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HIGH-RISK SEXUAL BEHAVIORS OF COLLEGE STUDENTS: PERSPECTIVES OF AFRICAN-AMERICAN COLLEGE WOMEN

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KHEPRA NURA-KHEM
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HIGH-RISK SEXUAL BEHAVIORS OF COLLEGE STUDENTS:
PERSPECTIVES OF AFRICAN-AMERICAN COLLEGE WOMEN

A Dissertation APPROVED FOR THE
DEPARTMENT OF EDUCATIONAL LEADERSHIP AND POLICY STUDIES

BY

Dr. Jerome Weber

Dr. Rosa Cintron

Dr. Dorsciné Spigner-Littles

Dr. Courtney Vaughn

Dr. Charles Butler

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Abstract

This study was a qualitative inquiry designed to uncover the underlying issues that discover or bring about an understanding of significant circumstances that place college women in general, and African-American college women, in particular, at risk for acquiring HIV/AIDS, and other sexually transmitted infections.

In the broadest sense, the purpose of this study was to develop more insight into and greater understanding of possible reasons why African-American women risk their health by continuing to engage in high-risk sexual behaviors. Detailed answers were sought to the research question: Which life-circumstances do Black women perceive have the greatest influence on their attitudes and motivations to participate in high-risk sexual behaviors?

The greatest benefit from this study was: that these data can provide Student Affairs program planners a framework for cultural-intervention with regard to risk-reduction or behavior change when working with sexually active African-American populations on campuses. If programs are to be effective then they must offer a variety of prevention techniques including: condom distribution, birth control and emergency contraception; and education workshops designed to prevent HIV/AIDS and other sexually transmitted infections. This study focused on eight African-American college women who were 18 to 30 years of age. Face-to-face individual and focus group interviews were conducted utilizing open-ended questions, which were used to facilitate an investigation into the participants' internal and subjective views.

Analysis of the results indicated that the reasons why African-American college women participate in high-risk sexual behaviors were: competition with the White female for the Black athlete; lack of self-esteem which includes fear of losing the relationship, naive, peer pressure or influence; personal choice; please or appease her partner; and trust and belief that she is in a monogamous relationship. Family morality-values and permissive behaviors of family members will also influence young women to engage in unprotected sex. On the other hand, most of these respondents believed that alcohol was used as an excuse to justify irresponsible behavior. In addition, smoking marijuana was not considered by these respondents, to be a behavior which led to unprotected sex.

Also, the results of this study demonstrated that these college women were able to continue with their academic life even though they had children in most cases, and in some cases had encountered a sexually transmitted infection such as trichomoniasis, chlamydia and gonorrhea. Even though becoming a parent gave these students more responsibility; it appears to have also provided them the needed purpose in life to continue their academic quest.

Today's institutions offer a variety of student support services focusing on sexual health and sexual responsibility. The author emphasizes that sexual health and responsibility should be covered and repeated, in a required freshman seminar class because reaching students early and often with information about appropriate sexual behavior is the key to preventing infection among students.

More research is needed on the African-Centered approach to problem solving. Asante (1980) described the African-centered philosophical approach to

problem solving as using the multi-disciplinary approach, which is a comprehensive application to problem solving. This philosophy recognizes that there is no separation from the student's social, spiritual and material world. In addition, scholars should investigate the connection between how African identity and self-concept development can empower people to take control of their sexual health.

CHAPTER 1

INTRODUCTION

Overview

Young people possess greater knowledge, understanding and awareness than ever before about HIV/AIDS. It is likewise true that young people know very little about other sexually transmitted infections (STIs). Today's students know even less about developing and maintaining healthy and intimate relationships that build into positive social experiences. College students, in particular, have been inundated with prevention information regarding sexually transmitted diseases. Despite medical and treatment progress made over the last decade, health professionals, prevention specialists, as well as student affairs personnel find themselves facing a new paradox; that is, how to convince college-age students to lessen their risks of exposure to HIV/AIDS and other sexually transmitted infections by developing positive behavior changes. The most serious and expensive health and social problems that afflict Americans today are caused (in large part) by behavioral patterns established during youth. High-risk sexual behavior is certainly a part of other risk behavior patterns experienced by young people that include and are not limited to: tobacco use, high-fat diets, violence, and alcohol or other drug use. Nevertheless, different units such as student affairs and other college health programs could become one of the most efficient avenues to utilize in enhancing and/or reducing major health and social problems that confront American citizens. The reduction of risks associated with health problems that afflict young people and thereafter threaten adulthood can assist

in reducing rising health care costs, enhance educational outcomes, improve societal economic productivity and overall quality of life.

According to Gould & Keeling (1992), the belief that colleges and universities are responsible for providing effective health education regarding HIV and other issues of sexual health derive from the very framework of the missions of higher education. According to the National Association of Student Personnel Administrators:

> One of the basic purposes of higher education is the preservation, transmission, and enrichment of the important elements of culture the product of scholarship, research, creative imagination, and human experience. It is the task of colleges and universities ... to vitalize this and other educational purposes as to assist the student in developing to the limits of ... potentialities and in making contribution to the betterment of society (NASPA, 1987, p. 21).

The above philosophy imposes upon educational organizations the obligation to consider each student as a whole, including the student's intellectual capacity and achievement, emotional make-up, physical condition, and social relationships (Gould & Keeling, 1992). Health behaviors are impacted by health beliefs that include thoughts, feelings, and cognitions (Belgrave, Molock, Kelley, & Nana-Sinham, 1991). This research shall explore and discover the causal effects of high-risk sexual behaviors of college students from the African-American females' perspective.

Background of the Problem

According to Rosenberg (1992), STIs should be of much greater concern for women for a number of reasons. First, it is easier for women to be infected with STIs from men than vice-versa. Second, STIs are frequently asymptomatic in women. Third, STIs are more difficult to diagnose in women. Rosenberg (1992) states further that: "it is in women that STD complications have their greatest effect" (p. 6).

A strong case must be made for targeting African-American college women because Black females ages 15 to 24 have the highest death rate from HIV/AIDS. Even though African-Americans only total 7% of the population in Oklahoma, the incidence of HIV/AIDS is 2.7 times greater for Black women when compared to Hispanics at (0.3) and Whites at (0.4) per 100,000 (National Center for Health Statistics [NCHS], 1990). Also, Black females, age 20 to 24 reported the highest syphilis rate, 100 cases (per 100,000) compared to only twelve, seven, two, and zero cases (per 100,000) for Asians, Hispanics, Whites, and American Indians, respectively (Oklahoma State Department of Health [OSDH], 1993). In addition, Black females lead in infection rates from gonorrhea in two age groups: 940 cases in the 15 to19 year-old age group and 678 cases in the age group 20 to 24 (OSDH, 1993). Furthermore, syphilis and gonorrhea are the number first and second-best predictors of HIV/AIDS (Johnson, Gilbert & Lollis, 1994). Accordingly, the HIV/AIDS rates among African-American women are 16 times higher than that of Caucasian women (American Association for World Health [AAWH], 1997). Likewise, the Surgeon General of the United States of America, states that a Black woman is nine times more likely to die of AIDS than any other woman

(Brownsworth, 1993). In Newark, New Jersey, AIDS is reported as the number one killer of Black women ages 25 to 44 (Perez, 1990/1991). Nationwide, heterosexual Black women are contracting HIV/AIDS faster than any other single group of Americans. Thirty-six percent of the total number of Black women with HIV/AIDS were infected through heterosexual contact (Centers for Disease Control [CDC], 1993). The greatest number of new AIDS cases has been among African Americans and is spreading most rapidly among women (CDC, 1997a). Finally, the National Center for Health Statistics (NCHS, 1990) reported that Black women ages 15 to 24 have the highest death rate from cervical cancer which is a disease primarily acquired from engaging in unprotected sex with multiple partners.

According to the late President of the Carnegie Foundation for the Advancement of Teaching, Ernest Boyer, higher education "has an urgent obligation to be engaged in the issues of the day. The campus should be a staging ground for action ... whose purpose must include the capacity of colleges and universities to implement strategies that promote disease prevention" (CDC, 1995b, p.4). Kolbe, Collins, & Cortese (1997) emphasize that if colleges are to "improve the well-being of people in the United States, one must first understand the health problems that afflict the nation" (p. 256). According to Sherry (1998) the CDC in its Healthy People 2000 campaign, has a specific goal for colleges and universities to provide HIV education for students and staff on at least 90% of American campuses. While the above goal may exist, issues of health and disease prevention (especially HIV), have not received high enough priority on higher education agendas. University and college students are not generally perceived as a high-risk group. Consequently,

many educational leaders do not perceive that this issue demands extensive attention. Nevertheless, as will be further discussed, there is abundant evidence that college students are vulnerable to STIs/HIV/AIDS.

