Glaser & Strauss, 1967). Once data are gathered and analyzed using coding and theoretical sampling, theories are generated by interpretive procedures (Glaser & Strauss, 1967; Haig, 1995; Rudestam & Newton, 2001; Stern, 1980). The following guidelines were the basis for the qualitative method guiding this investigation: (1) not conducting an exhaustive literature review of the primary focus of study, which allows theory to emerge directly from the data [the literature review in this study was based on requirements of the doctoral program]; (2) literature is reviewed continuously throughout the systematic examination of data; (3) the sample includes participants who are reflective of the social phenomenon being investigated; (4) descriptive language must be plainly stated to provide a logical explanation of steps used in the process without “forcing” the data; and (5) the constant comparative method (data compared continuously with other data) is used to identify emerging categories and

themes (Glaser & Strauss, 1967; Rudestam & Newton, 2001; Stern, 1980). Even though some scholars of qualitative inquiries are concerned about existing theories creating biases or barriers to new concepts emerging from collected data (Glaser & Strauss, 1967), the review of the literature might prove to be advantageous in some ways. For instance, investigating existing models in the context of risky sexual behaviors among African-American women identified gaps in the literature, and established a foundation for focusing this inquiry. The “fit” between purpose, approach, and theory is critical in conducting any type of research (Rudestam & Newton, 2001).

The challenge for researchers using qualitative inquiry is recognizing that specific steps are taken in a systematic manner, while theorizing about the collected data (Wuest & Merritt-Gray, 2001). According to Creswell (1998), “This situation is one in which individuals interact, take actions, or engage in a process in response to phenomenon” (p. 56). The researcher is responsible for making multiple contacts with respondents in the field, collecting data, coding clusters of information, categorizing data simultaneously, and forming hypotheses from the data. The aim is to ground the theory in data collected during the observation of small groups of participants. Relative to this principle, grounding means making it true to the data (Creswell, 1998; Stern, 1980).

Building trust in order to collect a true representation of information among participants is especially challenging for qualitative researchers, particularly when contact is limited, and when researcher bias influences the design of the study or data collection (Rudestam & Newton, 2001). Coffey and Atkinson (1996) argue that “research should always be methodical” and analysis is not a separate process from theorizing. Furthermore, even though some participants may be previously influenced or not always

credible, researchers must be cautious of first impressions or stereotyping that can ultimately bias the outcomes of qualitative studies. In contrast, some scholars focus on sample size as a disadvantage to qualitative investigations. For example, a small sample of participants is not necessarily representative of the larger population, which means the outcome is not generalizable, leaving the impression of insignificant scientific findings (Coffey & Atkinson, 1996; Meloy, 2002; Rudestam & Newton, 2001). These disadvantages are addressed under the “trustworthiness” [reliability-validity] section below. Each design has pros and cons regarding the purpose and approach of the investigation (e.g., cost, time, researcher bias), but exploratory designs are critical in generating hypotheses to advance the discovery of new knowledge (Coffey & Atkinson, 1996; Meloy, 2002; Rudestam & Newton, 2001).

Research Design

In this study, I targeted African-American heterosexual women residing in the Indianapolis vicinity. The sociodemographic or descriptive data collected from participants included their age, educational background, income range, marital status, and their self-reported HIV status [medical records were not checked]. Participants completed a survey when engaging in events associated with the *Women In Motion* prevention program. Additional statistical information about participants was available from this source.

I was searching for the women’s perceptions of the risks involved in sexual decision-making through their “voices.” Due to the limited scope of this study involving intimate relationships exclusively with male partners, women engaged in lesbian or bisexual relationships were not included. Participants were not restricted by specific

income, educational attainment, or marital status. However, participants were primarily recruited from a community-based outreach program targeting inner-city, socioeconomically disadvantaged African-American heterosexual women, at least 18 years of age, with no specific upper limit regarding the age of participants.

An increasingly disproportionate number of African-Americans in Indiana are infected with HIV, which corresponds with the national trend (DeJong, 2001). Within the state of Indiana, intravenous drug use (IDU), men having sex with men, and heterosexual transmission are some of the key factors contributing to the spread of HIV infection, consistent with national statistics (AccessIndiana, 1999). African-Americans represent only 8.5% of the Indiana population, but constitute 40% of the current HIV cases. Furthermore, an alarming 33% of AIDS-related cases are linked to African-Americans (Indiana Minority Health Coalition, 2005). A 2005 review by the Indiana Minority Health Coalition reported that there were approximately 7,461 [this number could be higher] people living with HIV/AIDS in Indiana, with the largest population of 3,172 residing in Marion County. Out of the female HIV/AIDS cases reported, 50% were African-American females in comparison to 45% white females and 1% Latino females.

Out of approximately 4,125 HIV cases in total [not including AIDS or other STDs] in Indiana, 843 are women. Out of these 843 cases of HIV, an estimated 412 are African-American women. This is a disturbing statistic based on the small representation of this target group in Marion County. Out of a total of 450,000 women residing in Marion County, 11,000 women are African-American (Indiana Minority Health Coalition, 2005). Men having sex with men [MSM] is the leading cause of HIV spreading in Indiana, with heterosexual transmission representing the second largest number. Out of

an estimated 3,282 men living with HIV in Indiana, approximately 1,080 are African-American males, close to 33%. This is a troublesome statistic for this population of men (Indiana Minority Health Coalition, 2005).

Individuals in the age bracket of 20-39 continue to be a primary concern regarding heterosexual transmission of HIV, but unprotected sex among Indiana's young people yields shocking sexually-transmitted disease statistics (Indiana Minority Health Coalition, 2005). In 2005, 7,240 Chlamydia cases involving youths [36.2%] were reported statewide. In comparison, national statistics in 2005 indicated 2,797 cases of Chlamydia per 100,000 among 15 to 19-year-old (CDC, 2006).

Primarily, I examined the sexual perceptions of African-American women participating in the *Women In Motion, Inc. (WIM)* community outreach HIV/AIDS prevention program. The *WIM* organization was founded on September 3, 2003 and is a 501 (c) 3 non-for-profit organization. This community-based organization is sponsored by private donations (e.g., Friendship Missionary Baptist Church, Pedigo Chevrolet, Studio 22). Refer to Appendix B for permission from the director of *WIM* to engage participants in the study.

The focus of *Women In Motion* is the empowerment of women through promoting spirituality with a goal of long-term behavior changes. This holistic and healthier-living initiative affects individuals, couples, and families, resulting in community empowerment as well. The program encompasses outreach to jails, halfway houses, churches, shelters, and schools, with the number of participants varying due to the availability of volunteers and the frequency of outreach efforts. Women are introduced to the program by word-of-mouth, flyers, local advertisement, etc. Trainers and volunteers provide education on the

prevention of HIV/AIDS, substance abuse, smoking cessation, obesity, and STDs. For instance, *WIM* staff sponsored a “DIVAS” Day. Women were invited to attend an afternoon of recognition by promoting self-esteem with interactive group activities, gifts, free food, the viewing of HIV/AIDS prevention videos, and voluntary HIV testing with no charge for participants. *WIM* offers encouragement and hope to many women in need of support and services. For example, through the “Bear Forward” project, women are given a little bear with a T-shirt with contact information for *WIM*, and participants are instructed to write down this contact information, and then pass the bear along to another woman in need of support.

The protocol of the pilot study and this current investigation required a full review [due to the economic disadvantages of participants] by the Institutional Review Board (IRB) affiliated with IUPUI. The Continuing Review of this study was approved January 22, 2008. The Summary Statement included the recognition of the potential emotional harm to this population due to the sensitive and personal nature of the topic, which was addressed in the informed consent.

There was a pilot study conducted on the basis of exploring the appropriateness of the question guides that were used in this investigation. Four interviews were conducted in the pilot study, with one participant interviewed twice to assist with addressing reliability issues concerning participants’ responses. One participant served in the role of program coordinator of the *Women In Motion (WIM)* program when the pilot study was conducted in January 2004 through March 2004. Each interview was transcribed and coded. Emerging themes were advantageous in the refinement of the question guides. The rationale for this pilot study was supported by the definition of pilot studies offered in

The Social Work Dictionary. According to Barker (2003), this approach is beneficial in social research as, “a procedure for testing and validating a questionnaire or other instrument by administering it to a small group of respondents...” (p. 327). The women in the pilot study were not participants in the primary sample, but were representative of the target population in this inquiry, recruited from a small community-based HIV/AIDS prevention program.

The *Women In Motion (WIM)* program is conducted in a similar fashion to a *Tupperware* party. Primarily, women-of-color gather together to discuss issues relevant to them, ranging from domestic violence to HIV/AIDS prevention. Trained educators recruit hostesses, who invite coworkers, neighbors, and friends to their homes for a group session or “party.” Sessions may also be arranged in advance and located at designated community agencies or restaurants throughout the community. Prior to a scheduled meeting, I addressed the rules of the session with the designated educator by phone or e-mail. It was important to respect the educator’s leadership role and establish trust. We discussed such matters as the time of the party, location, distribution of informed consent forms, and clarification of my role during the session. The educator was informed that my primary task was to gather data. I used question guides [one for individual interviews and another for the focus group] in order to conduct semi-structured interviews. Please refer to Appendix C for the question guides used in this investigation.

Another means of interviewing women included the pre-arrangement of contact with participants through educators at a time and place convenient [and private] for participants not directly involved in house parties. Space was available at the office of

WIM, if preferred by participants, or in the homes of participants. The goal was to achieve a satisfactory comfort level for women being interviewed for the study.

Examination of the Applied Method

I collected data from participants over a span of seven consecutive months beginning in May, 2007. The groundwork of this inquiry involved observation of one sex-in-the-city house party with four female guests in attendance, along with the hostess of the event, one focus group held on the IUPUI University campus with five women attending, and seven individual sessions conducted in participants' homes, the IU School of Social Work, and the *Women In Motion [WIM]* office. Unfortunately, one individual interview was not transcribed verbatim due to the tape breaking. However, detailed field notes were taken immediately following this interview. There were seven individual interviews, and four women participated in one focus group, along with the recorder [one participant was interviewed individually and also participated in the focus group].

The level of trust reciprocally created during this investigation was evidenced by some participants' agreeing to schedule our meetings in the privacy of their homes, and my willingness to accept these arrangements unconditionally. This required uncharacteristic adventures into areas of the city that were unfamiliar, and occasionally unapproachable to many outsiders. For instance, some participants were housed in shelters requiring approval from strict proprietors enforcing customary protocols. The role of the gatekeepers was critical in permitting my initial admission to these places. Also, I was finally given the green light by one of the hostesses to attend her house party due to my association with *WIM*.

Data Collection

For the most part, the length of time for the individual interviews varied between 60 to 75 minutes; only one interview lasted 90 minutes. Even though I used a question guide for semi-structured interviewing, women were encouraged to share their stories in a minimally-controlled manner based on what they felt comfortable sharing [4 women preferred to be interviewed in a home-setting; 2 on the IUPUI campus; 1 at the WIM office]. Only one male partner in the home-setting initially attempted to remain in the room during the interviewing process. After briefly discussing the need for a private interview, the male partner agreed to go upstairs and allow us to continue in the kitchen of their small apartment. The participant indicated that she was satisfied with continuing the dialogue there, after I offered to transfer the interview to the campus for more privacy. Another situation in the home-setting involved a participant's father, who was diagnosed with Alzheimer's disease. He was at the stage of diminished cognitive functioning, and he needed constant supervision. His daughter was comfortable with him remaining in the kitchen where she was interviewed. The participant stated, "He will not remember what we'll discuss anyway, so go ahead because it doesn't bother me." At that moment, I had to quietly explore my uncomfortable feelings with his presence. But, after her father was given his lunch, he just nodded off for his afternoon nap, and the interview continued without interruption. The other noteworthy incident that occurred in the home involved a mother with a pre-adolescent daughter watching TV in the living room when I arrived. The participant decided to arrange the interview in her bedroom because of her daughter's "nosey nature." Again, I felt my comfort zone on edge sitting in a woman's bedroom that I had just met. However, after reluctantly setting up for the interview, I

realized that her bedroom was her private haven where she stayed most of the day. She had her private bathroom, entertainment center, phone, and all the comforts of an efficiency apartment.

Only one woman declined to participate in the study. After several unsuccessful phone contacts and leaving messages, she did return my call. This woman explained that in the beginning when we first discussed my research study, she felt at ease talking about sexual matters in the educational groups at *WIM*. However, this potential research participant later decided that she was not ready to disclose such personal matters regarding her sexuality on a one-on-one basis. When I convinced her that it was perfectly fine for her to decline to participate in the study, she seemed relieved that I was not upset with her. It was as though she needed my permission to say no. I discovered that this difficulty with some women saying “no” to situations that are not comfortable for them later surfaced as a salient issue for participants engaged in dialogues related to sexual decision-making.

Data Origin And Analysis

I used the qualitative software program Atlas.ti 5 to assist with coding the six individually-transcribed verbatim interviews. I received IRB approval for one of the graduate students in the School of Social Work to assist with transcriptions of interviews guided by my supervision. Initially, I used 5 x 8 white index cards to write down significant quotes identified in the text of the interviews. Next, I began to distinguish labels based on these quotes and placed them on the same card. After purchasing the student version of the Atlas.ti 5 program, I was able to expedite this same process

electronically. I created a project in the Atlas.ti system called the hermeneutic unit [HU] and imported the transcribed interviews into the main workspace area.

From a drop-down menu each transcribed interview was retrievable for the purpose of organizing the findings, such as, codes, memos, audio/visual passages, etc. According to the Atlas.ti 5 manual, this is described as the textual component of the software system. The conceptual capabilities focus on model-building and linking codes to networks. This intricate system enables numerous tasks to be performed with data analysis. I used the Atlas.ti program primarily for efficiency of time with coding, categorizing emerging themes, and memoing for the examination of my research data. This computer-assisted approach, along with the labor-intensive use of index cards, provided the basis for analysis within and across interviews.

Field Notes

Detailed field notes [Refer to Appendix D for example of format] were made after the sex-in-the-city group observation and the one focus group. Individual interviews were tape-recorded for purposes of accuracy regarding information being shared by participants. Data was handled in a sensitive and confidential manner, and information was maintained in files in the privacy of my home. No identifying information was attached to participants' interviews. There was a reference file accessible with identifying codes, but this index was locked up for confidentiality purposes in the privacy of my den.

Apparatus and/or Instruments

No specific measuring instrument was used in this inquiry. A guide was used to direct open-ended questions during interviewing. A notebook and index cards were used for memoing to assist with coding [I also used a recent student version of Atlas.ti 5 for

qualitative data for coding]. Audio-taping was used for individual interviews only. The focus was on gaining insights into the daily lives of women and their means of coping with decision-making in their lives, including sexual decisions with intimate partners.

Informed Consent

The protection of confidentiality was outlined in the informed consent form. Please refer to Appendix E for copy of the informed consent form. Confidentiality was imperative, not only to safeguard participants' rights, but to protect them from the stigma attached to HIV/AIDS in African-American communities. Confidentiality was discussed with members prior to engaging them in the study. The locations of meetings were not revealed, including interviews held in participants' private homes. The aim was for women to feel safe and protected. Every precaution was taken to protect participants' identities, and involvement in the study was voluntary. However, I advised participants that if required by law, I would need to reveal sources (e.g., cases of child abuse). Women were informed that they need not divulge any information that they did not feel comfortable sharing. Participants were not obligated to continue the study if they did not want to proceed. Inquiries related to the study were encouraged. I highlighted my name and contact number on the consent forms in case women had questions pertaining to the investigation.

Summary of Methods

According to Rudestam and Newton (2001), qualitative researchers have a standard to judge naturalistic research by using terms like creditability, fittingness, and triangulation, which results in the trustworthiness of studies. These scholars describe trustworthiness as a "general term representing what conventional researchers think of as

internal and external validity, reliability and objectivity” (p. 98). However, as stated by Dick (2005), a qualitative inquiry cannot be judged by the same criteria as hypothesis testing research. Not only is literature perceived differently in qualitative inquiries [as part of the data collection process without special significance], the same is accurate regarding “the way in which methodology and theory develop gradually as data and interpretations accumulate.” In other words, a qualitative inquiry has its own sources of rigour. Qualitative inquiries are based on a continuing search for evidence, and rigor is based on how the final shape of the theory is likely to be “a good fit” to the research situation (Becker, 1993; Dick, 2005; Glesner, 1998). The salient issue is the rigor associated with the “good fit” of how the theory is built related to sexual decision-making among African-American women. Again, the aim is not to prove a hypothesis. The focus is to discover the theory emerging from the data through consistency of coding, which concerns the replication of the study under similar circumstances or reliability of the inquiry (Creswell, 1998; Dick, 2005; Rudestam & Newton, 2001). Also, it is critical to note that analysis is expected to be modified both during and after data collection (Rudestam & Newton, 2001). The accuracy of this investigation is briefly examined through the following two concepts: reliability [or dependability] and validity [or generalizability/trustworthiness].

One means of establishing reliability in this study was through identifying underlying assumptions in the study and detailing the research method, along with conducting a pilot study. For example, the primary assumption guiding this approach was that power disparity exists in intimate relationships between the genders. Even though findings were not transferable to the larger population of African-American heterosexual

women, the method used can be transferred to other settings and applied to other vulnerable populations. The appropriateness of the question guides based on a previous pilot study proved advantageous in interviewing participants.

Dependability of the study was enhanced by the use of the Atlas.ti 5 qualitative software program. Primarily, coding became more effective through structured categories that could easily be retrieved and memos stored in a confidential manner within the workspace of the hermeneutic unit. Also, through collaboration with my chairperson and other qualitative researchers, I was able to address issues of bias and subjectivity throughout the investigation. For instance, I had the opportunity to discuss open coding in relation to the computer software program, Atlas.ti 5, with Dr. Sabrina Williamson Sullenberger in Bloomington, Indiana. This colleague was knowledgeable of this program, and she was able to validate the coding approach that I had chosen. She offered valuable resources on qualitative investigations. Also, with frequent collaborations with my chairperson, Dr. Carolyn Black, I openly discussed my observations and questions regarding data collection and analysis.

In addition to establishing reliability in this study, I addressed issues of validity through triangulation. For instance, I used multiple methods of participant observation, a focus group, and individual interviews of participants. The purpose was to obtain multiple perspectives of sexual decision-making among African-American women. I detailed my interpretation of what transpired at a *WIM* house party through thick description. Along with interpreting the interactions among participants, I gave a thorough description of what I observed. Theorizing is not a separate step in the research

process, but is critical, in thinking about and analyzing data (Becker, 1993; Coffey & Atkinson, 1996; Creswell, 1998; Stern & Covan, 2001).

I spent incalculable hours journaling, taking notes, studying memos, and collaborating with gatekeepers in order to demonstrate trustworthiness of the data collected. This approach allowed for the principle of re-contextualizing data or emerging theory as I sorted and categorized themes. This process could only be accomplished by staying close or grounding the data as mentioned above. It is vital to think of this process as non-linear (Stern, 1980).

I reflected on the most appropriate way to portray critical accounts of the experiences African-American women shared as they emotionally undressed their innermost thoughts about sexual decision-making with their male partners. Several women confessed that they had never disclosed some of these untold truths about the risks they encountered in intimate relationships before, sometimes while wiping away tears. I remained sensitive to the emergent theory as women shared their narratives. This sensitivity is a principle critical to qualitative inquiries (Becker, 1993; Coffey & Atkinson, 1996; Creswell, 1998; Stern & Covan, 2001). Limitations of the study are examined under the discussion chapter.

FINDINGS

In this study I had the opportunity to explore the meaning of intimacy, and other aspects of sexual decision-making, from the perspective of African-American women. One of the most thought-provoking remarks shared with me during my extraordinary interviews with African-American heterosexual women came from a 34 year-old single mother. Participant E explained how some women desire to get married, to the extent that they will rush to sexual intimacy in relationships with male partners, without taking the time to become acquainted with them. However, I think this participant's unique words expressed her viewpoint candidly:

Some women want to be married. They want to be in a relationship and it gets to the point where age comes in as a factor and if they meet someone they start wearing that [sic] heart on the sleeve or rushing intimacy along because they are hoping. You know, there is a song that I heard on the radio where she was saying she had just met him, and she is saying, 'I hope that you are my last first kiss.' So, she is already saying, I am ready to be with you. I think you are for me, and I am for you, let's do this [sexual intercourse].

Metaphorically, this painstaking statement hidden in the song heard on the radio haunted me days after the interview with Participant E was over. I wondered what this assertion meant for the female vocalist craving that feeling of "my last first kiss" with her unknown male partner. I envisioned countless women yearning for intimate connectedness with male partners, even if they knowingly placed themselves at risk for HIV/AIDS and other STDs. The results of my research study on sexual decision-making conflicted with this notion of intimacy. Also, the findings revealed some insights into the perceptions of African-American women involved in sexual encounters with male partners despite the HIV/AIDS pandemic.

I focused on observations and information specific to the primary research question in this investigation. [How are African-American heterosexual women perceiving their risk for contracting HIV/AIDS during sexual decision-making when involved in issues related to power disparity (e.g., condom negotiations) with male partners?] It was necessary to remain faithful to this simple and straight-forward approach in order to present the wealth of complex, and at times, disturbing data that emerged in a manageable manner. Prior to presenting the format of the findings, a demographic description of the participants is provided.

Sample Appraisal

I have summarized the demographics of my sample population in a written format. Demographic description of the participants (gender, age, experience, etc.) may be written and/or presented in table format (Roberts, 2004). The individually-interviewed participants were primarily affiliated with the *Women In Motion [WIM]* community-based HIV/AIDS prevention program and ranged in age from 32-52, with a mean age of 41. Out of these 7 women, 2 were married; 1 separated; and 4 were single. Their educational level varied, with 4 reporting attending college, but of these women, 3 did not finish [1 graduated from medical school]; 1 high school graduate; 1 GED; and 1 went to grade 11. Furthermore, out of 6 women, 3 reported annual income ranges below \$20,000; 2 between the ranges of \$20,000-\$30,000; and 1 between the ranges of \$40,000-\$50,000. One participant declined to report her income. The number of children per participant was 0-5, with a mean of 2 children. Four of the seven individual participants stated they were employed. In terms of religious affiliation, 3 reported being Christian, 2 Baptist, 1 Pentecostal, and 1 non-denominational.

The members of the focus group consisted of one recorder from *WIM*, and 4 participants, ages 19, 34, and 37 [one participant in the group declined to identify her age but appeared to be 35]. The role of the recorder was to observe and take detailed notes; she was not viewed as an active participant in the group. The recorder was non-verbal throughout the group process. The 34 year old participant in this group was also one of the women interviewed on an individual basis. Out of 4 women, 2 were single, 1 recently divorced, and 1 married. There were 2 college graduates [one had a masters degree] and both were earning incomes between \$40,000-\$50,000; 1 currently in college as a freshman, with income below \$20,000; 1 attended college for four years but did not graduate earning an income between \$30,000-\$40,000. The number of children per participant ranged from 0-3; with 2 reporting 0 children, 1 with 1 child, and 1 with 3. All four focus group participants were employed. In terms of religious affiliation, 1 was Methodist, 2 Baptist, and 1 Christian among focus group members.

All participants in the study [individual interviews and focus group] signed their consent forms after reviewing the content. Most participants were given a copy of the consent form in advance in order to read it over in detail prior to the interviews. They had no specific questions regarding the phrasing of the form. However, several women needed to be verbally reassured of their confidentiality remaining protected. I used this need for reassurance as an opportunity to establish trust and build rapport with these participants. All the women identified as African-American heterosexual females, predominately residing in Marion County. Some were not affiliated with any particular political party; however, several women indicated that they were democrat. A few were

independents; one was republican; but most of them declined to identify a particular political affiliation.

An overview of the findings of this study has been explicated under the following three main headings: (1) Observation, (2) Interpretation, and (3) Application. Observation is salient to inductively capturing the essence of the perceptions of HIV/AIDS risk among a small purposive sample of African-American women. As a result, possible deductions can be inferred about the broader population of these women (Berg & Latin, 1994; Roberts, 2004; Stern, 1980).

Observation

Many researchers will elect to obtain data by observing behavior or a trait, rather than have participants self-report directly on acquired knowledge retrieved during a research study (Berg & Latin, 1994; Silverman, 2004). Often, this approach will enable accurate and genuine information from unsuspecting participants (Becker, 1993; Berg & Latin, 1994; Coffey & Atkinson, 1996). I had the long-awaited opportunity to observe a house party, referred to as a “sex-in-the-city” party by the hostess. The significance of observing a house party is related to the informal discussions about sexual decision-making and HIV/AIDS prevention that allegedly occur at these gatherings. I had the idea that observing at least one house party would be another method of validating my research findings [triangulation]. Hostess K received a gift certificate for Wal-Mart [\$25.00] from *WIM* as an incentive to host the party. Electronic invitations were sent to guests, giving details of the date, time, and location of the party. I was fortunate enough to overhear Hostess K discussing her party with another participant at an educational session of *WIM* early one Saturday morning. I politely waited until her conversation was

over before approaching her about my desire to be a guest. After explaining to her the focus of my research, and the length of time I have been waiting to observe a house party, she agreed to add me to the guest list. The following is a detailed excerpt from my observations of this event:

Thick Description

6-16-07

I attended an educational session today where I met one lady who invited me; or rather I invited myself, to her house party to be facilitated by *WIM* on June 29th. We exchanged contact information. I will plan to follow up with her within a week to reinforce my interest in the house party!

6-29-07

I left over an hour early in order to give myself time to get lost on the east side of Indy. I did mapquest the directions, but I still did not know the area. When I arrived 20 minutes before the party was to start at 7 PM, I wasn't sure what to do. So, I rode around to scope out the neighborhood. The brown brick house was on a crowded street with neighboring houses lined up like full-sized matchboxes. After circling what appeared to be an upscale working-class neighborhood several times, I parked my car a ways down from the dark and unwelcoming house waiting for other guests to arrive. After waiting nearly 15-20 minutes spying from where I was hidden, I wondered if I had the wrong address. It was now approximately 7:30 p.m., so I decided to knock on the door bravely, and wait to see if a familiar face would answer the door. After knocking for what seemed like an eternity, Hostess K responded wearing blue jeans and an old T-shirt with her hair in curlers. I thought I had shown up on the wrong day. She smiled and invited me to come into her house. I was directed to an empty room with one brown chair and a lonely plant with hanging vines. She turned on the stereo in the corner and apologized for the tenth time for running late. It turned out that all her other guests were running late as well. Therefore, I sat alone in the room without furniture wondering where the other guests would sit. Hostess K excused herself, and she disappeared upstairs where I heard another voice in the distance. Hostess K explained to this female voice that I was just the lady from *WIM*, and I was going to educate them about HIV and "other stuff like that." In fact, I was not the educator for this party, but only the detective observer. One

of my gatekeepers, who I knew well, was going to be the educator for this event. But, I decided this information would be discovered soon enough, so I sat and waited and waited and waited. I had plenty of time to study the white walls and brown borders in the room. I noticed the bare spot on the far wall where a picture could have been hanging, but was not. The light tan carpet appeared practically brand new. I was left with the impression that Hostess K was an immaculate housekeeper in need of more furnishings. It seemed as though this was an older, but well-preserved house, with a new occupant.

Finally, approximately 30 minutes later, Hostess K returned dressed in a beautifully mingled-colored formal blouse with long sleeves and a fancy collar, black dress pants, and high-heeled black shoes, with flattering accent jewelry. Her hair looked like she had just stepped out of a beauty salon, and I questioned if I had underdressed for the occasion after all...I was later moved from the lonely sitting room to one filled with very nice matching light brown furniture with plenty of sitting room for all the guests that arrived, four ladies total. Hostess K prepared Mexican food sizzling on the back burner of the bleached-white stove in the fairly-large, but well-organized kitchen, while washing and cutting up vegetables with my assistance. I guessed from the aroma that she would be serving tortillas later after the party started. When the first guest arrived in her fancy dress-styled attire, she looked like she was ready to go to a local club and party all night, except she had her toddler son. The other two ladies arrived later dressed to party also, but one woman had her 4 year-old son. She was carrying a beautiful, but colossal bouquet of flowers for the hostess, and colorfully wrapped gifts for everyone attending the party. The other lady in attendance, the distant female voice upstairs, was an out-of-town girlfriend traveling from an anonymous city to visit for the weekend and party with the other guests. The last person to arrive was the bona fide educator for the evening. The mood quickly shifted from laughter and friendly chatter to the “now-it-is-time-to-get-down-to-business” ambiance.

The hostess briefly introduced the educator, who confidently shared a brief description of the WIM program. She swiftly inserted the educational video into the VCR, which described the risks associated with HIV/AIDS. Then, afterwards she spent approximately 30 minutes highlighting pertinent information from the video, and allowed time for questions. When the two children began to fight over the toys, chaos

erupted from what started out being a professional educational session. The unwavering educator persevered, even when the toddler hit the other child in the head with his GI Joe. After what momentarily seemed like a time-out for the children, I noticed one lady who looked like she was in her mid to late twenties, with cocoa-brown skin, and flawless eye make-up, raising her hand from the corner of the room. She wanted to know how to put on a condom using only your mouth when performing oral sex with your man. The other women started laughing hysterically, while she looked a bit embarrassed. But, she immediately came back with a defensive remark. She retorted, "Don't you guys laugh when you know that you wanted to ask the same question, but was just too afraid." They all nodded their heads affirmatively, but still giggled like middle-school girls during study hall when the teacher's back was turned. The educator stated that she wished she had remembered to bring her model of a penis to the gathering to demonstrate, but she would have to improvise. I watched the facial expressions of the other women while the educator cautiously used a substitute model of a penis to place the condom on just right with ease...These women watched and listened attentively as though they were preparing for a final exam in human anatomy. After all the questions were answered, and the comments made about how valuable the information was, the surroundings again changed to a festive tone. The educator and I departed, without an extended invitation to stay by Hostess K, just when the party among friends was about to start. I was starving on the lingering walk back to my car. I was thinking about tortillas, and the phenomenal event that I had just observed over the last several hours among a sisterhood of African-American women.

What did I essentially see occurring among these women at the party? This was one of the primary questions that I asked as I later processed this event. I observed a sincere eagerness for the women to learn from the educator. They watched the video on HIV/AIDS awareness, and they listened attentively to the educator's presentation. They commented among themselves about new facts they were learning. For instance, the educator explained to the sisterhood of women that when male partners are stimulating them sexually, and the males' fingernails come in contact with their vaginas, they should

be careful not to get infected from bacteria found underneath the men's fingernails. They looked at each other rather amazed, as though to be hearing this information for the first time. One woman spoke up and said immediately, "I am going to manicure my man's nails time [sic] I get home tonight." All the women laughed uncontrollably, but I felt this was relevant information that would earnestly be committed to memory long after the party was over. According to Berg and Latin (1994), observational studies require special attention to detail in real world settings. As the women sat around the cozy and inviting living room laughing, talking, and policing unruly children, I observed imperative information about HIV/AIDS prevention being shared among loving friends.

The use of thick description after observing this party gave me the opportunity to reflect upon the women's behavior as though I was watching through a one-way mirror. The women knew I was associated with *WIM*, and probably assumed I was the educator's assistant, with the exception of the hostess. I behaved as though I was just a silent guest at the party, and ethically this felt appropriate (Berg & Latin, 1994; Roberts, 2004; Stern, 1980). As a researcher, I respected the boundaries of my role as observer. When it was time to leave, I regretted the party ending prematurely for me. However, it was fitting and respectable for my timely departure. I sensed my presence as a perceived outsider could have made it uncomfortable for these women to explicitly continue their sisterly dialogues, and rightfully enjoy their planned evening of celebration.