Statement of the Problem

The CDC estimates that two-thirds of the twelve million Americans infected with sexually transmitted infections (STIs) each year are under the age of 25 (Reinisch, Sanders, Hill & Ziemba-Davis, 1992). The CDC also estimates that only 14% of all HIV/AIDS cases have been reported in the 20 to 24 year-old age group, which includes traditional college undergraduates. In addition, in 1990, the CDC estimated that 2.5 of 1,000 college students are infected with HIV.

The Nebraska Council to Prevent Alcohol and Drug Abuse ([NCPADA],1994) estimates that:

1. 8 million people under the age of 25 have an STI;
2. 50% of college students have two or more sex partners a year;
3. 34% of college students report using condoms.

Gray & Saracino (1989) state that two-thirds of sexually active college students do not use condoms. Thus, college students are also at high risk for HIV, the virus that causes AIDS and other STIs, especially: chlamydia, gonorrhea, syphilis, herpes, human papillomavirus (HPV) the virus that causes condyloma, more commonly known a genital warts, and hepatitis B.

Peterson, Cantania, Dolcini, & Faigeles (1993), add that:

1. Black heterosexual men and women are ten times more likely to be diagnosed with AIDS than are White men and women,

2. One-in-five Blacks (in high-risk cities) face exposure to HIV or other STIs because Black men reported having unprotected sex with multiple partners.
3. partner selection typically occurs within one's own race; and
4. Black women face substantial risk of being exposed to HIV & other STIs (p. 263).

In Oklahoma, according to the Oklahoma State Department of Health (OSDH, 1993), the Black population reported the highest rate of syphilis and gonorrhea cases. The age group most affected was 20 to 24 year olds. The highest rate of chlamydia is also found among Blacks age 15 to 24. The age category of 20 through 29 represents 23% of the AIDS cases. This is second only to the age category 30 through 39 (OSDH, 1997). When Oklahoma's AIDS cases in the age group 20 through 29 is compared to the United States cases in the same age category; Oklahoma's AIDS cases at 23% are greater than United States AIDS cases at 18%.

The number of AIDS cases among women in Oklahoma was 227 as of September 1996, with Black women representing 23% of those cases (OSDH, 1997). This is extremely disturbing since the total number of Blacks in Oklahoma only represents 7.4% of the state's population. The reported rate of AIDS cases among Black women is 35 per 100,000; whereas, the reported rate for Caucasian women is 7.5 per 100,000. This indicates a rate that is four-to-five times greater for Black women. The OSDH (1997) confirms 40% of the AIDS cases among Black women are attributed to heterosexual transmission, while the remaining 60% is among White heterosexual women. Since 1988, the annual number of women ages 20 to 29 with

heterosexually acquired AIDS has increased by 96% nationwide. The majority of these women were infected as adolescents or young adults (DiCarlo, 1996). The age category 20 to 29 should be carefully examined because it takes at least ten years for most people to discover they are infected with HIV/AIDS (Snabes, Weinman, & Smith, 1994). Therefore, the implementation of prevention education for adolescents and college-age students must be a priority.

In Oklahoma, AIDS is the second leading cause of death for Black females age 25 to 44. During 1997:

1. 65% of the reported syphilis cases occurred among Blacks
2. for every one White male with syphilis, there were 35 Black males with syphilis
3. for every one White female with syphilis, there were more than 20 Black females with syphilis
4. 70% of the 4,421 cases of gonorrhea were reported in Blacks (i.e.: black males at 1,504 and white males at 21 cases)
5. Black females reported 1,139 cases compared to 51 cases reported in White females 84% of 6,982 cases of chlamydia were diagnosed in Oklahoma with Whites reported 43% compared to 37% in Blacks (OSDH, 1998).

Although many more Whites have contracted HIV/AIDS than any other racial or ethnic group; Blacks experience the greatest impact, i.e.: 2 to 2½ times greater than that of any other race or ethnicity (OSDH, 1998). Proportionately, Blacks are most significantly affected. It is important to clarify that race and ethnicity are not risk

factors for HIV transmission. Race and ethnicity, however, are important indicators for intricate political, social, economic and cultural issues (OSDH, 1998).

This study identifies and examines the psychosocial experiences of African-American college women relative to their sexual practices. More specifically, the study documents and records essential issues that serve to shape and influence the participant's attitudes and motivations which potentially contribute to high-risk sexual behavior. In the broadest sense, the purpose of this study is to develop more insight into and greater understanding of possible reasons why African-American women risk their health by continuing to engage in high-risk sexual behaviors. Related to this central concern are questions of life-history, personal experiences, and other psychosocial factors that contribute to African-American females decisions to engage in potentially risky personal behavior on a college campus.

Research Question

In researching the perspectives of African-American college women regarding high-risk sexual behaviors, detailed answers to the following question guided the present study: Which life-circumstances do Black women perceive have the greatest influence on their attitudes and motivations to participate in high-risk sexual behaviors?

Research Terms

In this study, certain terms were defined as follows:

Acquired Immune Deficiency Syndrome (AIDS): Acquired immune deficiency syndrome is the late stage of the illness that has been triggered by HIV in which the white blood cells (aka CD4 of T-cell) count has dropped to 200 or less and

certain opportunistic infections which appear common with advanced immune deficiency (CDC, 1992).

Coding: Coding is the process of selecting and recording text in a document to a specific category. The text that is selected can vary from a single character or single word to complete sentences or paragraphs. The entire document can also be coded. For example, an interview from a female respondent might be coded to the category *Female* (Miles & Huberman, 1994).

High-risk behavior: High-risk behavior is behavior that contributes to unintended pregnancy and sexually transmitted disease (STIs) including HIV/AIDS. (Youth Risk Behavior Survey, 1998). According to the Oklahoma State Department of Health and the Oklahoma Comprehensive Plan (OSDH,1999), females age 18 and older are at high-risk for HIV through heterosexual transmission if their behavior includes unprotected oral, vaginal and/or anal intercourse with multiple sexual partners; women who have sex with men and women; women whose sexual partners include men who have sex with men; women whose sexual partners include men who have sex with men and also use drugs via needle injection.

Human Immunodeficiency Virus (HIV): Human immunodeficiency virus is when the white blood cells (aka CD4 of T-cell) count has decreased from a healthy count of 1500 to 500 or less because of damage to the immune system; which may have been caused by high-risk sexual behavior or sharing of drug needles with an infected person(s) or through the birth process in which infants receive the virus from the mother (CDC, 1992).

Life-circumstance: Human activities centered around a social, economic or political condition; a fact, or significant event (Webster, 1986).

Life-history: Life-history is the study of the life experience of individuals from the perspective of how individuals interpret and understand the world around them (Gall, Borg & Gall, 1996). It utilizes a qualitative research technique via in-depth interviews with the intent of capturing one person's interpretation of his/her life (Guba & Lincoln, 1985).

Patterns: Patterns unite the categories and emerging themes into a meaningful whole idea or concept (Miles & Huberman, 1994).

Phenomenology: Phenomenology is the study of the world as it appears to individuals when they place themselves in a reflective state of consciousness (Gall, et al., 1996); and an interdisciplinary approach to qualitative research wherein the participants subjective experience is at the center of the inquiry (Tesch, 1998).

Psychosocial: Psychosocial status relates participants' social condition to their mental health (Webster, 1986).

Sexual Transmitted Infections (STIs): Sexually transmitted infections are contagious illnesses that may or may not be noticeable or painful; and are usually passed from one person to another through sexual intercourse or other kinds of intimate contact (Planned Parenthood, 1989).

Themes: Themes are central ideas found within a project. Themes can be captured when coded as single categories or several categories can be clustered to form a central idea (Miles & Huberman, 1994).

Qualitative Research: Qualitative research is non-numerical information collected to answer a research question; typically used in association with described text; through interviews and participant observations that seek patterns or themes within the data (Langenbach, Vaughn, & Aagaard, 1994).