Journaling

I considered it necessary to transfer my observations about participants to actually writing my views on paper. This approach supported the processing of my emotions associated with the intensity of doing this type of up-close and personal research. I

believe self-reflection and meditation are vital to understanding the narratives of African-American women regarding sexual decision-making and the threat of HIV/AIDS. The following journal entries illustrate this opinion:

6-12-07

This is a wake up call for me. Women of color are now faced with the “reality” of HIV/AIDS...when the truth is finally hitting them about their male partners having sex outside of intimate relationships or marriage. I watch the emotions reflected on women’s faces as they talk about trust and intimacy. Sisters can no longer deny what is going on with their men. I think it is important to find out what other African-American women are thinking about what to do...this leaves me feeling sad and disappointed. This is a pivotal point in my research study. I now can “feel” rather than just think about why this research is so important. I listen to the stories that women are telling me and it hurts at times. I was blessed to have positive male role models growing up. But, as an adult woman, I thought I had married Prince Charming, the fairy-tale romance. Now, I personally feel their pain because in reality I share it too. I have faced some of the same dilemmas in my past relationships with African-American men. How can I start to trust what I know is a barrier to intimacy? Knowledge about HIV/AIDS makes it difficult at times to turn the switch off in my head as women are telling their stories. I start to think back on hurtful relationships I have encountered with African-American men that I truly cared about. Now, I am forced to process my feelings about some of these relationships that I always preferred to remain irrelevant in my life. This is a heavy burden to carry. I will talk to Carolyn [dissertation chair] about this during our next meeting, if I can’t figure it out on my own. I feel like I need to get away from all of this HIV/AIDS and relationship sadness, and just feel like I did before this research started...when I was like all the other sisters out there not really facing the truth. Sometimes, I wonder how did I get to this place, why me?

I never really wanted to do this research before coming to Indy. I was focused on helping women of color cope with issues related to breast cancer. I wonder how I could have handled it if I had contracted HIV during a time of blindness to the truth. E’s lifestyle [ex-husband’s battle with drug addiction] warranted more caution than I took at times in the past. He is gone, and I am left to mourn, but safe from consequences of

taking risks. I understand the vulnerability of these women. I feel angry and thankful all at the same time. I am angry because I miss him, and I am thankful that I don't have to live with regrets any longer. I don't regret the part about the divorce; I definitely do not regret that...but, for staying angry for such a long time. It is too late to turn back, so I have to pray for the strength to just keep listening to the unraveling stories of hurt and disappointment and try to keep it out of my head when it starts to feel overwhelming.

6-19-07

I e-mailed several more ladies regarding the focus group. Hopefully, I will get at least 5 women to commit to the group. It will be held at a place difficult for some women to find on campus, and I am concerned about that. Anyway, I am looking forward to women sharing what they really feel about risks they have faced. Today, I am feeling better about where I am at in the process. My grief is hard to discipline at times, but I care about moving forward with this study. I am going to have to remember to take the tissues to the focus group.

Summarizing my feelings about what I observed, and how I felt during data collection, deepened my understanding of the hidden fears and emotions of participants. Journaling provided a visual aid to help chronicle my own emotional baggage, and self-discovery. Note-taking, along with journaling, served as a useful tool to assist with navigating my way through this discovery process.

Note-taking

While I was processing this research, scattered thoughts dominated my existence. I had notebooks and scraps of paper all over the house, in my car, and wherever ideas were expected to surface. I obsessively wrote down my thoughts and feelings before they vanished. Furthermore, I had written my notes on the flipside of tissue boxes. Even though this obsession might appear insane, it actually created the basis for my question guide that I used while interviewing participants. I have included the following examples of these critical notes:

10-13-07

Is celibacy a choice for African-American women, or is it the result of decision-making based on default...partners not being available and suitable to the needs of women? I would like to ask women what they think of this dilemma. I have been hammering this idea around in my head, but it makes no sense to want an intimate relationship with a man, only to find more of the same disappointment, if expectations are not met. However, undesired celibacy creates unwarranted frustration for many women. Wow!

11-16-07

Stepping out of fantasy into reality; I have heard women comment on broken dreams and disappointments. Are their expectations of male partners grounded in reality, or is this part of the same fantasy that I grew up with? I don't know.

12-9-07

I think some women will need to practice safer sex until it becomes a new habit like changing eating habits, and other undesirable behaviors. Changing most habits usually will not have such severe consequences if you make a mistake.

12-11-07

I heard from P__ today. Her message was inspirational and appreciated. I will need to call her next Tuesday about the event acknowledging National Black HIV/AIDS Awareness Day in February.

1-18-08

What do our women want more...the gratification of sex or the peace that comes along with protection? Why does this have to be such a hard choice, or even a necessary one when in a committed relationship with a male partner? I wonder what the guys think when women have hurt them or disappointed them in relationships also. Are guys on the down low feeling guilty for betraying unsuspecting female partners? I need to ask men these questions in my next study. It seems as though sexual decision-making is becoming more complex than it should be.

I discovered that personal involvement becomes part of the process of understanding qualitative data when focusing on people's experiences from their point of view. I believe this critical step is often diminished among reporting the findings of the

naturalistic study. It is vital to acknowledge personal involvement, rather than framing the findings as though feelings and biases are non-existent. It seems as though observation, along with journaling and note-taking, should be documented co-stakeholders with the data collected from participants, instead of superfluous elements to be excluded in the end results. Personal involvement is not to be mistaken with violation of ethical boundaries in research. On the contrary, it means reflexivity becoming recognized as a mandatory component of the rigor of data reporting. The painful process of deconstructing my past relationships with African-American men personally liberated me to listen more objectively to the narratives of African-American women. Without the time-consuming process of journaling, note-taking, and understanding my role as observer, I would have been greatly restricted in my effectiveness as interpreter of the emerging data. This is the nature of personal involvement that I believe is essential in understanding the perceptions of African-American women and sexual decision-making with their male partners.

Interpretation

According to Roberts (2004), “Because there are no inferential statistics to be performed in qualitative research, some students mistakenly believe it to be ‘easier’ to conduct than a quantitative study. This is not true!” (p. 112). The individual interviews transcribed in this study averaged 25-28 pages of typed text [including margins for coding]. The length of those interviews was 60 to 75 minutes. Also, it was necessary to conscientiously analyze the data from the focus group, which lasted approximately two hours. Additionally, Roberts (2004) asserts that there is no standard way to correctly code textual data because individual researchers undertake the coding process differently. As I

shifted from observation [What am I actually seeing?] and self-discovery, to the interpretation of the data, I began to ask the question, “What does the data mean”?

I decided on the systemic approach of reading all of the transcriptions completely at first, and then later identifying significant quotes from the text of each interview. Afterwards, I attached identifying labels to the quotes during the coding process, which involved the enhancement of the process from the Atlas.ti 5 qualitative software program. I reduced the total number of categories by grouping related labels or topics. The conceptual schema from this data became apparent as the interrelationships developed between these groupings. It was necessary to occasionally recode my data as I further identified emerging categories. For instance, I focused on elements related to the interpersonal aspects of sexual decision-making. Such as, power differentials, condom negotiation, sexual abuse etc. from the narratives of participants. These constructs developed into themes related to this central core [interpersonal aspects] of sexual decision-making. These emerging themes became the dominant influences framing the meaning of sexual decision-making from the perceptions of participants. This process included the primary beliefs of African-American women regarding gender roles and sexual attitudes, the structural and contextual implications of the “triple burden” in their every day lives, and the affect of childhood sexual abuse and influences of African-American male role models in their lives.

Each one of these major aspects related to sexual decision-making emerged after a myriad of categories were saturated during the analysis process with the assistance of index cards and the Atlas.ti 5 software program. To illustrate this stance further, the concept of gender role influences involved social networks related to family and the

surrounding community. Sexual experiences were often generational influences passed down from grandmothers, aunts, older sisters, or sexual influences from peers, neighbors, faith-based organizations. As women began to share their stories regarding these influences, I grouped them under childhood experiences they shared and experiences they encountered as adult women. This analysis resulted in the process of understanding sexual decision-making or the “school of hard knocks.” Additional framing of these constructs related to sexual decision-making created a category concerning the understanding of intimacy or “God will send me what I need.” The last major category was related to power disparity or condom negotiation with male partners or “Nothing ventured nothing gained.” This very brief summary of how categories and themes emerged related to the construct of sexual decision-making from the perceptions of participants does not give justice to the extensive narratives shared by these women. The interrelationship of emerging categories required me to stay close to the data by returning to transcribed interviews for further evaluation, field notes, journals, and the literature. Prior to discussing specific aspects of sexual decision-making and condom negotiation with this population of women, I made the decision to focus on their general perceptions of making healthy choices and prevention.

Possessing Health Consciousness

Participants seemed to make the connection between the holistic care of the body, mind, and spirit. This was evidenced in a memo I recorded on this topic [memoing is a way of capturing vital information throughout the coding process as a means of note-taking]. The memo included the following question: Are women cognizant of the need to make universal health choices in their lives? I was curious about their recognition of

ways to stay healthy. I thought if women possessed this general knowledge, and discussed this non-threatening topic openly, this could unlock the door for more in-depth dialogues later in their interviews. Participant P [participants are referred to as respondents in the transcriptions] disclosed her impressions of making healthy choices:

RES: Well, for me, and I have to turn things back around to me, today [slight pause] I am not going to cry... I eat better...and [P fights back tears] and huh...I just don't do the things that I normally do. I am still not...I still smoke cigarettes and drink too much coffee. Umm...I have a high sex drive, but I am not actively involved with anyone...and that is true. I don't know if it is because...well, I am really careful of...I have been tested and tested and tested but I am really careful that ummm....relationships take a lot and I don't have that. I have too many things going on in my life and I don't have that much energy. This is a perfect choice that I made for myself.

Participant P started the interview overwhelmed with emotions. She explained that her recovery process from drug addiction had left her on an emotional roller coaster. But, after assessing her comfort level and well-being, Participant P assured me that she was ready to continue...

RES: Okay...at 46 years old I do the normal yearly mammogram. I am not a person that normally gets sick a lot. So, I do the yearly pap, the yearly mammogram, and a yearly physical just to make sure that there is any thing...you know preventative. And then, well, I lived a destructive lifestyle for so long and I am just so grateful that I do not have any major ailments. It feels good today to eat properly, it feels good today to take vitamins, it feels good today to do these things because there was a time that it wouldn't have even dawned on me to go there. So today, I really enjoy that.

Participant P demonstrated awareness of the need to have an action plan for maintaining proper health and prevention by scheduling annual pelvic examinations [pap smears], mammograms, and taking vitamins. Most of the participants responded in a similar fashion by recognizing the need to eat properly, exercise, and schedule routine

physicals. For instance, Participant M quoted, “An ounce of prevention is worth a pound of cure.” It appeared there was a perceived need for discipline and consistency in order to prevent negative health outcomes down the road. Participant M explained her views:

RES: You have an opportunity to get better results because you are able to meet the disease or meet the condition all along until waiting until it is out-of-control... To eat well, exercise, to be preventive when it comes to Ummmm...to looking at health issues.

I interviewed a female physician by selecting theoretical sampling. This type of sampling cannot be predetermined due to the ongoing processing of the data (Stern, 1980). I wanted to better understand the potential health risks challenging Participant P and Participant M, along with the other women. Doctor P is African-American, mid-thirties, and recently married. She is currently engaged in her residency at a local hospital in Indianapolis, specializing in internal medicine. Despite her hectic schedule, and planning her wedding, Doctor P agreed to meet with me. She is committed to promoting preventive health care on behalf of women. As the data emerged from speaking to participants, Doctor P gave her impressions of making healthy choices concerning women:

RES: Visit your doctor annually ummmmm...and if there's any concerns about anything, even during the year, consult your doctor, eating healthy, exercise, and I think in addition to physical health, as well as spiritual health, and mental health are ways that women can stay healthy and if they don't know any avenues for that, then again there are plenty of resources through their physicians that can get them the type of help physical, not physical but spiritual and emotional support...pause...well again I think it boils down to knowledge as far as prevention is concerned and I think that is where the physician's role comes into play because the physician is a teacher and they should provide information for prevention of any physical ailment if you will, prevention of heart disease. In other words, don't smoke...prevention of obesity. In other words, portion control, exercising, nutrition, things like that. I

think once the prevention measures are taken care of and the patient understands what prevention is, and then I think they can make a conscious decision to be healthy.

According to Doctor P, knowledge is the catalyst for women making healthy choices, once they understand the importance of prevention. In addition, Doctor P discussed her impressions of the valuable information and support women should receive from their physicians. This excerpt from her interview elaborates this view further:

RES: It is true, and we are responsible for our healthcare, no one else is. When I prescribe a medicine that patient has a choice, they can take it or not take it. I tell them you have to help me help you. You are responsible ultimately for your health. You have to have some input in this you know. Don't have the man or your partner dictate your health. Pretty much that is what you are doing if you are passionate [sic] about condom use and things like that. You are pretty much having him dictate your health.

INT: So maybe part of it is that women have to understand that making healthy choices in their lives overall includes making choices about being sexually active with your partner and you have to choose whether you are going to put yourself at risk. You have to choose whether you are going to insist upon a condom being used or not.

RES: You know the consequences of not. You know what the possibilities could be. Yes, he is monogamous great you know but I think it is even harder...

INT: Very true...

RES: when you are talking about two monogamous people, it is a lot harder. And I know this may be on the focus of sex, but too, African-American women and drug use. You catch HIV from drug use from IV drug use so I mean education has to go not from just the sexual standpoint, but also from the drug use.

INT: That is a very good point because they need to understand all the ways that they are at risk. That is true. And I think it reinforces what I was telling you about the woman that didn't even know that she could turn down sex. Women

have to know that it is okay to say no to things that are not healthy. It is like it is giving them permission to say no.

RES: Right. Sometimes, it just takes someone like you and me to say, “you can say no.” They need just a little push you know that you can say no. You would be surprised on the impact that you have on women’s lives by sitting here talking, getting to know their feelings things like that. Just a word can change their lives.

INT: And you never know what that could be that could make that change. You can never predict it. That is true.

RES: Never

Participant E mentioned concern for a friend who was recently diagnosed with diabetes in her early 30’s. In agreement with the sentiments of Doctor P, Participant E’s perception was that knowledge and healthy choices were connected:

RES: I think just being educated. I think being conscious and educated because some people are just not educated. They are just not aware. For me, like I said, it came from experience and other people. But if people don’t have friends who have contracted any diseases or diabetes then they are kind of in a world that is kind of lost, like I was before. I felt like I could eat anything I wanted and whether my weight went up and down I thought, oh well, I’ll just lose it. It’s even more than just the weight; it’s what you eat...whether you are skinny or healthy size, just putting in your body certain things, just being educated and conscious.

Collectively, African-American women in the study seemed to illustrate keen awareness of health consciousness. Some women truthfully acknowledged that they were not always practicing healthy behaviors. For instance, they were aware of the importance of eating properly, but some women still indulged in unhealthy eating patterns. Others acknowledged the dangers of lung cancer associated with smoking cigarettes, but continued to smoke. Nonetheless, I had the impression that participants connected making healthy choices with having a plan to prevent negative health outcomes. At times,

it was questionable concerning the level of discipline practiced by some participants in order to maintain ideal health. Subsequently, what did this general knowledge of making healthy choices and prevention mean with regard to sexual decision-making with this sample of women?

Possessing Sexual Wisdom

Some participants described their sexual experiences with men as the “school of hard knocks.” Women contrasted their knowledge of sexuality [related to sexual desire and sexual intercourse] in their past age of innocence and irresponsibility to their present age of wisdom and full-grown development. This process of ripening to modern-day astuteness was a high price for their educational awareness as expressed by a number of participants:

Participant L

RES: Well, I won't have to worry about catching any STD's. I won't have to worry, if I change things in my diet, I won't have to worry about my stomach. When I eat fried foods it just gets ugly. My stomach gets to burning and I guess acid reflux comes all up in my throat and my throat hurts. I am 45 and I like sex but it gets scary now, I don't want to die. I am too young. All of that is just connected to one big word, “healthy.” When you put healthy foods and abstinence together there is a connection.

Participant P

RES: I make a conscious choice. It is the same way with men. I have a big appetite for that too, but I say Lord, you know what...I just don't want to go there. I don't have the energy to worry about STDs and all of that stuff. I choose to be abstinent. It is helping me right now. I am healing. God will place someone in my life when I am ready. I believe that you attract people to you at the level that you are. And, I always liked the real bad boys. {P starts laughing out loud now}. So, in order to get healthy I have to stay away from that. I call them boy toys.

I shouldn't say this...I am 46 and what can they do for me outside of sex? There is nothing else that they can do.

Participant M

RES: For sure...the school of hard knocks. It wasn't always the case you know early in life. Oh yeah, I am going to do it, but you know...then...so right now I am outside of the circle I am not, maybe as a teenager or younger person I was more active so that has its own set of questions, but right now I am more outside of the circle because I have been abstinent. My questions are very bland in the sense that it is not anything about the sex act itself, but whether or not I am actually going to have sex. So, that is the nature of sexual decision-making for me...

African-American women in this study often related sexual wisdom to abstinence. Yet, there were times before the interviews began that several participants whispered in an apologetic-like manner that they were not presently in a relationship. The decision not to be in a relationship with a male partner seemed to cause some women relief, while others appeared more remorseful.

General knowledge about healthy choices and prevention apparently intersected with choices about safety from HIV/AIDS and other STDs. Abstinence was recited as the only way to totally receive protection from STDs. In contrast, condom use was perceived as at least a means of having safer sex, with no guarantee of safety. This revelation of acquiring sexual wisdom was understood as taking “baby steps” to reach the decision of abstinence. Participant L acknowledged that she had neglected her health for numerous years related to crack-cocaine addiction. However, she is now convinced that there is a connection between sexual wisdom and eating properly [she is struggling with obesity], because both are just “healthy.” Sexual decision-making involved a complex interwoven process for these women when examining experiences with male partners. This process is explored under the following three main themes, which emerged during data analysis: 1)

The School of Hard Knocks, 2) God Will Send Me What I Need, and 3) Nothing Ventured Nothing Gained

The School of Hard knocks

Participants encountered varied experiences in regards to sexual decision-making with male partners. Their perceptions of sexual decision-making were constructed through circumstances with males as young girls, which influenced their views of sexual decision-making as adult women. According to Munroe (2001), the nature of women centers on their need for affection, while men need sex. This motivational speaker, who is lecturer and educator, further alleges, “She needs an environment of affection in order to feel loved and fulfilled” (p. 173). Yet, in reality, sexual decision-making often was influenced by painful past experiences.

Learning About Sex as Little Girls

Young girls learn love and affection from growing up in their families and social environments (Dillow & Pintus, 1999; Munroe, 2001). Culture, along with traditions in families, provides a model of gender development and sexual identity for children (Munroe, 2001). As evidenced by participants in this study, when dysfunctional behaviors and distorted views of parental child-rearing disrupt childhood development, negative outcomes occur. These consequences appeared to blur healthy boundaries for participants attempting to establish a direction for sexual decision-making. Several participants disclosed some of their early childhood experiences:

Participant L

RES: My mom had me stay in the car while she went to visit her other sick friend or something and he drove off and said, “Oh, I’ll just go around the block or the corner or something.” At ten years old this man raped me. He was a drinker too, an alcoholic.

He turned around in the seat coming back there on top of me and I am like get off me, get off me and he tells me, "Oh, I ain't getting off of you... you are going to give me some of this." And I am going no, no and he (inaudible) and put it up to my throat at ten years old and said, "Oh, you going to give me some of this" and raped me. When he got through I told him I am going to tell my momma and he said, "Who do you think set this up?" That burned in my head for that long. I carried that for a lot of years... I never had told anyone about it. I guess when I was getting high it had laid dormant inside of me and I couldn't remember until I started getting clean and then bits and pieces of my life, my past started coming back. That one particular thing came back and I heard those words come out of his mouth, "who do you think set this up for me to have you" and at the time there was nothing I could do about it but that feeling. That feeling of betrayal, that was stronger than anything. I had no love; it was like my feelings were just numb from the betrayal.

Participant L emotionally described the devastating event that occurred in her childhood. Her mother was abusing alcohol, and L blocked the betrayal for years until she was going through recovery from drug addiction. She recalled that her mother sold her to a male neighbor for alcohol. L's mother knew her ten-year-old daughter was going to be raped. The betrayal from her mother was even more demoralizing when she was later revictimized by her biological father. Participant L revealed her story of rape by her father:

RES: Yes, my dad, my father. He was the first one to have sex with me to where I reached a climax and I didn't know what was going on with me. I told him get off of me, something is happening, something is happening and he said, "Aw, you just reaching a climax." I was like Uh, I am only fifteen that is disgusting to me. And um, so, I went to school, we struggled; we had a fight me and my dad. It was like (inaudible) in the house, go to the store, go here and go there, he gave everybody money and I am the only one left so, I jump up and get ready and he claims that I did something and am on punishment so I couldn't go. Next thing I know he is yelling for me to come into his room so I go in there to see what he wants and he grabs me by the arm and throws me down on the bed and starts giving me oral sex. I was asking him what he was doing and

saying get off of me and then after he gives me the oral sex. He has sexual intercourse with me and while I am trying to push him off he is hitting me in the face and busting my lip and all of this stuff.

The next day, I had to go to school because that day was on a Sunday, I had to go to school and I told somebody and they called the police. I had to tell the police and they sent me to the Guardian's Home. The police investigated. When the police showed up at the house he had went on the run; he was running from the police. After that, everything else, we had the court thing, I lost the case because he had done paid the police not to show up with my lie detectors test. It was all messed up. But, after that I didn't want to see my father again. He had gotten married, I just didn't want to see him again, I didn't want nothing to do with him. Then, when I had my son all of a sudden he wants to see his grandson and yeah, I want to do things with my grandson. You know, you will have nothing to do with your grandchildren, I am sorry. But, you hurt me and then I had a daughter and he is really not going to see my daughter. I didn't want to put her in that danger with him. I told him that he would never meet her because of what you did to me you will never get to touch her. Then, there was a younger sister after I left, she stayed there, he tried to get her too and she said she ran away. He didn't get to get her, so I was grateful for that.

Participant L's story of childhood sexual abuse is shared by another woman in the study. Participant F made reference to her belief that childhood sexual abuse is common in black communities. Participant F conveyed her views:

Participant F

RES: I can only speak from my experience; my decision-making came from what was going on with me as a young child. The things that were happening in my life. I was being molested. I thought it was okay to have sex. I thought that because I was being molested and I didn't know I was being molested, I thought that that was something that was supposed to be done to me. So, I became...I started giving away sex because I thought that was what I was supposed to do. So, I became promiscuous and I didn't find out that was what I was until I was older. So, a lot of times our environment, we are products of our environment. You know, especially the black community. For years I have been promiscuous because of my

lifestyle and how things were happening to me, and I am just now starting to learn that I don't have to do it anymore.

While Participants L and F both experienced childhood sexual abuse as young girls in what was expected to be the protective environment of loving homes, Participant P disclosed a different experience of sexual abuse.

Searching For Independence as Adult Women

Participant P grew up in a loving and protective home with parents focused on providing their children with quality education. Participant P ventured off to college when she was 18 years old, away from the “watchful eye” of her parents, for the first time in her life. She encountered an older man, mid-40s, who she described as a pimp:

Participant P

RES: I was in Miami, Florida. I was going around campus, and he comes down. He picks me up and would give me things and he was an older man. I didn't understand...that man taught me more about my own body, and he never even penetrated me. That man was...at that time I didn't know...I was just that gullible and naïve coming from {location of city not disclosed} Indiana. I had never seen an ocean; I was in awe for months you know. That man played with me and taught me more about my body than I had ever known possible. Then, one day he told me to go over there and be nice to this man. And, I didn't do that and he ended up hitting me. And I wasn't into drugs or anything like that, and I was so devastated. So, basically he left me. He left me way out in the Keys somewhere. I couldn't remember which Key it was. He left me there and my dormitory was back in Miami.

Based on the stories told by participants, quite a few of them grew up confused about appropriate sexual behaviors due to years of childhood sexual abuse, parents not feeling comfortable speaking openly about sexual matters, and/or lack of appropriate resources available to them as youngsters. Participant P was the victim of a sexual predator seeking out young and unsuspecting freshman girls on college campuses to use

them for profit. This participant was left feeling hurt and perplexed about her “attentive male friend” suddenly abusing and abandoning her. She felt the distress of the situation long after this older man disappeared from the college campus and her promising life.

The most devastating barrier to learning appropriate sexual behaviors among some participants centered on sexual abuse endured as young girls. This violation of trust and betrayal created dilemmas with sexual decision-making as adult women. It seemed as though women needed to experience some normal growing pains in life in order to mature and develop into independent and confident women. Unfortunately, childhood sexual abuse interrupted the progression of this natural development.

I consulted the literature in order to gain a better understanding of sexual abuse among African-American women, as issues of incest and sexual violence emerged from the data analysis. As these diverse labels of abuse unfolded from participants’ narratives [e.g., incest, rape, molestation, sexual violence, fondling], they were placed under the related core category of sexual abuse. I specifically singled out more information regarding sexual abuse among young African-American females.

Childhood sexual abuse is only one of many high risk categories for young, poor African-American women, but it is a risk which warrants further examination (Johnson & Young, 2002; West, 2002; Wingood & DiClemente, 1997). Wingood and DiClemente (1997) conducted a longitudinal study of 165 African-American women, 18-29, from a lower socioeconomic community in San Francisco. HIV/STD sexual risk factors, alcohol use, physical abuse, effective health, and relationship commitment were assessed through face-to-face interviews. Of the 165 women in the study, the prevalence of childhood sexual abuse [experiencing forced sex prior to age sixteen] was 13.3% [n = 21].

Furthermore, women who reported a history of childhood sexual abuse were 5.1 times as likely to have a partner who had been physically abusive within the three previous months of the study. Relevant to the aim of this investigation, these same women were 2.6 times as likely to have a partner who was physically abusive when asked to use condoms, and 2.6 times as likely to worry about acquiring HIV.

These findings were restricted by the absence of data on the duration and intensity of physical abuse, and the lack of causal relationships in this study. Still, these findings supported the notion that African-American women in physically-abusive relationships were less likely to use condoms, and more fearful to ask their partners to use condoms. More importantly, “sexual assaults initiated during a girl’s childhood, including sexual abuse, have been associated with sexual practices that increase a woman’s vulnerability for HIV” (Wingood & DiClemente, 1997, p. 380).

According to Robinson (2000), abused women need safe places to come together to heal, weep, and share their stories. If women are empowered to become survivors, victimization does not have to be a permanent condition (Robinson, 2000). This stance is further reiterated in *Mikki’s Story*, an article based on the progression of healing and survival for a woman victimized by domestic violence (Jumpper-Black & Shelly, 2005). Nonetheless, even within the boundaries of healthy childhood sexual development, it seems like many women tend to mistake attention and sexual gratification from men, as vows of committed love and affection. African-American women in this study communicated their views of intimacy in relationships with male partners.

God Will Send Me What I Need

The construct of intimacy was challenging for participants to describe. They were not sure if it should be defined as a physical sexual attraction, a social connection of spending recreational time together, or an emotional bond of sharing intimate secrets and childhood memories. As women struggled with the meaning of intimacy, the definition became all-encompassing of close and comfortable human interactions between women and their male partners. Unfortunately, while some participants confidently expressed past encounters of sharing intimate times with male partners, for others, it was just a fantasy.

Sharing Sex On a Deeper Level

Participant L exclaimed that the men she had experienced relationships with always told her that if she loved them, then she would have sex with them. This participant expressed her meaning of intimacy as though it was a scene out of a romance novel:

RES: I describe intimacy and relationships sitting by the fireplace, I am just a romantic. I love intimacy. I would rather do intimacy than to have sex any day. You don't have to have sex to be intimate. The fireplaces, with your kool-aid (laughter) because you know I don't drink, the candle light dinners, sitting on the beaches with a fire going, that kind of stuff, the flowers. That type of intimacy of just lying up and holding me all night without touching me sexually. That is the kind of intimacy I dream of.

INT: Have you ever experienced it?

RES: No, I have only fantasized about it.

INT: Never had the opportunity to have ever had that?

RES: Everybody that I have always ever met wants to have sex. That is why the relationship wouldn't last very long because I was like, where is the romance?

Participant L continued to describe her frustration with men that just could not understand her needs for emotional love. I asked the following question to Participant L as a way of clarifying what she had just said: "So, you are saying that intimacy does not mean the same thing as having sex?"

RES: No, it doesn't. Just because I open my legs to you, it's not showing that I love you. It is not showing that I don't love you just because I don't have sex with you. Don't you understand the emotional love, that deep love that comes from inside? I have met a lot of men who don't get that. Oh, sex is the answer with the guys I know, it is the answer and that is the way they are showing you that they love you and it is all a big lie.

Participant E was torn between perceiving intimacy as physical or emotional, so she decided to use these conjectures of connection interchangeably throughout her interview.

RES: Um, well, there are a lot of different definitions for that. I guess it depends on what level you are at. Um, for me personal intimacy would be cuddling or holding hands, showing affection. Um, off the top of my head those are the things that I can think of that would show affection, quote intimacy.

INT: So, when you are thinking about intimacy, you are thinking about an emotional kind of connection?

RES: Yeah, when I think about intimacy, I think about an emotional and a physical. When I think of the word intimacy, I think about emotional and physical. I think of both and it just depends on where you are at in your relationship where those two will fall. I think to me in the beginning of a relationship being intimate is the holding hands, the arm around your shoulder, maybe cuddling on the couch watching a movie. I think of that as intimate. If you are in a serious relationship,

intimate is more where there is contact, maybe kissing, touching.

Participant E depicted the fairy-tale wedding that she had planned since she was in her early 20s. She kept a thick folder with completed wedding invitations, a guest list, pictures of wedding gowns, etc. She confessed that approximately six months ago she threw the entire folder in the trash after nearly fifteen years. This is the rationale for her decision:

RES: I threw the whole folder away because I said this is all planned. It is okay to plan some things but this was too deep. And the more I am growing into my faith, I don't think this is what God would want me to keep focusing on, so I am putting this first and I pitched it. And I said, "If I meet somebody and it is the right person I can do this again." But, right now this is holding me back. It is hindering me, and it is keeping me in that mind state... meet somebody, rush it through, and hopefully this is the right person. But, I am just on a walk right now where I am not even looking. It is not even on my mind. I am not thinking about it. I just want to go day to day and be in this day. So, I just pitched it. I thought it's just time and it's gone...don't regret it, don't think about it. Do I ask myself why did I do that? Nope, it's just gone and I am okay with it.

Participant P had to pause for a while before she agreed to emotional closeness as the true meaning of intimacy, whereas, Doctor P perceived intimacy to be spiritual in nature, along with the physical and emotional connection:

Participant P

RES: {long pause} Closeness is, can we date? Can we spend time together? On an intimate level, I can go months and not have sex. We can make love with all of our clothes on. We can get to know each other mentally. So that to me is closeness. So, if you can do all of that without the actual physical part, then that is intimacy instead of putting sex before that.

RES: [Dr. P] Intimacy, I would define it as a [pause] not only a physical connection...a physical attraction, but also

emotional and spiritual as well. It doesn't even have to be anything physical you know as far as kissing or sex, but I think it is...it is tough to put into words but I know what I am trying to say...a mental connection just everything being on one accord. I am not sure if I am saying it quite right but to be intimate with someone just have this heartfelt sincerity mentally, physically, spiritually. That is probably all there is for that [Respondent chuckles].

Intimacy for Participant P, and others, definitely was a difficult concept to grasp. As they struggled with the meaning of intimacy, it challenged their views of sexual decision-making. Some women unknowingly used intimacy and sexual intercourse interchangeably during their interviews. On the contrary, other women made a distinct differentiation between intimacy as emotional closeness, and sex as the physical act of making love. At times, sexual intercourse was not perceived as an act of intentional love-making, but rather undesired sex. This is the type of sex that women do not rush to read about in romance novels.

Sharing Sex When Unwarranted

Some participants related emotional intimacy and affection as foreign concepts to them. Occasionally, women disclosed that they just wanted to get the sex act over with, given that they were trading sex for drugs or money. Other participants described emotionally-distant men unwilling to practice intimate gestures of love and tenderness. According to Munroe (2001), "Showing affection is expressing one's love constantly in little ways. Many men don't know how to do this because they didn't have fathers who showed affection to their mothers. Hopefully [sic] their sons will be better at it" (p. 175). This was not the case for some of the participants. They depicted situations involving men engaged in controlling and power-driven sexual relationships. Women told several stories unrelated to intimacy:

Participant F

RES: Well, I was drug by a car and that was because I did not want to do it [sex], and I would not give the money back. So, they held on to me and they drug me.