Need for the Study

The study may provide student affairs personnel the opportunity to move toward more relevant educational and prevention programs that will address sensitive social behavioral issues in a realistic and culturally competent manner. This study may also assist campus advisors and counselors in understanding the complex gender, age, and racial factors that contribute to risk-taking behaviors among African-American college women. According to the NASPA (1987), "colleges should allocate optimum provisions for positive development of individuals. Moreover, special attention should be given to the physical and mental health services whose orientation is not only the treatment of illness, but also, and even primarily, an educational program of preventive medicine and personal counseling" (p. 36). The findings from an in-depth qualitative study may also provide information that may benefit female college students who seek heterosexual relationships with male students. Perhaps the results of this research will motivate college women to acquire greater awareness and concern for their sexual and reproductive health.

In conclusion, there are four compelling benefits of this study:

1. The results of this study will provide student affairs personnel an additional opportunity to examine and develop a preventive approach to STIs/HIV/AIDS disease;

2. Help explain and clarify aspects of risk-taking behavior when working with the African-American population on campus;

3. Sexually-active, single, college-women may develop stronger negotiation skills with respect to the number of sexual partners and the use of barrier protection methods; and

4. This study will add to the data on essential, deeper human questions about self, relationships, community, culture, and the obligations and responsibilities of individuals and societies.

The researcher has exhaustively reviewed the literature available regarding high-risk behavioral issues associated with sexually transmitted diseases among college age students. Literature review has not yet revealed a substantially similar study to the subject examined here. The recent onset of the AIDS epidemic has once again brought to the public's attention many issues associated with preventing HIV/AIDS and other STIs. There is little doubt among scholars that young, college age students, are at the peak of their sexuality. Young, college age students are generally very impressionable and vulnerable as many are experiencing early adulthood which includes decision-making about whether to engage in sexual activity. While it is obvious that these issues affect many young adults, it is difficult to find research that documents the related thought processes that precede one's participation in high-risk behavior. These behaviors may ultimately result in, at the least, acquiring a sexually transmitted disease, leading, at the worst, to death

Little research has been conducted regarding the decision-making processes and value systems (or lack of value systems) on which college students rely to guide

their judgments. Further, it is abundantly clear from the demographic data obtained by the researcher, and previously discussed here, that African-American college students have one of the highest incidences (based on race) to acquire sexually transmitted infections. There appears to be no other study within the literature which focuses on the behaviors which lead to high-risk sexual activity among female, African-American, college age students. Despite the fact that acquiring sexually transmitted infections occurs regardless of one's ethnic or demographic background, research efforts should first focus on the population associated with the highest frequency of incidences of sexually transmitted infections. It is unfortunately clear that the population that has been most adversely affected and infected has been identified as female African-American, college age students. Essentially, this type of study has never before been conducted, especially with African-American college age women as target population. This study will therefore likely bring new knowledge to the field of Student Affairs.

Conceptual Framework

Magolda (1995) describe three sets of epistemic assumptions, or ways of knowing, that are prevalent among college students:

1. absolute knowing, characterized by viewing knowledge as certain;

2. transitional knowing, characterized by a growing awareness of uncertainty in some areas of knowledge; and

3. independent knowing, a perspective in which most knowledge was viewed as uncertain.

This study describes three critical thinking processes or three ways of knowing. Emphasis is placed on recognizing the importance of knowledge-of-self, while accessing and processing ones own, and others perspectives.

Reisser (1995) re-visits the work of Arthur Chickering to describe how theoretical perspectives must evolve in order to meet the challenges students face within today's society. Since the 60s, Chickering has been consistently regarded among the most widely applied theorists of student development, finding a substantial base of research to support his seven vectors (guide to dimensions of identity) analysis. Chickering's original seven vectors of development include: developing intellectual competence, managing emotions, developing autonomy, establishing identity, freeing interpersonal relations, developing purpose, and developing integrity.

Developing Intellectual Competence. Reisser (1995) argues that Chickering (1969) takes into account recent advances in what is known about reflective thought, brain dominance and learning theory. Chickering (1969) accounted for a more complete understanding of nutrition, exercise, and other wellness concepts. Reisser (1995) suggests that a sense of competence is subjective. It involves how students feel about their overall performance and the worth of their accomplishments, based on (1) how they think their performances compare with other students and (2) on feedback from faculty members, coaches, advisors, and peers. Reisser (1995) contends that movement toward greater confidence and acceptance of self is progressive.

Managing Emotions. Reisser (1995) confirms that Chickering (1969) focused on the emotional trials of younger students, with special emphasis on the taming and

harnessing of sex and aggression. Age does not necessarily correlate with emotional maturity. "Younger students and returning adults bring a wide variety of emotional baggage such as excessive anger, fear, anxiety, depression, guilt, shame, and dysfunctional sexual or romantic attraction which can be disruptive and self defeating" (p. 507).

Developing Autonomy. Developing autonomy can also be phrased as self-governance. Reisser (1995) argues that Chickering (1969) updates this vector to developing interdependence or moving from individualism to a greater emphasis on social responsibility and global interdependence; recognizing that interdependence is the capstone of development. Autonomy is also defined as emotional independence or freedom from a continual and pressing need for reassurance, affection, or approval. Reisser (1995) distinguishes instrumental independence as the ability to carry on activities and solve problems in a self-directed manner, with the freedom and confidence to be mobile and self-sufficient. Blimling (1995a) further states that there may be behavioral tendencies based on gender differences: males asserting autonomy through separation, individual rights, and playing by the rules, and females more often working out autonomy issues in ways that preserve relationships and harmony (p. 507).

Establishing identity. Reisser (1995) says that Chickering (1969) added recent concepts about gender role development, including sexual orientation, and dissolved the age norms that link career and family. Reisser (1995) references Miller (1976), who states that a woman's sense of self becomes very much organized around being able to make, and then maintain, affiliations and relationships. Reisser (1995) thus

argues that establishing identity encompasses all other vectors. Reisser (1995) referring to Josselson (1987), states that establishing an identity is the root of balance and security. Reisser (1995) explains that as a result of this solid beginning, students can discover or confirm their core characteristics and increase their comfort level with being male or female, gay, straight, or bisexual. Reisser (1995) adds that any experience which helps students define *who I am* and *who I am not*, can help solidify one's sense-of-self.

Reisser (1995) describes a study by Straub & Rodgers (1986) who found that female students scored significantly higher on the Relationship Scale of the Student Development Task Inventory than on the Autonomy Scale, implying that the movement along this vector occurred earlier than movement along the autonomy vector. According to Reisser (1995), Straub & Rodgers (1986): "theorized that women may need to become autonomous in their relationships before becoming autonomous in their own right" (p. 508). Consequently, Reisser (1995) moved the vector on relationships to an earlier place in the sequence because the interplay among autonomy, interdependence, and intimacy is very complex. Reisser (1995) notes that relationships, for both men and women, provide powerful learning experiences about feelings, communication, sexuality, self-esteem, values and other vital aspects of identity. Reisser's colleagues questioned this approach. In response, Taub (1995) confirmed that mature interpersonal relationships provide a context for autonomy development. As cited in Blimling (1995a), Taub (1995) stated that Chickering's (1969) model, which was relied upon by student development professionals, "does not appear to fit well [into] the development of college women in

its description of the sequence, content, and process of developing autonomy" (p. 508). Reisser (1995) states further that Chickering's response to Taub's (1995) findings indicated the updated study seemed entirely consistent with, and supportive of, the basic formulation which emphasizes the critical importance of relationships among peers, reference groups, and non-parental adults as disengagement with parents occurs.

Freeing Interpersonal Relationships. Reisser (1995) originally defined freeing interpersonal relationships as students abilities to develop:

1. an increased tolerance for others,
2. a capacity for intimacy, and
3. relationships based on trust.

Chickering (1969) places a greater emphasis on the importance of developing high levels of tolerance and acceptance because of increasing cultural pluralism in America. Reisser (1995) further contends that Chickering (1969) recognizes the changing conditions under which students learn about intimacy. Consequently, Chickering (1969) focused on learning about single parenthood, dual couple relationships, unmarried couples living together, and homosexual relationships.

Developing Purposes. According to Reisser (1995) clarifying purposes is the students ability to develop a sense of purpose in their lives, which may lead to proper implementation of plans and priorities for careers, avocations, and lifestyles. Reisser (1995) believes that Chickering (1969) moves from the assumption of one life and one job pattern to a multiple career perspective.

Developing Integrity. Chickering (1969) defined this as the ability to develop a personally valid set of beliefs with internal consistency, thereby providing behavior guidelines. Reisser (1995) explains that Chickering (1969) would update this to include development of a sense of social as well as personal responsibility. Chickering (1969) now believes students must be educated about environmental pollution, toxic wastes, exploitation of the powerless, and the increasing gap between *the haves* and *have nots*. Chickering (1969) also believes knowledge implies a responsibility to act.

Reisser (1995) states that the last two vectors: developing purpose and developing integrity should not be altered from its original precepts. She explains that developing purpose (by extending the spirit of its original operationalization) is more in-depth than its original construct to include: clarifying vocational plans, sharpening priorities based on personal interests, making initial lifestyle choices based on clarity and persistence toward goals, despite barriers. Developing integrity includes personalizing values and shifting away from automatic, uncompromising beliefs. Those human values involve consciously affirming one's own values and beliefs, while respecting others viewpoints.

The theoretical source appearing most closely related to this study is provided by DiClemente & Peterson (1994) who describe several theories and methods of behavioral interventions for preventing AIDS. First, their Health Belief Model states individuals will take action to ward off, to screen for, or control ill-health conditions if they regard themselves as susceptible to the condition. They will also take action if they believe the health condition to have serious consequences. Second, DiClemente

& Peterson (1994) discuss their Social Cognitive Theory which states that: "people need to be given not only reasons to alter risky habits but the behavioral means, resources, and social support to do so" (p. 25). The effective self-regulation of behavior is only achieved by the act of will. Behavior requires a strong belief in one's ability to exercise personal control. The Social Cognitive Theory argues that if a woman has a high degree of self-confidence, she is more likely to adopt positive behavioral change.

The Social Cognitive Theory recognizes that many behaviors are largely determined by expectations and reinforcements or incentives. Expectations include:

(1) one's beliefs about how external events are related or connected;

(2) one's own opinions and the perceptions of others' opinions regarding the consequences of her personal action, and

(3) her belief in her own ability to perform the necessary behavior change (OSDH, 1996). This source explains incentives as the values one perceives will be derived from achieving the outcome, such as approval of others and/or improved health status due to exercising risk reduction techniques.

Third, their Theory of Reasoned Action states that behavior is determined by underlying behavior which is primarily a matter of changing underlying beliefs. By changing behavior or normative beliefs, one can change corresponding attitudes and/or subjective norms. If this can be accomplished, then one can change corresponding intentions. The Theory of Reasoned Action asserts that a woman's attitude and social values predict behavioral intentions. In short, research has shown that behavioral intentions correlate with actual behavior (OSDH, 1996).

The Theory of Reasoned Action postulates that most behavior is a reflection of one's formulated intentions to behave a certain way or to take on new behavior or stop old behavior. The behavioral intention is the result of the individual's attitude toward performing the behavior as well as his or her perception of prevailing social norms in the community. In other words, the stronger the intention to behave in a certain way, the greater the probability that the individual will perform the behavior (OSDH, 1996).

If behavioral change is to be successful, the intervention must focus on the individual's particular needs; and be flexible using a multifaceted approach. Fennell (1993) argues that behavior change is more likely when educators can offer a positive plan for action, rather than only a list of prescriptions. In this study, humor was used by students in role plays to overcome barriers to condom use. Fennell (1993) explains that each individual learns in a unique way; therefore, programs that offer written, oral, visual and experiential learning are more likely to have greater impact on behavior change. Sheer & Cline (1994) validate that knowledge alone is not enough to change behavior; there is a need to identify message and campaign strategies that lead to behavior change.

The Health Belief Model assumes that one's behavior is largely guided by one's expectations regarding the consequences of adopting new health-related practices. Four interrelated concepts guide the behavioral intervention/evaluation process:

(1) Susceptibility: does the person believe she is vulnerable to STIs/HIV/AIDS?

(2) Severity: does the person that STIs/HIV/AIDS has consequences?

(3) Benefits minus costs: what does the person believe to be the positive versus negative effects of adopting one or more practices and do the positives outweigh the negatives?

(4) Health Motive: whether perceptions of the negative consequences of contracting a sexually transmitted infection are great enough to alter or reduce existing behavior practices (OSDH, 1996).

The ability to practice control over one's personal behavior requires self-confidence and assertive communication skills. In other words, talking frankly about all sexual matters (especially on how to prevent sexually transmitted infections) will ensure the use of protective sexual methods. DiClemente & Peterson (1994) explain that research on women's failure to implement safer-sex has revealed that often they do not have the necessary skills needed to protect themselves and frequently hold attitudes and beliefs incompatible with initiating safer-sex. The range of skills needed to practice safer sex includes initiation of the topic of safer sex with partners, negotiation or resolution of conflict with partners who disagree about practicing safer-sex, and the ability to purchase a condom and to assist her partner in correct usage. Not only do women lack these necessary skills, they are frequently unwilling to attempt behavior change because they lack confidence in their ability to be successful. Thus, the Health Belief Model states that if a woman believes she may be at risk, she is more likely to take measures to protect herself. In brief, the above discussion includes three behavior change models that are closely connected to the

conceptual framework via Magolda's (1995) epistemic assumptions and Reisser's (1995), application of Arthur Chickering's (1960) seven vectors of development.

In conclusion, the high incidence of HIV/AIDS and other sexually transmitted infections among the young adult population is well documented. There should be an alarm posted for the African-American community because where there are high rates of syphilis and gonorrhea they are certain to encounter HIV/AIDS. Specific focus has been given to the African-American female because her role as mother and caretaker of the family. Likewise, the sexual health of college students is also vital if the United States is to have healthy, stable families that are able to contribute. The following is a report of the literature that has been written on high-risk behaviors among college students, sexually transmitted infections, and behavior change theories.

CHAPTER 2

REVIEW OF THE LITERATURE

Overview

The incidence of sexually transmitted infections (STIs) among college students is ever increasing. The literature reviewed and presented here reveals differing rates of STIs based on the behaviors of racial/ethnic college-student populations. While safer sex practices are taught to an extent at mid-high and high-schools throughout public school systems, the data indicating increasing rates of STIs among college-student populations reveals that the educational curricula necessary to effectuate prevention and/or reduction of STIs has not yet been adequately addressed. Part of the educational challenges among college-student populations is a common perception that they *have heard it all before*. This actually results in a misperception among college students that they do not need further education regarding safer-sex practices and in fact, places this population at increased risks of acquiring STIs. This lack of interest creates even more difficult challenges for university administrators and educators to overcome in effectively educating college students from a variety of racial and ethnic backgrounds regarding risk reduction and/or prevention of acquiring STIs through education and behavior modification(s).

Sexual Behaviors Among College Students

The literature reveals that many related studies have been reported in medical journals, public health reports and college student personnel journals. Thus, the material reviewed here comes from diverse sources. A study by Spears, Abraham, Sheeran, & Abrams (1997) attempts to measure the judgment of college students as it

relates to HIV-risks and sexual practices. The objective was to examine what college students consider to be the risks of different sexual practices or behaviors (with different sexual partners) and how such perceptions are affected by other important demographic characteristics such as gender and age (as cited in Blimling, 1997). Study results revealed that unprotected vaginal sex was regarded as unsafe . . . it is perhaps interesting to note that a view of unprotected vaginal sex as more dangerous for the female was not reflected in these judgments (p. 109).

Poindexter-Cameron & Robinson (1997) argue very little research relates to African-American women's gender role attitudes and gender role identity. Gender roles are complex for Black women because they often adopt traditional and non-traditional roles simultaneously. Their argument is that no research exists comparing racial identity and gender role identity attitudes of African-American women in different college settings. Minimal research exists concerning relationships among sex, race, racial identity attitudes, and gender roles (as cited in Blimling, 1997).

Elliot, Johnson & Jackson (1997) stated that undergraduates who report more effective problem-solving skills also have been found to have greater adaptive habits and attitudes toward academic life. The point of this study is that students who feel they have more control in their lives will be able to deal with problems more successfully. If female students lack control over their lives then they are inclined to suffer more acutely (as cited in Blimling, 1997).