INT: Did it require you to be treated in the hospital?

RES: Oh yeah, because of the dragging the skin was pulled off, so it was like I had third degree burns.

INT: How long were you in the hospital?

RES: ** Inaudible, individual is talking low and mumbling **

INT: So that could have been...that sounds like a life threatening situation.

RES: Right, that was.

INT: You had some serious consequences. What changed after you were released from the hospital; did you continue to take those risks after that incident?

RES: Yes, I did because I was an addicted person, nothing changed, and my mind hadn't changed. I still wanted to get high.

INT: Even with the extensive injuries?

RES: Even though the extent of the injuries.

INT: Do you wonder who that woman was? What could she have been thinking?

RES: Yeah, I think about a lot of things that I have done and wonder how did I get there? I don't have it in me to do it again; you know what I am saying?

INT: Uh huh

RES: I actually get scared when I think about the whole thing. I wouldn't have the courage to do it. It is funny how things shift so fast, I don't have the courage to do it. I am scared. I think it is a good fear, a healthy fear.

INT: It is a fear that prevents you from going back to those kinds of situations...

RES: Right

Some women like Participant F, described acts of violence, or fear of being hurt, if they did not give in to the demands of sex. On the other hand, Participant E shared another perception of control that did not involve the threat of sexual violence:

Participant E

RES: I felt controlled because instead of sticking with my guns and being adamant about it, I kind of, the way that person's demeanor was and he saying forget it, come on. I am just wondering why I let myself do that. I just felt like that was a control situation because I really could have said no.

INT: You didn't feel threatened by saying no?

RES: No, I didn't feel threatened just kind of maybe naïve. Maybe just not strong enough to be adamant or seriously put my foot down. That's how I felt controlled. Like I really could have and should have, but I let him control the situation and say oh no, don't worry about it, come on and I went a long with it. It just really made me feel afterwards that I was controlled and I don't like that.

INT: So, I guess part of it in terms of feeling controlled is going along with what your partner would expect or trying to please him. So, where do you think that comes from when women are in situations where they can't say no?

RES: I think my situation was more to please.

INT: Where does that come from E, that feeling of wanting to please your partner?

RES: I wish I just had the right words I am trying to find to use for that. When I think about it, I mean, I have seen, even myself, women who will say no quickly to their own mother, their sister but when it comes to that man it is almost like it is whatever you want. Not to that extent but there is much more leniency there. And I think it is about trying to please

because you don't want them angry or upset because you love this person, you are with them, you want them to be happy. Um, I think it is again about not putting you all the way first or even half way, you are putting them first. And it is because you want to please them and you want to make them happy.

INT: So, somewhere that happened, that expectation maybe to please your partner. It comes from somewhere, but you are not quite sure?

RES: I don't know how to describe it, it's just that I see it all the time, especially now when I am looking at friends or family members.

Physically-abusive situations are at times violent acts at the hands of controlling and abusive men. Other times, it involves women attempting to trade sex for money or drugs. Still, some controlling situations involving power acts and sexual demands by male partners are not based on fear of physical or sexual violence. According to participants in this study, these situations are grounded more on fears related to abandonment and emotional insecurities of women.

Even in situations when the sexual act is undesired, some women will voluntarily admit defeat to unwarranted sex, and engage in sexual intercourse. Rose (2003) examined twenty narratives of African-American women disclosing their unique experiences related to sexuality and intimacy. Similar to the women in this current study, participants in Rose's study had varied sexual experiences and diverse backgrounds. Yet, they commonly sacrificed their minds and spirits for love. Perhaps, it was too risky for these women to surrender the fantasy of love and intimacy, despite their male partners not fulfilling their dreams of Prince Charming.

Nothing Ventured Nothing Gained

Condom negotiation often is debated as though women have control over making decisions in intimate relationships with male partners. In reality, women are left vulnerable in regards to convincing their men to wear condoms, especially when partners persistently refuse to wear them. Participants revealed their perceptions of condom negotiation in intimate relationships with male partners.

Waiting for L-O-V-E

Participants were aware of the potential risks involving condoms breaking, allergic reactions to latex, or even the possible threat of men retaliating, if asked to use condoms. For those women choosing to be abstinent presently, they certainly did not give the impression that this would be a life-long commitment to celibacy. For instance, Participant T [interview tape broke], allegedly in a platonic relationship with her male roommate, admitted that she does not feel a sense of trust concerning black men. Her lack of trust was related to a physically-abusive marriage in Participant T's past, along with being raped at the age of thirty-three by a male acquaintance. Nevertheless, she is waiting for L-O-V-E. This participant slowly and dramatically spelled the word out, rather than actually stating it. Participant T announced that she is celibate by choice because she has been seeking a man who is trustworthy. However, Participant T was adamant that if a man refused to use a condom, she now has the capability to just walk away, without feeling the temptation to engage in unprotected sex. She associated this newly-discovered resolve to knowledge of HIV/AIDS prevention that she acquired through attending *WIM*. Other participants shared their perceptions of managing condom negotiation:

Participant M

RES: It makes me question them; I verbally question them. Again, I have not been active for a while, but I remember being in situations like that. And so it says to me I don't know who you have been with and you do not know who I have been with. I question them and they should question me. How do you know where I have been? You know. If you are doing this with me who else have you been with? You know. That is one mentality.

INT: So, if they refuse to use a condom you kind of challenge them on "Why?"

RES: Umhmmm

INT: Okay.

RES: And, I have not always abstained once they did refuse. And again that plays back to me being in addiction you know, because I have risked things before. With having played [Russian] roulette before...you are not as...you know once I dissociated myself from my past I am able...sometimes the mentality would be...you did it before, it is not your first time. But, I need to realize is that ...especially once I got in touch with it from this point on I can honestly say that I am okay.

Women appeared confident in declaring that they will now insist on men having HIV testing, along with wearing condoms. However, this was not the situation in the past. The lack of HIV knowledge, drug addiction, denial of potential risks, and emotional insecurities were just some of the contributing factors involved with these women taking risks with unprotected sex. But, Participant P disclosed that her participation in at-risk sex was basically connected to her strong sexual appetite.

The Comforts of a Man

Participant P

RES: I am glad that you asked that because I love sex, tremendously. I am not trying to put what I am about to say in a bad connotation, don't get me wrong, but...usually if a

man is not, well, I used to have sex with women, too. If a man does not have the same desire or appetite that I have, usually he cannot satisfy me. I can sense that...really, I can sense that. I am sure that they can sense that of me too. It is probably the sexual appetite. I think it all ties back to that. Dr. Gray, a theologian, really helped me so much. You feed that, what you want to grow and starve that, which you want to die. And if I apply that to my life, there are some things about me that I can change...change my personality, change my habits. There are some things about me that I do not have that capability or would not want to. If that is a good thing why would I want to change that? I need to take more time to find someone that have the same interests and desires that I do...that have that same sexual appetite. Today I am patient enough to wait...This comes from me going to prison. Most of our men going to prison, you would be amazed at the amount of men having homosexual relationships that aren't gay or like my friend who is married and been married all of these years and he goes to church. He is devout so you would never know. I own my body if I am married, if I am single. You can be married now and still...you know...I do not have a steady partner...I don't have sex. Casual sex is no longer with me for a nut, just for that comfort. I can give myself comfort. I bought myself a massager. That is comfort. A man holding you is comfort. If I sit there long enough I get really comfortable. And I can soothe myself without needing that man to hold me at night. I do not have to have the comfort of a man.

Participant T stated previously that she is celibate due to waiting on a man that will be trustworthy, whereas, Participant P is abstaining from sex because she is seeking a man with a strong sexual appetite similar to her own. Both of these women are willing to deprive themselves of the comfort of a man until their relationship needs are met. While these participants were cognizant of their privilege to make choices about their sexual desires, Participant L just recently discovered this revelation:

Participant L

RES: It means a lot to me and I didn't realize it until I went to *Women In Motion*. That it is my choice whether I want to have sex with you or not. It is my own will, I always thought

that it was the man who made the decision, but now I have control of my body. It is a joy for me to know that I get to make that decision about my body because I was never taught that. Mama wasn't there to tell me things like this. I had to learn these things the hard way. For me to make the decision on sex is a great thing for me. I never had the opportunity to make that choice. With what I have been through I thought it was the man who made that choice. Now for me to know, to find out through a program that I am really grateful for because without *Women In Motion* I would have never known that I could make a choice not to have sex if I didn't want to.

INT: Because you learned, let me make sure that I understand L, you learned through being abused sexually as a young girl that the man had power to make those choices?

RES: That is right

INT: Now as a woman you know that you have the choice?

RES: As a grown woman, I know that I have the choice and I have the power to make the decision. If I don't want to have sex, that is my decision and if you can't accept that then you need to move on to somebody new who gives a darn. Because right now with all the painful situations that I have been through since I have been clean, I am to the point where I surrender. I don't even want to, I don't even physically want to because you are not the man for me. Now I know the difference.

INT: Okay so, what happened, for instance L, if you are asking a partner to use a condom now and he refuses?

RES: What happens is they get up and they leave because they are feeling like you must have had sex with somebody and caught something. You know, that is a really good excuse. But, if you can't use a condom because I don't know where you have been, out of respect and love for me, you need to get your clothes on and get up and get out of my house.

INT: And you can stand by that?

RES: Yes, I can now (laughter) and I don't care if you ever come back. Because, with all the pain and all the hurt and all

of the stuff I have been through I am stronger now. I can handle it a lot better now.

Condom negotiation appeared to be an “all-or-nothing” situation presently for women in the study. If men refuse to wear the condoms, participants stated that it would be safer and healthier to just walk away from potential harm. Participants claimed to feel empowered to protect themselves because of knowledge they had acquired from the “school of hard knocks,” and participating in the *Women In Motion [WIM]* prevention program. In the past, when participants were naïve to the dangers of unprotected sex, their attitudes would have been more like “nothing ventured, nothing gained.” This implied that ignorance to the consequences of HIV/AIDS would have resulted in them taking risks to either have their needs met, whether it was sexual gratification, seeking intimacy, or trading sex for drugs or money, or taking risks to satisfy the needs of male partners. Now, participants convincingly remarked that they no longer need the “comforts of a man” if it means engaging in unprotected sex.

Application

I questioned how reliable the data was in regards to grasping the meaning of the individual narratives women were sharing, and interpreting the emerging information as themes developed. As a result, I wanted to know how does it work when you bring a group of African-American heterosexual women together to discuss their perceptions of HIV/AIDS risk, and sexual decision-making with male partners? Triangulation is the application of two or more methods of data collection in a study for the purpose of strengthening trustworthiness (Bell & Opie, 2002). The facilitation of the focus group was another approach to better understand the views of African-American women. The

focus group was held on June 30, 2007. The following message was sent to one of my gatekeepers requesting her assistance as recorder for the group:

K,
It was nice seeing you on Saturday. I am very pleased to hear that you are remarried and doing well, along with your daughter. K, I am facilitating a focus group for my research study on Saturday, June 30 at the IUPUI University Library, Room_____ from Noon until 2 PM. If you are available, I will need your assistance to observe and record [just take notes] during the group. I am not allowed to pay you on a cash basis for your assistance, but I can express my appreciation by taking you out to dinner (smile). I will wait to hear from you.

Gatekeeper K agreed to offer her assistance based on our mutual respect and trust over several years of working on the same vision of HIV/AIDS prevention among African-American women.

The participants' arrival times were staggered, with the last woman arriving close to 2:30 p.m. Introductions were made as each of the four women found the location of the meeting. The gatekeeper was briefly introduced with a description of her role as recorder. Once consent forms were signed and the demographic forms completed, participants reluctantly began to talk. As mentioned previously, one of the individual interviewees agreed to participate in the focus group. In order to allow time for group interaction from all members, unlike the individual interviews, general questions about making healthy choices and prevention were not asked. Three main themes, related, but somewhat different from participant themes, emerged from the focus group. Those themes were the following: 1) It Is Best To Be Safe Than Sorry, 2) I Kept On Wanting To Believe That He Would Change, and 3) Male Partners Are Just Not Truthful.

It Is Best To Be Safe Than Sorry

Group Member [GM] D was the only participant currently married, with no children. She boldly stated that she does not define sexual decision-making; it simply means that she is going to have sex or not. Apparently, GM D did not perceive this as making a decision about sex. Her primary interest was always whether her partner had a STD, or a history of one. GM D contended, "It is best to be safe than sorry. If possible, don't have sex at all. If so, be protected." The teenager of the group [GM S], a nineteen-year-old college student, shyly announced that she was still a virgin by choice.

GM S related the decision to remain abstinent to the religious influences of her mother, and the desire to focus on educational pursuits at this phase of her youthful life. The other members congratulated her on making such a wise choice. GM S proceeded to share her views of sexual decision-making, which could be quoted as, "having or not having sex." She perceived pressure from male partners as the reason why women are prevented from practicing safer sex. GM S concluded her remarks by saying, "The best way to have safe sex is by deciding not to have sex." The late arriver, GM L, nervously joined in by sharing her perceptions of sexual decision-making. She stated, "Educating yourself and your partners, having standards, setting higher standards," were all critical for making choices about sex. GM L was emotionally drained from a recent divorce that was uncompromising. GM E, the only participant who interviewed individually, responded in the same way as before. She related sexual decision-making, once again, to communication with your male partner, both verbal and non-verbal cues. GM E alleged that she knows when her partner is ready to go to the next level of physical intercourse by intense body contact and the heat of the moment. If neither one objects, the sexual act

continues without a verbal agreement. They both just know intuitively that it is right to have sex. On the other hand, if the time is not right, one partner will initiate a verbal dialogue to discuss the matter at hand [sex]. GM E later acknowledged that this approach is not without potential error. For instance, attempting to initiate verbal dialogue during the heat of the moment is extremely risky. No other member of the focus group disagreed with this point of view.

GMs relaxed after the first hour of discussion, and began speaking to one another, rather than directing all of their responses to me. As the facilitator, I was encouraging women to speak to one another by taking the focus off of my perceptions and asking other members their insights. The emerging theme that developed from these members centered on the violation of trust in intimate relationships. In general, participants perceived their willingness to trust male partners in the past placed them at risk for HIV/AIDS and other STDs.

I Kept On Wanting To Believe That He Would Change

There was a striking contrast between the GMs discussing the meaning of intimacy and the individual interviewees. The individual participants struggled to define intimacy along the continuum of physical, social, emotional, and spiritual connections. In opposition to this struggle, GMs immediately focused on the emotional aspects of trust in intimate relationships with male partners. GM E was struggling with trust issues in a long-term relationship for eight years. She knew her man was being unfaithful to her, but she continued to engage in unprotected sex with him. He eventually left her for another woman. GM E gave the following assertion with the passion of a testimonial, “I kept on wanting to believe that he would change, so I kept having sex with him without a

condom.” GM D instigated a heated dialogue when she vowed that she was never cheated on by any of her male partners, and she is confident that she is protected by the marriage covenant with her husband [he will not cheat on her either]. GM D felt that communication with your male partner was the key to assuring trust in the relationship. GM E challenged this stance by illustrating the numerous attempts she made with her ex-male partner over the years to address issues of unfaithfulness, only to be betrayed repeatedly. GM L’s mother died when she was a young child, and her biological father reared her. Her father was a womanizer and disrespected women. She described her ex-husband as behaving just like her father. GM S, the college student, sat with eyes wide-opened, taking in the discussion as though she was now in a new league, with issues unfamiliar to her status as a virgin.

GMs discussed factors preventing women from practicing safer sex. Similar to the individual interviewees, they recognized lack of knowledge, denial of vulnerability to contracting the disease, emotional dependency on partners, and men’s refusal to wear condoms as reasons for women not protecting themselves. However, betrayal and the violation of trust by male partners were the primary factors identified as contributing to women’s vulnerability to HIV/AIDS. According to GMs, the unfaithfulness of male partners engaging in sex with multiple partners [including men on the down low], placed unsuspecting women at the greatest risk for HIV/AIDS and other STDs. GMs did not disclose personal accounts of women they knew who had contracted HIV/AIDS, but told stories they had heard about other women. Perhaps, this preference for sharing stories about HIV/AIDS felt safer among unfamiliar faces.