There are several recent studies reported in scholarly journals that relate to college students risk behavior for acquiring a STI/HIV. There is a wide-range of topics including perceptions of vulnerability and college freshmen's safer-sex

practice (Johnson, et al., 1994; Snabes, et al., 1994; and Johnson, Douglass, & Nelson, 1992). Other studies measure attitude and behavior as well as test behavior-change theory (Mahoney, Thombs, & Ford, 1995; Jemmott & Jemmott 1991; DiClemente & Peterson, 1994; and Ford & Goode, 1994). Several studies measure the risk of women to HIV disease and the increased risk of HIV to the heterosexual population (Rosin, 1995; CDC, 1993; Kline & Kline, 1992; and Allen & Setlow, 1991). There were studies that describe current STI/HIV/AIDS trends (CDC, 1998g; OSDH, 1998, 1997, 1993; and, Shayne & Kaplan, 1991). Some studies measured the impact of prevention messages or the impact of educational programs on knowledge, attitudes and practices of low-income women of color (Cordova & Norwood, 1991; Flaskerud & Nyamathi, 1990). Some studies seek to describe sexual activity among college students (Wiley, James, Jordan-Belver, Furney, Calsbeek, Benjamin & Kathcart, 1996; Feighenbaum, Weinstein, & Rosen, 1995; Uwakwe, Mansaray, & Onwu, 1994; Jacobs, 1993; McGuire, Shega & Nicholls, Deese & Landefeld, 1992; Reinisch, et al., 1992; Ishii-Kunt, Whitbeck, & Simons, 1990; DiClemente, Forrest & Mickle, 1990; and Gray & Saracino, 1989). There were studies that described factors associated with high-risk behavior, especially alcohol use (National Association of Student Personnel Adminstrators, (NASPA) 1998; Kerr, 1998; Anderson & Mathieu, 1996; and Piombo & Piles, 1996; Carrol & Carrol, 1995; Weshler, Dowdall, Maenner, Gledhill-Hoyt, & Lee, 1998; Sheer & Cline, 1994; the NCPADA, 1994; Freimuth, Edgar, Hammond, McDonald, & Fink, 1992; Butcher, Manning, & O'Neal, 1991). Some literature described the role between sexually transmitted infections and HIV/AIDS (NASPA, 1998; CDC, 1996, 1995; Girls, Inc., 1996; and Gayle,

Keeling, Garcia-Tunon, Kilbourne, Narkunas, Ingram, Rogers, & Curran, 1990). Many studies concentrated on multiple partners as a high-risk category (Peterson, Catania, Dolcini, & Faigles, 1993; Choi, Rickman, & Cantania, 1993; Caron, Davis, & Halterman, 1993; Sawyer & Moss, 1993; Mickle,1993; Kline & Kline, 1992; and Fisher & Misovich, 1990). Finally, there were studies that measured attitude and behavior change through intervention (Simkins, 1995; Cordova & Norwood, 1991; Flaskerud & Nyamathi, 1990; and McLean, 1990). These studies will be discussed under appropriate subtitles on the pages that follow.

Student Perceptions of Vulnerability and Safer-Sex Practices

Johnson, et al., (1992), conducted a survey of STI rates and protective sexual behavior among a population of African-American male students. The results demonstrate that although monogamy, avoidance of casual sexual activity and drug and alcohol use during sexual activity tends to decrease the risk of exposure to HIV, consistent condom use is the only sexually related behavior that is considered significantly protective.

Johnson, et al., (1994), examined risky sexual behaviors, condom and drug usage, sexually transmitted infections, and attitudes of African American college students living with HIV/AIDS. A total of 408 (199 males, 209 females) African-American college students, representing 75% of the students enrolled in a southern university, were surveyed. The results revealed that 3.18% of students reported having HIV/AIDS. The students with HIV/AIDS had poor information in AIDS transmission and prevention knowledge. Furthermore, subjects with HIV/AIDS were more likely to engage in anal intercourse, experience sex with prostitutes, and abuse

drugs. STIs were also more prevalent among this group. The authors state specifically that syphilis was found to be the best predictor of HIV/AIDS.

Psychosocial/Moral Development of Students with HIV-AIDS

It was estimated by the World Health Organization that as of 1998, 30.6 million people have been infected with the human immunodeficiency virus (HIV) and that each day 16,000 more become infected. The Centers for Disease Control estimates are that between 650,000 and 900,000 people in the United States are infected with HIV (Bower & Collins, 2000). Further estimates from the Global AIDS Policy Coalition predict that as many as 33.6 million individuals worldwide will be infected with [the] HIV virus by the end of 1999 ... (Bower & Collins, 2000). It is also reported that demographic trends for HIV/AIDS reveal that as long-time HIV-infected individuals die, younger individuals become infected in increasing numbers, thus leading to a disproportionate number of adolescents infected with HIV. This is particularly true among heterosexuals, within the age range of 19 to 25 years of age. This increase of HIV among young people directly relates to the number of college students who are living with HIV and AIDS (Bower & Collins, 2000). Further, based on CDC estimates, up to one-half of new HIV infections may be among people who are under 25 years of age. It is further noted that: [o]f the 688,200 AIDS cases reported in the U.S. through June 1999, 27,860 were between the ages of 13 and 24 at the time of diagnosis (Bower & Collins, 2000).

Bower & Collins (2000) urge that student-to-student interactions represent significant dimensions of college student retention and success. It is therefore logical that perceptions and attitudes of the general student population regarding HIV/AIDS

may directly impact student success and retention among those who are diagnosed with HIV/AIDS. In other words, students who are living with HIV/AIDS perhaps will have much more academic success if they are able to interact with the general student population about HIV/AIDS. However, the student population must exhibit sensitivity and a caring feeling about people living with this disease and attending college. Further findings were documented by Vener, Krupka & Stamatakos (1991) who reported the results of a perception survey taken among 1,175 college students that focused on the utilization of services and facilities by students infected with HIV. It was found that 25% of students surveyed felt vulnerable to HIV-infections through sharing university facilities. As many as 86% of students were unwilling to share a residence hall room, 75% of students were unwilling to share a bathroom and 58% were unwilling to share a swimming pool with HIV-infected students. In a related study, Ashcraft & Schleuter (1993) surveyed 160 college students regarding approach and avoidance behaviors with students who live with HIV. The study revealed that females were more likely to react neutrally or positively toward HIV-infected students. The male students surveyed held more inaccurate views on how HIV was transmitted and were more likely to react in a negative manner than females (Ashcraft & Schleuter, 1993). Males also believed that HIV-infected people should be isolated from society. Generally, college students surveyed by Ashcraft & Schleuter (1993) held negative to neutral attitudes toward people with HIV/AIDS and the rights of those individuals. Similar attitudes were also revealed in a 1996 study of 187 college students conducted by Brandyberry & MacNair (1996).

Hayden (1994) suggests that HIV-testing should be routinely available on campus as part of health care. Williams & Stafford (1991) urged the expansion of college support services should be expanded to include programs which address the needs of partners, families, and friends of students diagnosed with HIV. Researchers have indicated that support services such as these will lead to a more accurate understanding of the needs of individuals coping with the disease and increased student understanding and tolerance of individuals with HIV/AIDs individuals (Ashcraft & Schleuter, 1993; Sugahara, 1995; Williams & Stafford, 1991).

AIDS education programs have often been multi-purpose. The primary goal of such programs is disease prevention. Other programs include attempts to change fear and negative perceptions of persons living with HIV/AIDS. Simon (1993) documented this student's response: "Most of my generation knew about AIDS before they were sexually active. It's always been there for us. You know, the sex equals death generation? That's us" (p. 52).

Earlier studies in AIDS education focused on experiences designed to decrease hemophilia (Croteau & Morgan, 1989). They reported that heightened awareness of HIV has resulted in a renewed intolerance and resurgence of hostilities toward issues related to homosexuality.

Another study by Castronovo (1990) culminated into a plea for university and college administrators to share the mandate to implement AIDS education programs designed to raise awareness of this disease. An education program based on Kohlberg's Moral Development

Theory was conducted by (Clayton, Pittman, & Gaines, 1994), which utilized situational role play to move individuals to next levels of understanding specifically regarding HIV-infected individuals. Kohlberg's (1971) study also noted that individuals progress through a sequence of stages as their thinking on moral topics becomes less concrete and more abstract, less self-concerned, and more based on principles such as justice and equality. The following three students have offered these observations after having becoming infected with HIV/AIDS:

> Leslie: The most important things are justice, fairness, equality, and truth. I can't believe that when I got to college I thought that Double Stuff Oreos and Absolute Vodka were the important things.
>
> Charles: I don't know what everyone thinks that life is all about. We are all living on borrowed time. ... [w]e all live together and should live for one another. I don't think most people realize that. We are all in this thing called life together Blacks, Whites, Hispanics, Russians, Croatians, everyone. But I was there, too, once. So I understand peoples' ignorance. I have changed a lot since having HIV.
>
> Unidentified. Things mean more now, people mean more now. My friends don't understand why or how I have changed and they get frustrated when my priorities are so much different (Kohlberg, 1971).