Male Partners Are Just Not Truthful

GM D discussed her shock when her husband asked her about HIV testing when they first met. He was the first male that ever initiated this type of discussion with her. Later, she was appreciative of his conscientious nature. Other women felt strongly that her husband was the exception and not the norm for African-American men. According to GM L, “Black men have a problem with coming out of the closet. Women will do a lot of searching about for other things, but will not do it with selecting partners.” GM L commented that as African-American women become older, they become more desperate. GM E was inclined to concur with this viewpoint, but she was passionate about the desperation of women still being linked to unfaithful men. GM S finally concluded that the other GMs were right with their perceptions of men, “male partners are just not truthful.”

The group interaction was lively and thought-provoking. The focus group did not terminate until a lengthy discussion ensued regarding the need for standards associated with sexual decision-making. For example, GM E stated that women must stop tolerating domestic violence. This is a standard that all women should live by. GM D told a story of how she recalled as a young girl, her mother retaliated when her father hit their mother. Her mother, and maternal role model, went into the kitchen and pulled out a skillet and hit him on the back of the head [he was not seriously injured]. Her mother apologized to her children for allowing them to witness this act. However, GM D’s father never hit her mother again. GM D stated that domestic violence was behavior that she would never tolerate in a relationship with a man, because her mother had established the protocol for her to abide by [the skillet protocol]. Other standards of behavior debated among GMs

included women not rushing into sexual intercourse with male partners, becoming educated on issues of sexuality for healthy sexual decision-making, and abruptly terminating relationships if male partners refuse to use condoms. This need for a code of behavior concerning sexual decision-making among African-American women is examined further regarding the conceptual schema that originated from the data.

Conceptual Schema

Behavioral changes over the years appeared to be challenging for participants as they associated making healthy choices to prevention on a universal basis. The meaning of participants' perceptions became the focus of developing a conceptual framework to better understand sexual decision-making among African-American heterosexual women. The primary aim was to seek an explanation of this phenomenon, as it relates to this target population. In the qualitative inquiry approach, references to pre-existing theories in the literature are not encouraged as the data are emerging. It is critical to stay close to the data [co-constructing a story with the data] through analysis (Stern, 1980). As new insights and observations developed, I created new labels to identify emerging categories and themes without preoccupation with existing theories in the literature. After the categories from the data became saturated, it looked as if women in the study were at various stages of modifying their sexual attitudes and behaviors. Their ways of thinking about sex and HIV/AIDS prevention seemed to be related to real life experiences they faced since childhood.

From reviewing the literature, the Transtheoretical Change Model appeared to have a good fit with the experiences of women in this study (Prochaska, DiClemente, & Norcross, 1992). In this model, the conceptualization of behavior change is viewed as a

five-stage progression [precontemplation, contemplation, preparation, action, and maintenance], with the understanding that individuals will in all probability relapse as they move along the continuum of change (Prochaska, DiClemente, & Norcross, 1992). For instance, Participant M confessed that in her previous relationships with men, she would not insist upon condom use consistently by rationalizing her behavior. She admitted to debating about what was good and bad concerning condom use. However, this inconsistency with multiple partners placed her at higher risk for contracting HIV/AIDS. Yet, she contemplated her decision. During the contemplation stage, there is some awareness of the need to change behaviors (Prochaska, DiClemente, & Norcross, 1992). Participant M disclosed that at this stage she was worried about contracting HIV/AIDS, but she wondered if it would be worth it to attempt to negotiate condom use with her male partners.

When Participant M started attending HIV/AIDS educational sessions at *WIM*, she began to better understand the need for condom use consistently. The educational sessions assisted her with moving into the preparation stage of change. She realized that if she was going to prevent HIV/AIDS, it would be necessary for her to change her attitudes about condom use. For example, purchasing condoms and having them readily available would illustrate that Participant M had transitioned into the preparation stage.

Presently, Participant M has decided to practice abstinence, with a focus on her personal recovery from drugs. She initiated an action plan by deciding not to engage in sexual intercourse. Participant M stated that she is confident that once she becomes sexually active again, she will insist upon condom use with her male partners based on her awareness of the HIV/AIDS risk factors. This decision to use condoms consistently

with her male partners when sexually active will move her to the action stage of behavioral change. Unfortunately, there is always the possibility that Participant M, along with other participants in the study, could engage in unprotected sex. This type of risky sexual behaviors has the potential to result in relapse for Participant M. According to Prochaska and colleagues (1992), any attempt for Participant M and others to change behavior is difficult to maintain consistently, and relapse should not be viewed as destructive or negative. However, one relapse involving unprotected sex could possibly result in Participant M, and others engaging in risky sexual behaviors, to contract HIV/AIDS and other STDs.

Several participants disclosed that they would become discouraged when they perceived themselves as failures when relapsing and engaging in unprotected sex. Participant E admitted that she felt controlled by her partner when this occurred. I acknowledged to Participant E how difficult it is to engage in condom negotiation with some partners. It seemed as though she needed validation of her feelings. I felt that Participant E was in the contemplation stage of making behavioral changes when she felt controlled, but was not ready to prepare or initiate an action plan to change her sexual behaviors with controlling male partners. Consequently, she decided to focus on child-rearing and career development, rather than having sexual involvement with a male partner at this challenging phase of her life. Currently, Participant E is preoccupied with single-parenting and active participation with work and church-related activities.

The only participant that gave the impression of being at the precontemplation stage of change was group member (GM) S. This young woman did not appear to perceive HIV/AIDS as a personal risk. Her age and status as a virgin did not warrant

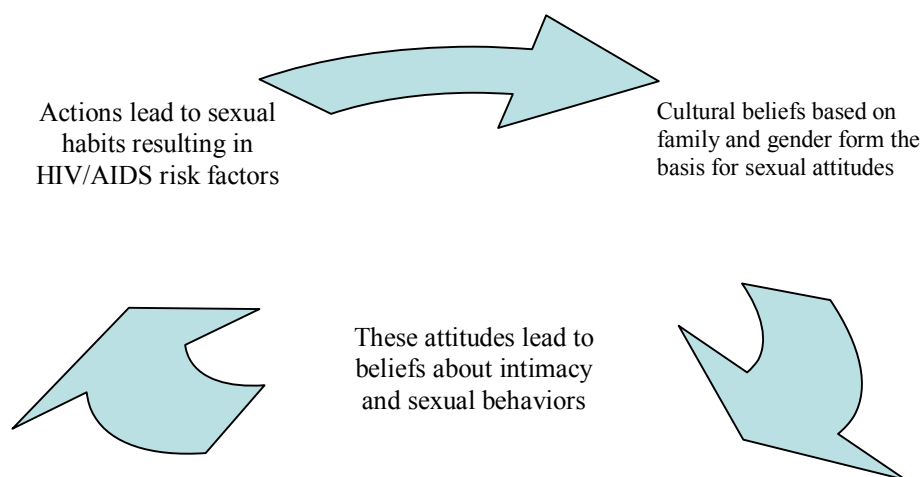
struggles with condom negotiation with male partners in comparison to older and more experienced participants in the study. GM S did not want to think about STDs and sexual encounters with men because she was focused on pursuing higher education. Once GM S listened to the narratives of other participants in the focus group, she could possibly transition to the contemplation stage of behavior based on the sexual experiences shared by other women. The insights discussed in the focus group established a standard for her to determine future sexual decision-making. When participants have established a consistent pattern of condom use with male partners [approximately six months to a year] they will ultimately move to the maintenance stage of behavior changes. This stage is centered on transformed sexual attitudes and new-found sexual habits.

The constant comparative analysis [comparing emerging themes] was the core of building upon participants' perceptions in order to better understand the phenomenon of sexual decision-making with their male partners. The steps taken in the constant comparative analysis of this study allowed for the emerging constructs to be applied to this sample. This was accomplished without pressure to code data based on the literature review.

The overview of analyzing the data in this investigation was based on (1) Observation of participants and myself [What did I see among African-American heterosexual women? What did I discover about my role as researcher?], (2) Interpretation of the data [What did the narratives from African-American women mean?], and (3) Application of another method, the focus group [How does a diverse group of African-American women relate to each other and share their experiences and perceptions together?]. As the data emerged in this investigation, participants were

apparently at various stages of readiness for change based on their diverse life experiences (Prochaska, DiClemente, & Norcross, 1992). For instance, participants who were just released from prison and/or engaged in recovery programs from drug addictions seemed to struggle more with self-esteem and empowerment issues in their lives. Their perceptions of HIV/AIDS risks were restricted by the need to remain clean on a daily basis, secure employment, and find suitable housing. Sexual decision-making with male partners seemed to rank below daily survival needs. Nevertheless, the perceptions of African-American women in this study in regards to sexual decision-making with male partners and HIV/AIDS risks are illustrated in the following diagram:

Diagram I: Conceptual View of Sexual Decision-Making



Sexual thoughts and attitudes among participants were influenced by early childhood experiences. These early sexual experiences resulted in sexual habits later forming the basis for sexual decision-making as adult women. However, as evidenced by the data, when cultural norms reinforce oppressive societal gender roles, then

impoverished, inner-city African-American women are disproportionately victimized by HIV/AIDS. Identifying an African-American woman's sexual attitudes is critical in understanding where she might be in the change process. Based on the perceptions of participants in this study, it is logical to infer that their sexual attitudes shaped sexual habits, which placed them at risk for HIV/AIDS. Power disparity in relationships with male partners often resulted in women participating in unwanted sex. Participants convincingly challenged one another, and other African-American women, to develop a code of behavior to prevent the spread of HIV/AIDS among this vulnerable population of women. After considering participants' dialogue related to a code of behavior for targeting HIV/AIDS prevention, I developed the following acronym (CONDOMS) to assist with reinforcing that code of behavior:

Standards For Practicing Safer Sex

C-Continue To Communicate [about how to manage your needs in intimate relationships with male partners]

O-Only Have Sex [with your intimate male partner]

N-Never Assume Faithfulness [even with marital partner]

D-Discuss Sexual Histories [both your own and your partner's sexual history]

O-Obtain Knowledge of HIV/AIDS [risk factors must be understood]

M-Marital Contract is Sacred [key to honoring yourself and spouse; domestic violence not tolerated]

S-Self-Protection Guides Sexual Decision-Making [consistent condom use mandatory to minimize HIV/AIDS risk factors]

I established this acronym on the primary principle that African-American women know how to make positive healthy choices in their lives in general and can learn empowerment strategies to practice HIV/AIDS prevention. Conversely, prevention of HIV/AIDS among this population of women must be reinforced by a standard based on their perceptions of reality. It appears that necessary transformations in sexual attitudes can result in life-changing modifications in sexual behaviors. It is necessary to adequately assess African-American women along the continuum of change regarding sexual attitudes and culturally-based sexual habits in order to adapt HIV/AIDS prevention strategies to their needs. Implementation of this approach provides a good fit to the phenomenon of sexual decision-making among this population. Even though this conceptual schema appears simplistic in nature and is based on the preliminaries of theory-building concerning this at-risk population, it provides a relevant conceptual framework in which to persist with empirically examining this critical social problem.

DISCUSSION

This chapter presents a summary of the social problem concerning African-American heterosexual women and sexual decision-making with their male partners in the midst of the HIV/AIDS pandemic. It includes the significant conclusions drawn from this study of the perceptions of African-American women. Also, it provides a discussion of the implications for action and recommendations for further research on this topic.

Summary of Major Findings

As I was analyzing the data from the narratives of African-American women, the word “survivor” came to mind continually. I sensed a determination to live and thrive from participants, whether these women were struggling with recovery from drug addiction, childhood sexual abuse, or homelessness. In spite of that, many participants exhibited symptoms common to “survivor syndrome.” This syndrome is characteristic of the “behavior patterns, traits, and symptoms that tend to occur in people who have experienced dangerous, life-threatening events or *trauma*...often have prolonged periodic anxiety, guilt feelings, anger, and fears, especially in situations that seem similar to the traumatic event” (Barker, 2003, p. 426). Based on knowledge of the survivor syndrome, I have recapitulated the major findings of this study under the following main headings: (1) Survival despite traumatic experiences, (2) Exposure to life-threatening dangers, (3) Powers of endurance, and (4) Inheritors of a legacy of survivors.

Survival Despite Traumatic Experiences

When I heard stories of childhood sexual abuse, including incest, molestation, and rape, I realized that some of these participants had an inherent nature to overcome the indescribable acts of abuse and violence. Cultural beliefs based on family traditions and gender patterns formed early in childhood guided their sexual attitudes as adult women. These sexual attitudes created blurred boundaries regarding sexual behaviors. It seemed as though women vacillated between sexual promiscuity “nothing ventured, nothing gained” to total sexual abstinence, not needing “the comforts of a man.” A few women commented that at the present, they preferred using a sexual device, rather than engaging in sexual intercourse with undesirable male partners.

Exposure to Life-threatening Dangers

Sexual attitudes created unhealthy sexual boundaries for many participants. As a result, women appeared confused between intimacy and the physical act of love-making. While some women used these two constructs interchangeably, others saw distinct differences between emotional intimacy and sexual intercourse. As women were searching for intimacy, regardless of the contextual meaning, they often ventured into dangerous situations. For instance, Participant P went away to college to seek quality education, only to find a sexual predator targeting unsuspecting freshman girls. Other women acknowledged that seeking sexual intercourse was only a means to an end, which happened to be crack-cocaine and other drugs. Trading sex for drugs or money had absolutely no relevance to intimacy for these participants. Participant L disclosed a traumatic event in her life when she refused to have sex with several men, after using

their crack-cocaine, and they dragged her with a car. After surviving this appalling situation, she confessed that she continued to engage in prostitution for drugs.

Powers of Endurance

Even though sexual attitudes resulted in negative actions and inappropriate sexual habits leading to HIV/AIDS risks for some women, many participants vowed to make positive changes in their lives. The will to survive and endure led many women into recovery programs for drug addiction, such as, HIV/AIDS prevention programs [*WIM*], and vocational training programs for job placement. I believe this was the foundation for establishing the groundwork for healthy sexual decision-making among this population of women. For instance, Wingood and DiClemente (1997) assert that HIV/STD prevention programs “should validate women’s victimization and attempt to increase a woman’s awareness of the relationship between childhood sexual abuse and their partner selection...” (p. 383). *Women In Motion [WIM]* is a HIV prevention program where women can attend educational sessions focusing on women’s sexual health. Participants are taught how to differentiate power and control issues operating in intimate relationships with male partners and strategies to cope with domestic violence situations. Educational sessions are designed to address HIV/AIDS risk factors and strategies to promote healthy sexual relationships with partners [e.g., communications skills, HIV testing, resources for counseling]. Furthermore, these participants are validated through an awareness of membership operating among this sisterhood of African-American women.

Inheritors of a Legacy of Survivors

Wheeler (2002) speaks of the advances of African-American women since the 1980s and 1990s and the black womanhood [e.g., Ntozake Shange, Angela Davis, Toni Morrison, June Jordan, Alice Walker, Audre Lorde and other black women academics from 1970s] that has evolved over the decades. However, Wheeler (2002) asserts that African-American women continue to struggle in many ways to overcome social and political oppression. Historically, African-American women have survived slavery, racism, sexism, and classism, and continued to rear children, pursue employment, even if it meant cleaning other women's houses, and achieve educational pursuits (Leashore, 1995; Wheeler, 2002; Wyatt, 1997). The legacy of being survivors has transcended many generations (Wyatt, 1997). Yet, the majority of women in this study revealed that they did not have appropriate role models in their younger years to guide them through puberty and sexual development. Despite the strength of African-American women's ancestry, there also seems to be the legacy of sexual abuse and blurred sexual boundaries that still affect this population of women. Family traditions, gender patterns, and secrets of incest appear to disrupt healthy sexual development among many young African-American girls. Wyatt (1997) challenges African-American women to reclaim their sexuality and to take back their lives. As evidenced by the findings in this study participants were taking steps to empower themselves to take back their sexuality and to establish healthy boundaries concerning sexual decision-making with male partners.

Findings Related to the Literature

The influence of the literature review appeared challenging on several dimensions throughout this study. Therefore, I decided to allow the data to direct me to areas in the

literature when clarity was needed concerning feedback from participants. Three major themes emerged from the data: sexual abuse, the triple burden of African-American women, and life style modification. The first theme was related to sexual abuse.