Kohlberg (1971) further urges that because they must deal with a life-threatening illness, these students are forced to confront a number of emotional, physical, and moral issues that do not challenge other students their age. They have developed a clearer appreciation for individual rights

and responsibilities, personal standards, justice and reciprocity. With reference to Arthur Chickerings seven developmental tasks or vectors, through which students typically progress in their college years, Reisser (1995) relate that:

> The second of these developmental tasks, managing emotions, is especially challenging for college students who are diagnosed with HIV. These students must cope with a wide variety and extreme depth of emotion that the majority of college students do not face. In a period that should be filled with excitement and idealism, these students must confront issues of vulnerability and mortality. The challenge of Chickering's second vector is for the student to learn to handle emotions in a healthy and effective manner and to strike a balance between emotional repression and appropriate expression. Students living with HIV are forced to spend large amounts of energy managing emotions (p. 507).

Of course, the real challenge for these students includes attempts to cope with these highly intensive emotions in a healthy manner, often with little or no support from family, friends or university personnel (Bower & Collins, 2000). Given the increasing number of young adults diagnosed with HIV/AIDS, universities and colleges are asked to provide expanded and new services to attempt to meet the needs of individuals who join college student populations. Students with HIV/AIDS also need services available to meet their physical

and emotional health care needs (Bower & Collins, 2000). Many student development professionals pride themselves on acceptance of others and awareness of critical student issues. Many students studied by Bower & Collins (2000) perceive that student affairs staff exhibit little knowledge regarding HIV and needs of students with HIV/AIDS. It is therefore necessary that in order for universities and colleges to directly support and assist students living with HIV/AIDS, they must consider the development of specific strategies and policies which are designed to address these students' concerns. Such strategies should likely include appointments of HIV/AIDS counselor/advocates, special training for student health center personnel and HIV/AIDS education for all college/university personnel. Students surveyed in the Bower & Collins (2000) study were, by necessity, quite knowledgeable about their diseases and expected that on-campus health professionals should likewise remain current with HIV/AIDS information. To that end, professional development and continuing education seminars regarding STIs and the means by which to effectively work with HIV/AIDS clients would prove useful for health care center personnel. Seminars for faculty and staff should become part of the university's strategy to assist these special students. The seminars should also include education regarding facts of the virus, including problems associated with physical and emotional issues that accompany HIV/AIDS, as well as enhancing abilities to respond to students with HIV/AIDS. These strategies will enable institutions to address the major concerns expressed by students in this study regarding their relationship to the

university and needs for confidentiality as they seek support services (Collins & Bower, 2000).

Many studies have revealed that college students do not positively interact with HIV-positive students. They tend to discriminate and stigmatize these students. Bower & Collins (2000) also documented that while educators have tried to combat this discrimination with educational programs and services, these efforts do not appear to have significantly altered students' perceptions. Two areas of social development that are extremely important to college students include their interpersonal and sexual growth. HIV-infected students therefore cope with intense feelings of loneliness, isolation, anger, anxiety, and fear. It is further noted that while most students demonstrate considerable awareness of moral issues, it is the complexities of their illnesses which contribute to difficulties in working through their psychosocial challenges.

These trends present overwhelming challenges to colleges and universities which are contemplating, developing and initiating STI/HIV/AIDS advocacy programs. Bower & Collins (2000) note that the HIV/AIDS counsel advocate should:

> be an individual thoroughly familiar with the issues surrounding AIDS and the physical and psychological needs of HIV students and students with AIDS. To help the institute execute a well coordinated plan of action, this individual should be acquainted with state and federal law pursuant to medical and legal issues of confidentiality. The students who participated in this study were extremely distrustful of staff members and concerned that information regarding their condition be

kept confidential. Part of the institutional plan of action for which the HIV/AIDS counselor would be directly responsible could be the sponsorship of support groups for HIV/AIDS students and their significant others (e.g., roommates, friends). The availability of a safe forum for sharing concerns and feelings was very important to the students in this study (Bower & Collins, 2000, pp. 440).

Studies That Test Behavior-Change Theory

Jemmott & Jemmott (1991), tested whether a social cognitive theory (AIDS prevention intervention) would increase intentions to use condoms among 109 sexually active inner-city Black female adolescents. Indeed, the research indicated higher intentions to use condoms occurred after the intervention than before; however, increases in general AIDS knowledge and specific prevention-related beliefs were not significantly higher.

Ford & Goode (1994) studied African-American college students health behaviors and perceptions. Findings indicate that 74% of the participants were sexually active, while 24% were not. This study also indicates that sexually active students were more concerned about preventing pregnancy, rather than preventing STIs/HIV/AIDS.

Mahoney, Thombs & Ford (1995) tested the Health Belief Model using a sample of 366 college students, whose ages ranged from 18 to 24. The study examined perceived susceptibility, benefits, barriers, and self-efficacy. Results indicated that sporadic users of condoms were best distinguished from both consistent

users and non-users as measured by number of sex-partners in the past year; frequency of drunkenness during intercourse; perceived susceptibility to HIV/AIDS and other STIs; and, assertiveness (self-efficacy). Sporadic users had significantly more sex-partners; were drunk more often when engaging in intercourse; perceived themselves to be more susceptible to acquiring STIs/HIV/AIDS; and, less confident in their ability to discuss and insist on condom use with a sex-partner.

The theories on behavior change discussed earlier relate to epistemic assumptions. For example Magolda (1995) described three critical thinking processes prevalent among college students. This author stressed the importance of knowledge-of-Self and others perspectives. The latter is a central competence within Chickering's theory.

Women and the Heterosexual Risk to HIV/AIDS

Allen & Setlow (1991) report that for sexually active heterosexual persons not in a monogamous relationship, the variables associated with an increased risk of HIV infection are multiple partners and the presence of STIs. According to the CDC (1993), AIDS is fastest growing among girls and young women, primarily as a result of heterosexual activity. Worldwide, 3,000 women a day become infected and 500 women a day die of AIDS. The CDC (1993) also reports that in the United States, more than 80,000 women between the ages 15 and 44 have been infected with HIV. In 1992, the number of AIDS cases attributed to heterosexual transmission was 4,045. In 1993, the number of AIDS cases attributed to heterosexual transmission totaled 9,288. This figure represents more than a 130% increase of AIDS acquired via heterosexual behaviors.

In 1996, African-American women reported 6,750 AIDS cases; 53% or 3,620 were infected through heterosexual intercourse, and 43% or 2,910, were infected through injection drug use. Over the last decade, AIDS cases among African American women increased most dramatically within the heterosexual category. Prior to recent treatment therapies, heterosexually acquired AIDS was increasing at a rate of 15% to 30%. In 1996, this increase continued, but slowed slightly to an increase of 11%. The CDC (1998) emphasized that injection drug use and intercourse with injection drug users contribute to the heterosexual spread of the epidemic.

A similar study by Rosin (1995), revealed through interviews that there is a huge number of bisexual men who do not identify themselves as being gay; suggesting, that some African-American female students may indeed place themselves at-risk from this source.

Current STI/HIV/AIDS Trends

Shayne & Kaplan (1991) argue that women constitute the fastest growing group of people with AIDS. In addition, a disproportionate number of poor ethnic women are affected. Furthermore, education and prevention campaigns have not been directed at this population. Consequently, combating HIV/AIDS in women offers a formidable challenge to social service and public health officials because it mandates consideration of injection drug use, unwanted pregnancies, poverty, discrimination and inadequate education.

The CDC (1998) reported that AIDS remains highest among men who have sex with men. However, AIDS increased most dramatically among women, African Americans, and people infected through heterosexual intercourse. Infections through

injection drug use continue to reflect a consistently high trend. AIDS increased among both men and women through 1994. However, the incidence of AIDS dropped slightly among men, with a more dramatic drop of eight percent from 1995 to 1996. The decline of AIDS incidences in men is due to earlier declines in HIV infections among White men who have same sex relations. The CDC (1998) indicates that this declining trend among gay white men is a result of targeted prevention efforts. Among women, AIDS increased annually at a rate of eight percent. From 1995 to 1996, AIDS among women increased at a rate of one percent.

The CDC (1998) reports that AIDS increased among all races through 1994, with the most significant increase seen among African-Americans, who by 1996, accounted for more AIDS diagnosed annually than Whites. In 1995, AIDS dropped slightly among Whites -3%, with a more dramatic drop seen in 1996 -13%, as treatment and new combination therapies (e. g., protease inhibitors) began having a greater effect on longevity. Hispanics and African Americans continued to see an increase in HIV/AIDS through 1995. In 1996, Hispanics experienced a five percent decrease with HIV/AIDS. African Americans did not experience a decline; they, in fact, remained at their 1995 rate.

Hispanic women in 1996, were diagnosed with 2,210 cases of AIDS. A surprising 60% or 1,320 were infected through heterosexual intercourse; while 38% or 830 were infected through injection drug use or intercourse with an injection drug user. In fact, over the past decade, heterosexually acquired AIDS has increased from 30% to 60% for Hispanic women; while cases acquired through injection drug use dropped by 8% (CDC, 1995). The good news for Hispanic women is that they are

experiencing slower rates of infection: dropping from 15% to an increase of less than 4% in 1996. The percentage of cases among Asians and Native American Indians remains less than 1% (CDC, 1998).

The CDC (1998), says that: "young disadvantaged women, particularly African-American women, are being infected with HIV at younger ages and at higher rates than their male counter parts" (p. 2). It argues that these data provide a snapshot of the continuing toll of HIV among young people in the United States who are economically and educationally disadvantaged. The data suggest that three interrelated issues play a role in the continued health disparities between economic classes:

(1) our nation's inability to successfully deal with substance abuse,

(2) the link between substance abuse and HIV/AIDS, and

(3) the relationship of HIV to other sexually transmitted infections.

The CDC (1998), emphatically states that the same populations disproportionately impacted by HIV are also impacted by other STIs. This indicates that acquiring "gonorrhea, syphilis, and chlamydia make[s] people two to five times as likely to both spread and acquire HIV" (p. 1). Therefore, it is clear that HIV cannot be adequately addressed without also combating the epidemic of acquiring other STIs.

The greatest proportion of AIDS cases has always been among Americans ages 25 to 44. In 1996, an estimated 57, 260 Americans were diagnosed with AIDS. Almost 75% or 42,460 were people age 25 to 44; 21% or 12,260 were over the age of 44. Only 4% or 2,040 of the cases were among people age 13 to 24. The remaining cases were in children younger than 13 years of age. Between 1992 and 1996, the

number of children with perinatally acquired AIDS dropped by 43% in all racial and ethnic groups. However, the majority of perinatal AIDS cases continues to occur among African American and Hispanic children. For example, in 1992, White children with perinatally acquired AIDS reported 133 perinatal cases, compared to African-American children at 566, and Hispanic children at 195 perinatally acquired cases. In 1996, White children reported 67 AIDS cases, a -50% reduction compared to African-American children with 331 cases, a -42% reduction; and Hispanic children with 111 AIDS cases, representing a -43% reduction.

Trends in the Latin, Asian, & American Indian Communities

In 1996, Hispanic men were diagnosed with 8,680 cases of AIDS, 45% 3,880 were attributed to men who have sex with men, 38% or 3,330 were attributed injection drug use, and 10% or 880 were attributed to heterosexual intercourse. About 5% or 470 were attributed to both men who have sex with men and injection drug use. The rate of increased AIDS cases for Hispanic men was evident in all categories; however, the greatest increase +11% occurred with heterosexually acquired AIDS cases, with corresponding decreases among Hispanic cases at a decrease of -8%, and a decrease in injection drug use cases of -5% (CDC, 1998).

HIV/AIDS and African-American Higher-Education Students

A more recent study by Moore & Blake (1999) notes that there has rarely been a challenge as complex and daunting as developing campus responses to the crisis of HIV/AIDS in America, and particularly its differential impact on African Americans. According to the Centers for Disease Control, as cited in Moore & Blake (1999), it was documented that:

> of the AIDS cases reported among adults 20-24 years, 41.4% were African American. Black females made up 56% of the cases reported. ... Of the 8,461 cases reported among children less than 13 years of age through December 1998, 4,935 [or] 58% were African American. Given the long period of incubation of the disease, it is likely that some current victims of HIV/AIDS contracted the disease during the college years (p. 1).

African-American Trends in Oklahoma

According to the OSDH (1998, 1997, 1993), Blacks have the highest reported syphilis, gonorrhea, and chlamydia infection rates. In 1997, 65% of the reported syphilis cases occurred among Blacks. Reports indicate that for every one White male with syphilis, there are 35 Black males with syphilis. Similarly, for every one White female with syphilis, there are over 20 Black females with syphilis. The age group most affected was 20 to 24 year olds.

The age group 15 to 24 reported the highest rate of chlamydia. In addition, when comparing Oklahoma's AIDS cases in the 20 through 29 age group to the same age category of United States nation-wide cases, Oklahoma's AIDS cases at 23% is greater than the nationwide age of 18% (OSDH, 1997). Since 1988, the annual number of women ages 20 to 29 with heterosexually acquired AIDS has increased by 96% nationwide (DiCarlo, 1996). The age category 20 to 29 should be carefully examined because it takes at least ten years for most people to discover they are infected with HIV/AIDS (Snabes, Weinman & Smith,1994). The data therefore

suggest a link between the early exposure to STIs and the later contraction of HIV (OSDH, 1998).

The reported rate of AIDS cases among Black women is 35 per 100,000, whereas, the reported rate for Caucasian women is 7.5 per 100,000. This indicates a rate that is four-to-five times greater for Black women. The state's leading health authority confirms 40% of the AIDS cases among Black women are attributed to heterosexual transmission, while the remaining 60% is among White heterosexual women. AIDS is the second leading cause of death for Black females age 25 to 34 (OSDH, 1997).

Even though death rates have decreased between 1994 and 1996, AIDS remained the leading cause of death for all males age 25 to 44. While male-to-male sexual contact accounts for 62% of the HIV cases in Oklahoma, 4% of the cases were attributed to heterosexual contact from 1996 through 1997.

Heterosexual injection drug use accounted for 13% of HIV exposure, while injection drug use among men who have sex with men (MSM) account for 9% of HIV cases. Without a doubt, many more Whites have contracted HIV/AIDS than any other racial or ethnic group. Nevertheless, Blacks have experienced the greatest incidences of infection which is 2 to 2-1/2 times greater than that of any other race or ethnicity (OSDH, 1998).

In 1999, more African Americans were reported with AIDS than any other racial or ethnic group. A total of 21,900 cases were reported among African Americans, representing nearly half or 47% of the 46,400 AIDS cases reported that year. Almost two-thirds or 63% of all women reported with AIDS were African

Americans. African-American children also represented almost two-thirds or 65% of all reported pediatric AIDS cases.

In 2000, The CDC reported that among African-American men with AIDS, injection drug use accounted for 34% of the AIDS cases which is the second most common exposure. Men who have sex with men represent the largest proportion of 37%. Thus, proportionately, the Black population is most affected. Heterosexual exposure among African-American men accounted for eight percent of the total cases AIDS cases. Finally, among African-American women, injection drug use accounts for 42% of all the AIDS cases; while a staggering 38% of the cases of AIDS among Black women were due to heterosexual contact.

Again, while race and ethnicity are not risk factors for HIV transmission; they are important indicators for intricate political, social, economic, and cultural issues. These reports clearly emphasize that the majority of these women were infected as adolescents or young adults. Therefore, prevention programs for adolescents and college-age students must be a priority.

Sexual Activity Among College Students

Studies of college students conducted between 1973 and 1988 report that 75% to 80% of males and 60% to 70% of females engage in sexual intercourse. Reinisch, et al., (1992) report that one-fifth of 477 sexually experienced women and men said they had had heterosexual anal intercourse. A study of United States high-school students found that 48% of females and 61% of males have had sexual intercourse by the time they reach college age.

McGuire, Shega, Nicholls, Deese, & Landefeld (1992) surveyed 158 college freshmen on an urban campus to determine their sexual practices, knowledge and attitudes about HIV/AIDS. Among the 77 sexually active students, many engaged in activities that transmit HIV: 58% did not use a condom with a new partner; 31% had two or more partners; 8% engaged in anonymous sex and 14% of the sexually active women had anal sex. These findings underscore the need for prevention programs that lessen the gap between knowledge and safer-sexual behavior.