According to Simien (2004), Black feminism examines the position of African-American women. The value and autonomy of African-American women are promoted through this ideology. Within this theoretical framework, sexual decision-making is based on power differentials and gender roles. Many participants' sexual attitudes were shaped by early childhood experiences related to abuse and inappropriate interactions with African-American male figures. These sexual attitudes reinforced risky sexual behaviors. In addition, Black Feminist scholars argue that social and economic factors place low-income African-American women at-risk for HIV disproportionately from other populations of women (Gentry, Elifson, & Sterk, 2005; Hamer & Neville, 1998; Taylor, 1998). The participants in this study with the greatest HIV risk factors were the women struggling with childhood sexual abuse, along with drug addiction and underemployment. However, many were not under-educated. This was a surprising occurrence based on the assumption by numerous scholars in the literature that high risk African-American women have a tendency to be inner-city, poor, and uneducated. Some of the women residing in homeless shelters and recovery programs were not only high school graduates but also had attended college. These women spelled out clearly that drug addiction, not influences from male partners, created their current circumstances involving recovery.

The second theme that emerged was the triple burden of African-American women. Even though a number of participants in this study acknowledged responsibility

for their drug addictions, many Black feminists would argue that under patriarchy, African-American women are disproportionately burdened with racial and sexual oppression, along with economic restraints [triple burden] (Wheeler, 2002). Furthermore, the bondage of African-American women has resulted in inequitable treatment leading to destructive behaviors (e.g., sexual promiscuity, drug addiction, mental illness) (Leashore, 1995; Wheeler, 2002; Wyatt, 1997). While black men are allies in the fight against racial oppression, Black feminists assert that black men are negligent in professing their role in the sexual oppression of black women (hooks, 1994; Simien, 2004; Wheeler, 2002). Still, another perspective of the perceived hardship among African-American women was examined as it related to the alleged lack of public concern.

Timmons and Sowell (1999) remarked that more than a few participants in their study related risk of HIV/AIDS among African-Americans to racist and discriminatory actions of the government. However, it is noteworthy to mention that only one participant in this current study identified the plight of African-American women and HIV/AIDS risks to racism. According to Bunting (1996), there is considerable evidence to support the notion that poor women of African-American and Latina ancestry have been stigmatized based on their gender and minority backgrounds, along with their poverty classification. If these women have the misfortune to contract this disease, their HIV-positive status more than likely will only heighten their stigmatization (Bunting, 1996). It is not within the scope of this manuscript to debate the stigmatization of African-American women in this society. However, the reality-based HIV/AIDS stigmatization facing African-Americans, along with the myths of government

conspiracies [genocide] warrant further examination as it relates to the escalating rate of HIV/AIDS among this population.

The third theme, life style modification, illustrated that women appeared to be at various stages regarding sexual attitudes and behavior changes. Therefore, I reflected on the literature review. In order to move the data from emerging themes to a deeper level of analysis, I examined the relevance of life style modification to the construct of sexual decision-making. Life style modification is a conceptual framework built on stages of change with the expectation that human beings will relapse and make mistakes along the way to changing behavior (Prochaska, DiClemente, & Norcross, 1992). Women in the study confessed to many years of struggling to change their behaviors, only to relapse back to familiar actions. The Transtheoretical Change Model [Stages of Change Model] allows for a wide range of sexual behaviors and addictive disorders (Prochaska, DiClemente, & Norcross, 1992).

Traditional rhetoric appears to define sexual behaviors along a straight/gay dichotomy. This type of dichotomy appears problematic when examining sexual patterns among African-Americans. For example, the phenomenon of African-American males not identifying as gay, but engaging in sex with men and women has been coined “being on the down low.” Wohl and associates (2002) assert that this behavior has been related to the taboo of homosexuality in the African-American communities. What I did not anticipate in this study, was a confession by Participant P that she also engaged in sex with women due to her huge sexual appetite. However, Participant P identified herself as heterosexual. Yet, she did not hesitate to share that her sexual experiences with other women were not out of the ordinary for her comfort level. Her conventional lifestyle,

marriage in the past, a child, college-educated, a previous high-ranking position in a Fortune 500 company, gave no indication that she would have a non-traditional sexual appetite. This assumption that men, along with women, fit into refined categories of sexual behavior appears to be a fallacy. If African-American men are identifying as heterosexual and having sex with men and women, it seems plausible that African-American women “on the down low” is much more common than indicated in the literature.

Limitations

One limitation to this study is related to member checking, which I did not conduct. Member checks allow for “researchers to return to informants to present written narratives or interpretations” in order to establish creditability of the data. Participants become “co-researchers” of the data (Rudestam & Newton, 2001). I had planned to use member checks as a means to validate findings of my study. I made an extensive effort to schedule a subsequent visit with Participant T, primarily due to her interview tape breaking. Unfortunately, she declined to follow up with another visit. Since I relocated to a different geographic area almost immediately after the completion of data collection, the implementation of member checking became extremely difficult. Another drawback worth noting is the restricted availability of some participants after the data collection was completed. This sample of women is largely transitional due to mediating environmental factors [e.g., temporary living situations, recovery related to drug addictions, estrangement from family members].

Also, I attempted to retrieve feedback from the recorder of the focus group, but she refused to make further comments. By this gatekeeper's own report, she had a

negative experience with a past research study. Therefore, it appeared that her role was strictly defined and time-limited. Nevertheless, her input was invaluable to the data analysis of the focus group.

In order to strengthen internal validity of the findings, I attempted to maintain meticulous record keeping [audit trail]. However, I often scribbled down notes on scrap paper when note pads or journals were not readily available. Organization skills are critical in tracking records and data. I believe this process is challenging for many researchers. But, the use of the Atlas.ti 5 qualitative software program was instrumental in strengthening my organization of data and tracking memos throughout data analysis.

In addition, external validity or generalization of findings were enhanced by thick description of data of a small sample size. Thick description involves detailed descriptions of the participants and the setting (e.g., clothes they wore, non-verbal interactions, etc.). However, the small sample size limited the reliability and generalizability of the findings to the larger population of African-American heterosexual women.

Conclusions

Contextualizing sexual decision-making with HIV/AIDS-related risk factors is critical on behalf of the disproportionate population of African-American heterosexual women contracting this disease. Participants' perceptions of HIV/AIDS risks and sexual decision-making with male partners were the foci of this investigation. These findings have significant implications concerning the contextualization of sexual decision-making among African-American women.

It seems as though women give and receive love differently from men. Culturally-related sexual attitudes and behaviors are creating a paradox for African-American heterosexual women. This paradox appears to be linked to the confusion among women regarding intimacy and sexual decision-making. Participants struggled with defining emotional, social, and sexual intimacy across the continuum of connectedness with male partners. Within the healthy boundaries of sexual development and loving relationships, women are encouraged to live out the fairy-tale of Prince Charming and everlasting love. The everlasting love provision is questionable for many women as evidenced by the narratives from the participants in this study. The understanding of the sexual needs between men and women is often complex, and unhealthy boundaries regarding sexual decision-making complicates this issue.

Traditional gender roles contribute to the paradox for African-American women. Intimacy is viewed by many women as that spiritual connection to your soul mate. This bond requires a surrendering of the “self” in order to satisfy your mate. Sexual fulfillment is part of the fantasy that women share with male partners. In the midst of love and romance, HIV/AIDS invaded the sexual needs of many women. The paradox for African-American women is created by the misfortune of learned sexual attitudes as young girls and HIV/AIDS. If African-American women focus on self-protection [use of condoms], they risk the loss of intimacy with their male partners. As a result, these women are left with the following choices: (1) abstinence; (2) the companionship of a sexual device on a lonely night; (3) the risk of retaliation from male partners, if women insist upon the use of condoms for protection; and/or, (4) sharing their men with other women because monogamous relationships might not be part of their men’s fantasy of everlasting love.

The alternative, which is unprotected sex, is described by some of the participants in the study as “Russian roulette” with your life and well-being. Sexual decision-making in this inquiry became an all-encompassing construct based on women’s perceptions of how they viewed the paradox of sexual needs in intimate relationships with male partners and the risk of contracting HIV/AIDS.

Implications for Action

African-American women are faced with the paradox of HIV/AIDS and sexual decision-making with their male partners. According to participants in this study, they collectively recommended self-protection [consistent use of condoms], and HIV/AIDS education, rather than risk contracting this disease. Several women preferred abstinence to undesirable male partners. In response to their proposals, I would encourage women to seek out social networks, such as *Women In Motion*. The process of learning healthy sexual decision-making is based on making informed choices regarding the broad-spectrum of health outcomes. This premise is illustrated by the holistic approach put into practice by *WIM*. For instance, Participant L associated eating healthy foods in order to prevent acid reflux disease to using condoms in order to prevent HIV/AIDS and other STDs. This holistic approach to sexual decision-making empowers women to not only learn effective ways to prevent HIV/AIDS, but to adapt to an all-inclusive wholesome and healthy lifestyle.

Implications for Social Work Practice and Education

Social workers and other helping professionals are in positions to be instrumental in this holistic approach to implementing HIV/AIDS prevention interventions. In the process of learning how to establish healthy sexual boundaries, many African-American

women have experienced oppressive episodes in their lives, including childhood sexual abuse and domestic violence. Providing a safe atmosphere for participants to share abusive episodes in structured groups fosters the healing process needed for survivors, while implementing critical HIV/AIDS education.

In order for HIV/AIDS prevention programs to be meaningful, women need to know the risk factors associated with this disease, and successful strategies to implement condom negotiation without harm. More specifically, African-American women must feel empowered to protect themselves against the interlocking forces of oppression placing them at a disproportionate risk for HIV/AIDS. I have witnessed culturally-specific HIV/AIDS prevention strategies among African-American women to be peer-centered, innovative, healing, and educational.

Culturally-relevant materials should be specific to the diverse population that you are targeting. For example, participants in recovery were more geared to the daily survival mode. Spirituality and meditation were interventions that created hope and comfort, along with tangible community-based services to meet their empowerment needs [e.g., housing, job placement, family reunification counseling]. Women living in environments where basic needs are unmet are more likely to prioritize daily survival over protecting themselves from HIV/AIDS and other STDs. Therefore, the empowerment needed for women in this target population to initiate and maintain healthy lifestyles is often attained through basic tangible services. However, barriers created by the triple-burden of African-American women frequently place them in vulnerable positions. For instance, racism, sexism, and classism are deep-rooted in our culture.

These inequalities often restrict available resources, including adequate health care, obtainable educational, and employment opportunities.

Social workers must be knowledgeable of how environmental factors can hinder HIV risk reduction among African-American women. For instance, cultural myths and HIV conspiracy theories promote mistrust of government policies, institutions, and health care facilities. This mistrust is embedded in the historical injustices experienced by African-Americans (e.g., slavery, Tuskegee experimentation, public lynching). If African-American women perceive that they are being treated differently by helping professionals because of race, gender, or social class, then their perceptions of mistrust can diminish the opportunity to effectively provide HIV/AIDS prevention interventions.

Social workers must be prepared to confront the challenges of HIV/AIDS prevention among African-American women by conducting comprehensive drug and sexual history assessments. This universal screening process requires knowledge of the cultural implications of sexual practices among this population of women. For instance, due to the imbalanced sex-ratio among African-Americans, social workers must understand the pressure and fear many of these women experience due to the unavailability of suitable male partners. Often this occurrence results in potential high-frequency relationship turnover with multiple partners. As a result, many women are left vulnerable to contracting HIV/AIDS due to risky sexual behaviors of male partners.

Also, Schools of Social Work must offer courses that examine the interface between drugs and risky sexual behaviors. Students should have the opportunities to experience the social networks among African-American women by participating in community-based educational sessions in the neighborhoods where this population of

women survives on a daily basis. Mentoring students in community-based HIV/AIDS prevention programs will better prepare them to experience the cultural aspects of African-American women disproportionately affected by HIV/AIDS.

Implications of Public Policy

Social policies influence the structural and environmental factors shaping the lives of African-American women and their male partners. For instance, the intersecting epidemics of crack-cocaine abuse and HIV/AIDS devastated many impoverished African-American communities. The war on drugs in the 1970s was officially declared by President Nixon. In 1986 President Reagan signed the Anti-Drug Abuse Act, which mandated strict law enforcement policies regarding marijuana, heroin, and crack-cocaine, etc. The Drug Enforcement Administration [DEA] was organized with the goal of eradicating the profiting of the distribution of illegal drugs. These policies resulted in the disproportionate incarceration of inner-city, poverty-stricken, African-American men. For instance, possession of crack, which is the cheaper form of cocaine, created harsher sentences. Lower income African-American men were associated with this population of crack users.

What is most significant about this social dilemma is the frequency of African-American men engaging in homosexual behaviors within the borders of prisons, and later returning to heterosexual relationships with wives and girlfriends once released. The underlying assumption that illegal drug use is a criminal offense, as opposed to a public health concern or health-related disease is debatable. However, the implications of secretive sexual behaviors, MSM/W, have resulted in unsuspecting African-American women placed in vulnerable positions regarding HIV-related infections. Sexual decision-

making is played out in the larger social and structural influences affecting risky sexual behaviors among African-Americans.

Implications of Cultural and Gender Influences

As a discipline focused on the empowerment of marginalized populations in our society, social work professionals must learn to communicate with African-American women concerning the influences of oppression in their lives, particularly in relation to HIV/AIDS prevention and sexual decision-making. In order for African-American women to find meaningful ways to integrate HIV/AIDS prevention strategies, they must feel a sense of comfort with their own sexuality. This is often challenging for women when male partners are influenced by gender norms shaping sexually aggressive behaviors, men having sex with men and women on the down low, and/or engaging in high risk behaviors like intravenous drug use. Since African-American women must survive in a patriarchal society where societal expectations demand them to be strong in the face of adversity, struggles and fears related to sexuality frequently are unheard. Social workers have the opportunity to interrupt this silence by creating an open dialogue around survivorship and exploring the meaning of sexual decision-making with them. Many of the African-American women in this current study revealed that they have never been asked the meaning of sexual decision-making and intimacy. In the process of African-American women learning how to prevent HIV/AIDS and establish healthy sexual behaviors, social workers can foster trust, respect, and the desire to understand more about these women's perceptions of the triple-burden existing in their lives. This approach has the potential to exert a sense of control over what is occurring in their surrounding environments, and encourage skill-building and problem-solving.

Implications of Social Networks

In addition to building upon social networks, I advise African-American women to secure appropriate role-models, beyond sponsors for their personal recovery work. For instance, Dr. P referred to physicians, social workers, and other health care professionals assisting women with understanding their HIV/AIDS-related risks to become instrumental in screening for risky sexual behaviors by taking a detailed sexual history. The physician or health care provider becomes the role-model for many women who never had this type of assistance in their lives. Participant L was diagnosed with gonorrhea of the throat, but she was ashamed when it was time for her to receive instruction regarding her treatment. According to Dr. P, these types of situations occur frequently. This style of role-modeling will require a complete sexual history of a woman, time to build trust in the patient-helper relationship, and an understanding that behavioral changes are not linear, but occur along a continuum.

Recommendations for Further Research

Findings from this study provided the preliminaries for further empirical examination among African-American heterosexual women and sexual decision-making with their male partners. Even though the small sample size restricted the external validity of the sample, participants' narratives divulged pertinent insights into the needs of these women founded on their realities. Gatekeepers are critical to the recruitment process, and exploring their perceptions of participants' interactions are advantageous to empirical investigations. Additionally, I would recommend conducting more than one focus group to strengthen the triangulation approach of a study. Careful selection of the

interviewing site is very important. The university site presented the barriers of parking and size which caused some women to arrive late.

Further study is needed to examine the role of intimacy and sexual thoughts among African-American women as it relates to sexual decision-making. For example, participants recommended a standard or code of behavior for women to base their sexual decision-making. How much of this standard is influenced by sexual fantasy versus the reality of HIV/AIDS and other STDs? This is a question that warrants further investigation.

Other areas of concern include the exploration of African-American women “on the down low” and the implications for sexual decision-making. What is actually known about African-American women who identify as heterosexual but engage in sexual behaviors with both men and women? Also, a better understanding is needed regarding physicians as role-models and the fight to eradicate the spread of HIV/AIDS among African-American women.

Women faced with the fearful consequences of contracting HIV/AIDS have to make an informed decision based on knowledge of HIV/AIDS risk factors. When a woman is involved in an intimate relationship with a male partner(s), she must ask herself the following critical question: What do I want more, sexual gratification or the safety of protected sex? Even in situations when physical intimacy is not motivated by love and sexual gratification, women still need to make an informed decision based on healthy choices and prevention. Participants in this study demonstrated self-efficacy in the general area of making healthy choices and awareness of prevention. Yet, when this general knowledge of making healthy choices was applied to HIV/AIDS prevention,

participants seemed to be along a continuum of making informed choices regarding sexual decision-making ranging from celibacy and abstinence to insisting upon condom use or no sexual intercourse with male partners.

Researchers appear challenged to establish an operational definition for self-efficacy across studies. How will self-efficacy be measured regarding African-American women and risky sexual behaviors in a meaningful way to this population of women? It seems like behavioral changes on a wide-ranging scale is critical to examine in order to alter the prevalence of HIV/AIDS among this population. However, the diversity among African-American women creates difficulty for researchers attempting to specify measurable behaviors on such an all-inclusive scale. For instance, the measurement of complex risky sexual behaviors is hindered by the mentality of the straight/gay dichotomy. There is considerable evidence to suggest that sexual boundaries often are blurred in many African-American communities due to cultural taboos and myths related to homophobia and HIV/AIDS.

Perhaps, it is possible to trigger individual [micro] behavioral changes by fear. In retrospect, fear has the potential to impede risky sexual behaviors, but it can also promote heightened homophobia and myths. Still, it seems as though broader structural-level changes [macro] are needed, along with micro and mezzo level changes, to instigate a paradigm shift required to alter the spread of HIV/AIDS among vulnerable populations. For example, on a micro level personal risk appraisals must motivate behavioral changes based on self-perceptions of risk and the desire to initiate changes regarding sexual attitudes and behaviors. On a mezzo level comfort regarding sexuality and the ability to communicate about condom negotiation foster skills needed for partners to establish

healthy patterns of sexual decision-making and the prevention of HIV/AIDS and other STDs. These behavioral changes among couples must be based on mutual respect and trustworthiness. Lastly, on a macro level behavioral changes are directed by available resources and community-based support targeting HIV/AIDS prevention. Community-based research (CBR) involves the participation of community leaders and members working together on desired health outcomes. More programs similar to *Women In Motion* are needed to educate community members about risky sexual behaviors. CBR initiatives develop research questions, establish methods for data collection, along with disseminating findings. This multidimensional approach to instigating a paradigm shift regarding risky sexual behaviors seems logical in regards to addressing HIV/AIDS prevention among African-American women.

This exploratory study was an opportunity to continue the examination of African-American women's perceptions of HIV/AIDS risks and to better understand the phenomenon of sexual decision-making with their male partners. I felt honored to interview this group of African-American women. The summary of this chapter encapsulated the magnitude of this social problem, and the approach that I used to capture and interpret the perceptions of participants in this study. I was surprised by some of the stories they shared, horrified by the abuse many of them endured, and proud of the steps they had taken to empower themselves. What was most astonishing, I gained insight into my own journey of healing and self-discovery.

Appendix A

DEFINITIONS OF MAJOR CONCEPTS

Client target population

The client target population is the specific group or population to whom preventive efforts are directed. This population will vary in characteristics and dynamics. According to Cournoyer (2004), "Members of a special population actually or potentially affected by a social problem constitute a target client population" (p. 27).

Condoms

A condom is a sheath worn over the penis during intercourse made from lambskin, sheepskin, and other natural materials, or latex. Results of research have shown that latex condoms are more effective in the prevention of HIV and other sexually transmitted diseases [STDs]. Apart from sexual abstinence, condom use is the best way to protect oneself from STDs. Water-based lubricants are strongly recommended with condom use because these products will not harm the effectiveness of condoms (American Social Health Association [*asha*] www.ashastd.org).

Constant comparative analysis

Codes are identified based on data collected from participants and grouped into naturally occurring categories. An indecisive [up and coming or budding] conceptual framework is formed. In other words, the focus is on the "emerging" process. After comparing emerging data, one category will occur with a high frequency of mention and this will be identified as the core category. It is possible to have more than one core category emerge (Creswell, 1998; Dick, 2005; Scheiber & Stern, 2001).

Crack-cocaine

Crack-cocaine is processed form of powdered cocaine hydrochloride transformed to a smokable substance. Ammonia or baking soda and water remove the hydrochloride. Use includes snorting, smoking, and injecting (National Institute on Drug Abuse [NIDA], 2002).

Drug treatment

An important part of HIV prevention strategy, but not the only strategy. Drug treatment is effective in helping many drug users overcome addiction, decrease needle exchange, and reduce risky sexual behaviors, but not all drug users are ready to discontinue drug use (National Institute on Drug Abuse [NIDA], 2002).

Empowerment

This is a conceptualization based on raising social consciousness, and for minority groups and individuals living on the margins of society, it is a developmental process [not an absolute process]. This enables people to attain power for themselves and communities through varied processes including individualized skills-building, focus group interactions, community advocacy, and/or quantitative and qualitative research data (Lee, 2001).

Grand tour question

This is the primary question that will guide the investigation and rationale for the qualitative research design of this study. From the grand tour question follows the subsequent research questions (Creswell, 1998; Meloy, 2002; Stern, 1980).

HIV/AIDS

Human immunodeficiency virus (HIV) is the virus that causes AIDS, or acquired immunodeficiency syndrome. HIV is found in certain body fluids (blood semen, vaginal fluid, breast milk) and can be passed from one person to another through contact with blood and other bodily fluids.

Memoing

This is primarily a note to oneself [researcher] about some hunch or hypothesis about a category or property. As categories emerge it will be helpful to note what is pertinent about the relationships between categories. This process is significant to data collection, and occurs simultaneously with collecting data, note-taking and coding (Dick, 2005).

MSM/W [Men who have sex with men/women]

For purposes of this study this abbreviation refers to African-American men who hide having sex with men and women [MSM/W], and identify primarily as heterosexual. This behavior is commonly referred to as being "on the down low" [DL]. The abbreviation MSM refers to men who have sex with men.

Outreach

Essential component of HIV prevention efforts targeting out-of-treatment drug users. Drug-use is a highly stigmatized illegal activity and drug users and their sexual partners may be difficult to access through traditional medical and social service agencies.

Relationship of the knower to the known

This construct can be interpreted as meaning the processes of generalizing and analyzing data. This requires the qualitative researcher to go “beyond the data” and begin to think with the data. In other words, theorizing is not perceived as a separate stage of the data collection and research process, but is aligned to analysis. It is necessary to explore the relationship between the researcher [the knower] and the analyzing and theorizing of data [what becomes known] (Coffey & Atkinson, 1996).

Risky sexual behaviors

For purposes of this study, any behaviors or practices that give support to HIV and other sexually transmitted diseases (STDs) to enter the body through coitus or other intimate exchanges [oral sex and anal intercourse]. These infectious diseases are transmitted by contact through the mucous membranes found in the mouth, rectum, eyes, penis, and vagina.

Self-efficacy

This construct could be interpreted as a desire or capability to produce change in one's behavior. There are many mediating factors influencing the ability for one to achieve self-efficacy. Also, this concept is understood to mean confidence in one's ability to take action (Redding et al., 2000).

Sexual decision-making

This concept involves a process of evaluating attitudes, values, and environmental conditions related to sexual behavior (Gilbert, 2003).

Theoretical sampling

This is purposive sampling which enhances the diversity of the sample as the data collection proceeds. If the core category and its linked categories saturate, the researchers no longer searches for different properties, or continues theoretical sampling [this is a sign that it is time to move on to sorting]. This type of sampling is a critical component of qualitative inquiry, and is often confused with selective sampling. The representation of selective sampling involves the decision to pick who and where the sample will be obtained prior to data collection, whereas, theoretical sampling cannot be predetermined due to the continuous process of examining data in relation to the emerging theory (Creswell, 1998; Dick, 2005; Stern, 1980).

Triple-burdened

This construct relates to structural barriers existing for African-American women faced with racial inequalities, gender-biases, and economic disadvantages in society, while simultaneously facing the struggles of daily living, including the disproportionate risk of contracting HIV/AIDS (Gilbert, 2003; Perry, 2003; Quinn, 1993).

Trustworthiness

Qualitative researchers have a standard to judge naturalistic research by using terms like creditability, fittingness, and triangulation, which results in the trustworthiness of studies. These scholars describe trustworthiness as a general term representing what conventional researchers think of as internal and external validity, reliability and objectivity (Rudestam & Newton, 2001).

Appendix B



October 2, 2006

To Whom It May Concern:

Delthea Hill, doctoral student at IUPUI, has my permission to interview participants of the Women In Motion HIV/AIDS prevention program for the purposes of completing her independent research study and requirements for the doctoral program. I understand that each participant will sign an informed consent form and participation is strictly voluntary. Ms. Hill has agreed to treat information in a confidential manner, and participants' identification will be protected. The focus of her research is not Women In Motion prevention program, but a source for recruiting participants for the sample of the study.

Ms. Hill also informed me that community support numbers will be given to participants in need of supportive services beyond the scope of the research study. This contact information is listed on the informed consent form and participants will be given a copy of this information.

If you have any questions or comments, please call me at 317-767-7677 or 317-938-0107.

Pamela Goodwin-Williams
Executive Director

Appendix C

QUESTION GUIDE FOR STUDY

1. What are some of the ways that women can try to stay healthy and not get sick?
2. How are ways to stay healthy and prevention connected?
3. How do women prevent HIV/AIDS when involved in serious relationships with male partners?
4. How do you describe intimacy [closeness] in your relationship with your male partner?
5. What is the meaning of sexual decision-making?
6. How did you learn to make decisions about sex?
7. What experiences did you have with your male partner(s) that influenced your decisions about sex?
8. What has happened that placed you at risk for HIV and other sexually transmitted diseases (STDs) in the past?
9. How do you handle it with your male partner(s) when you ask them to use a condom and they refuse?
10. Then, how did your male partners react in these situations?
11. What have you changed about your decision-making or your behavior that will help prevent HIV/AIDS?
12. What situations have prevented you from practicing safe sex?

FOCUS GROUP
{question guide}

African-American Heterosexual Women Facing The HIV/AIDS Pandemic: Giving Voice
To Sexual Decision-Making

Saturday, June 30, 2007
University Library-IUPUI

1. What is the meaning of the phrase safer sex?
2. What prevents women from practicing safer sex?
3. How do you define sexual decision-making?
4. How do you describe intimacy [closeness] in your relationship with your male partner?
5. When discussing HIV/AIDS prevention, what are some ways that practicing safer sex and sexual decision-making are connected?
6. What has happened that placed you at risk for HIV and other sexually transmitted diseases (STDs) in the past?
7. How do you handle it with your male partner(s) when you ask him [them] to use a condom and they refuse?
8. Then, how did your male partner(s) react in these situations?
9. What have you changed about your sexual decision-making or your behavior that will help prevent HIV/AIDS?
10. What did you gain from participating in this focus group experience?

Initials_____

Appendix D

FIELD NOTES

Stern- Spring 2001

Date

Topic

Location of Inquiry

Informant (s)

Key Participants Involved

Narrative/Observations (Continued on back) Cite all references included in study
when applicable

Changes or amends to initial note (include date of changes made)

S726-Advanced Social Work Research: Qualitative Methods
Instructor: Dr. Gail Folaron
Student: Delthea Hill
Log Sheet

DATE	HEADING

Appendix E

IUPUI and CLARIAN INFORMED CONSENT STATEMENT FOR

African American Heterosexual Women Facing The Pandemic: Giving Voice To Sexual Decision-Making

STUDY PURPOSE:

You are invited to participate in a research study exploring the views of African American women regarding sexual decision-making with male partners. The purpose of this study is to reduce the risk of contracting HIV/AIDS among women of color.

NUMBER OF PEOPLE TAKING PART IN THE STUDY:

If you agree to participate, you will be one of approximately 5-8 women who will be placed in a focus group, and there will be a total of 3 small groups. Also, you might be one of approximately 6 participants that will be asked to do individual interviews on a voluntary basis in this local research study.

PROCEDURE FOR THE STUDY:

If you agree to an individual interview you will do the following things:

Not all participants will have an individual interview. Women will be considered on a voluntary basis, and the final selection will be based on availability and your willingness to discuss personal sexual decision-making.

You will be involved in a face-to-face interview that will last approximately 45 to 60 minutes. The questions in the study will be related to ways you feel that you can protect yourself from HIV infection and problems that you might have with getting your partner to use condoms. If you are comfortable with the idea, I will ask your permission to audiotape our interview in order to report correct information for the study.

If you agree to participate in a small group with other women of color you will do the following things:

You will be asked as a group to share thoughts about ways that you have learned to change your behavior in order to live a life that is free from the risk of HIV infection, and the ways that these changes have been meaningful for you. You will not have to share information that is not comfortable for you to share with others. Group sessions will not be taped.

RISKS OF TAKING PART IN THE STUDY:

There are minimal risks involved with this study, with no potential interaction resulting in anticipated physical injury [for personal injury check with your insurance provider].

Participant's Initials_____

It is common for people to be fearful to share information about HIV/AIDS, since there is a negative label attached to this disease. However, information will be treated in a confidential and sensitive manner. Your personal names will not be shared during the research process. At the completion of the study, all tapes will be erased.

If you participate in the focus groups all participants will be asked not to share information discussed during group interactions outside of the group. You are not required to share your name or personal data with group members. You do not have to share any information or respond to any questions that you do not want to. You may refuse to answer any questions or withdraw from the study at any time without consequences.

BENEFITS OF TAKING PART IN THE STUDY:

The greatest benefit involved in this project, is the opportunity to make a difference in your community by helping other women of color learn more about how not to get HIV/AIDS. This will also make a difference to their family members.

ALTERNATIVES TO TAKING PART IN THE STUDY:

Instead of being in the study, you have the option to participate or obtain information about sexual decision-making and sexually transmitted diseases from the director or volunteers associated with the *Women in Motion* HIV/AIDS prevention program.

CONFIDENTIALITY:

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. For instance, in the case of child abuse, the child protection agency must be notified of alleged child abuse, or if there is a concern about suicide the crisis intervention hotline will be called.

Your identity will be held in confidence in reports in which the study may be published.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the investigator and his/her research associates, and the IUPUI/Clarian Institutional Review Board or its designees. For questions about your rights as a research participant or to discuss problems, complaints or concerns about a research study, or to obtain information, or offer input, contact the IUPUI/Clarian Research Compliance Administration office at 317/278-3458 or 800/696-2949.

COSTS/COMPENSATION:

You will not receive payment for taking part in this study, nor will there be a cost to you to participate in this study.

Participant's Initials _____

CONTACTS FOR QUESTIONS OR PROBLEMS:

For questions about the study or a research-related injury, contact the researcher Dr. Carolyn Black [317-278-1767] office number or Delthea J. Hill at IUPUI School of Social Work [317-274-6705].

In the event of an emergency, you may contact Delthea Hill at (317) 490-2016. There is voice mail available to take messages. If you cannot reach the researcher during regular business hours (i.e. 8AM-5PM), please call the IUPUI/Clarian Research Compliance Administration office at 317/278-3458 or 800/696-2949.

VOLUNTARY NATURE OF STUDY:

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which you are entitled.

SUBJECT'S CONSENT:

In consideration of all of the above, I give my consent to participate in this research study.

I acknowledge receipt of a copy of this informed consent statement.

SUBJECT'S SIGNATURE: _____

Date: _____
(Must Be Dated By Subject)

WITNESS: _____

Date: _____

Profile Sheet
IUPUI Research Study

Date _____

Male _____ Female _____ Transgender _____

Age _____

Educational Level _____ GED High School [Did you graduate? _____ If not,
last grade completed _____] College [Did you graduate? _____ If not, how many
years completed? _____]

Race _____

Religious Affiliation _____

Political Affiliation _____

Marital Status _____ Single Married Separated Divorced Widowed

Number of Children _____

Are You Currently Employed? _____ If So, Type of Employment _____

Income Range _____

Below 20,000

Between 20,000-30,000

Between 30,000-40,000

Between 40,000-50,000

Above 50,000

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