According to Gray & Saracino (1989), approximately 80% of college students are sexually active. Among those who are sexually active, approximately 50% reported having at least two sexual partners in the past year. In addition, research shows that 66% of sexually active students do not use condoms. DiClemente, Forrest & Mickle (1990) indicated that a large proportion of students never used condoms during sexual intercourse. The respondents also admitted having multiple partners in the previous year. Jacobs (1993) reports that television and friends are shown to be the primary AIDS education/communication sources for college students. Uwakwe, Mansaray & Onwu (1994) sought to identify the factors that place female Nigerian university women at risk. Although the results indicated a significant number of female students are sexually active, misconceptions about disease transmission persist. Another study revealed that neither fear nor knowledge about STIs/HIV/AIDS influenced students decisions to abstain from sex (MacDonald, Wells, Fisher, Warren, King, Doherty, & Bowie, 1990). Feigenbaum, Weinstin & Rosen (1995) acknowledge that 25% of college men and 20% of college women

reported having six or more partners; 85% of men and women had experienced oral sex; while 22% experienced anal sex.

According to Wiley, et al., (1996), among Texas college students 81% reported that they had sexual intercourse at least once, and 1/4 of the sexually active men had more than 10 partners. As many as 36% of men and 21% of women at a midwestern university reported being sexually unfaithful to their partner. Indeed, 3/4 of men and 1/3 women never did ask partners about past sexual experiences. Men admitted that they lied to sexual partners more than women (Stebelton & Rothenberger, 1993). Binson, Dolcini, Pollack & Cantania (1993), warn that heterosexual men, age 18 to 25 are more than twice as likely as women of the same age group to have multiple partners. Additionally, if heterosexual men, age 18 to 25 are unmarried, they are eight more times as likely to have multiple partners. Consequently, if one is between 18 and 30 years old, sexually active with multiple partners; and not inclined to use condoms or other barrier protection forms, then one is at high-risk for sexually transmitted infections (STIs), including HIV/AIDS. According to NASPA (1998), the number of women with AIDS in the United States increased by 63% from 1991 to 1995. This report emphasized colleges and universities will find themselves faced with students, faculty, and staff who are both infected and affected by this disease because of improved healthcare and new treatment therapies, which now permit people to live longer and better lives.

Ishii-Kuntz, et al., (1990) conducted interviews with heterosexual college students which revealed that the most popular risk-avoidance method involved two presumptions: First, individuals usually choose a partner from within their own

social network; and therefore, presumed themselves to be safe. A second presumption is that infected people are somehow distinguishable from uninfected people and can therefore be recognized and avoided as sexual partners. Another factor contributing to college students' decision(s) to engage in high-risk sexual behavior is trust. Consequently, when partners indicate that they trust each other and believe they are in a monogamous relationship, they are less likely to use risk-avoidance precautions. Lifson, O'Malley, Hessol, Buchbinder, Cannon, & Rutherford (1990), state emphatically that: "all sexually active persons should be clearly counseled that receptive oral sex especially with ejaculation carries the potential for HIV transmission" (p. 15).

Factors Associated with High-Risk Behaviors

According to the NASPA (1998), alcohol is the most common drug of choice for college students. The use of alcohol and other drugs can affect judgment and lead to serious risky sexual behaviors that include unintended intercourse and date rape. Alcohol and other drugs contribute to accidents, motor vehicle crashes, personal injuries, and suicide attempts. Alcohol can also weaken the immune system, thereby increasing the susceptibility to infection and diseases (NASPA, 1998, p. 2). NASPA's (1998) report also refers to a 1995 National College Risk Behavior Survey (NCRBS) which monitored health risk behaviors among United States college and university undergraduates. Survey respondents reported that 30 days prior to the survey: 34% of the respondents had consumed five or more alcoholic drinks on at least one occasion; 27% consumed alcohol and then drove a car; 49% had smoked marijuana; 70% had not used a condom during their last sexual intercourse; 46% of

the students reported having been taught about HIV in classes; 58% reported having received HIV/AIDS prevention information; and one in five 18-to-24 year olds, reported alcohol or other drug use, at the time of last intercourse.

Alcohol Use and Other Drugs

There is a relationship between alcohol use and high-risk sexual behaviors. Kerr (1998) recently reviewed studies conducted from 1990 to 1995. This research indicates that alcohol is commonly used in conjunction with sexual activity. Kerr (1998) emphasizes that STI/HIV/AIDS educators shall need to address alcohol as a possible gateway to infection. The author explains that these gateway properties include dis-inhibition and impaired judgement. Kerr (1998) recognizes that educators must begin to discuss the strong relationship that exists between drinking alcohol and resulting high-risk sexual behaviors that may occur (Sherry, 1998). Next, Fisher & Misovich (1990) indicated that 29% of sexually active males and 32% of sexually active females reported more than half of their sexual activity was associated with alcohol use. The use of alcohol correlates with an increase in the numbers of casual intercourse partners, as well as the total number of partners a student has over a lifetime.

Freimuth, et al., (1992) studied 204 college students in a large Eastern university and found that 42% of respondents reported that during their sexual liaisons they, and their partners, were using alcohol or drugs. Carroll & Carroll (1995) recount that at a predominately White-Midwestern university, only 8% of men reported participation in sexual intercourse during 1994; compared to 79% of females during that same time period. Further, 25% of men and 16% of women had sex with

a casual acquaintance; while 16% of men and 10% of women reported drinking alcohol before having sex with a casual acquaintance. Patrick, Colvin, Fullop, Calfas, & Sherry, (1998) stated that out of 3,810 California students, 22% said they used alcohol or drugs before the last time they had sexual intercourse.

The Binge Drinking Effect

There is definitely a relationship between condom use and alcohol use. Butcher, et al., (1991) reported that 47% of men and 57% of women said that while they were drunk, they engaged in sexual intercourse from one-to-five times. The authors indicate that this is a phenomenon that increases with age. Meilman, Burwell, Smith, Canterbury, Gressard, & Turco (1993) also studied high-risk behaviors of college students. This research indicates that the connection between alcohol and sexual intercourse is most pronounced in students who report binge or high levels of drinking. Meilman, et al. (1993) indicated that these groups were more likely to report previously unplanned, alcohol-induced, unprotected sex. The survey revealed that 35% of students had some form of sexual contact; while 18% said they had penetrative intercourse. In fact, 15% reported they disregarded all safer-sex practices because of drinking alcohol. The NASPA (1998) refers to another study by Meilman & Haygood-Jackson (1996) which examined a state university in their Middle Atlantic region. "Close to one-third of all victims of sexual assault had been incapacitated during the attack because of alcohol consumption" (p. 6). The report emphasizes that alcohol can hinder a person from escaping a sexual attack.

Anderson & Mathieu (1996) also collected survey data from 1,902 college students on twelve different campuses. Their report indicates: 32% of men and 17%

of women would drink more than normal; evidently—in order that they could allow themselves to engage in sexual intercourse. Piombo & Piles (1996) studied the influence of alcohol on sexual practices at a large public, mid-western university. This research found that 70% of female binge drinkers reported having sexual contact while under the influence of alcohol or other drugs. In contrast, only 37% of non-binge drinking females reported sexual contact while under the influence of alcohol or other drugs. The authors also report that 48% of these female binge drinkers had unprotected intercourse compared to only 24% of non-binge drinking females who reported unprotected intercourse. Hingson, Strumin, Berlin, & Heeren (1990) report that 16 to 19 year-old heavy drinkers were almost three times less likely to use condoms than were light drinkers. On the contrary, a 1994 study found that students who rarely used condoms reported that they had more sexual partners than students who indicated they usually practiced safer-sex with condoms, in spite of these risky behaviors (e.g. multiple partners, inconsistent condom use, and use of alcohol with sex). The NCPADA (1994) argues that students appear to exhibit personal concern about HIV/AIDS. For example, 32% of 18 to 24 year olds and 50% of those students over age 25 reported they had been tested for the virus that causes AIDS.

Cited in Sherry (1998), Wechsler, Dowdall, Maenner, Gledhill-Hoyt, & Lee (1995) found that 50% of students binge drink; and that 26% of female students had been confronted with unwanted alcohol-related sexual advances. A 1998 Harvard-based study also by Wechsler, et al., reported that 42%, or two out of five students, were binge drinkers; and 20%, or one out of five, were frequent binge drinkers. The NCPADA (1994) reported that Black students (over 25 years old) were more likely

than White or Hispanic students to be sexually active; while female students were significantly more likely than male students to have participated in sexual intercourse.

Alcohol Use and Adolescence

A report from the National Institutes of Health (NIH) indicates that the number of people with STIs is increasing, in part, because many Americans have sex at an early age, with multiple partners, and without barrier protection (Walker, 1989). According to the CDC (1995), adolescents and young adults are at higher risk for STIs because they are more likely to have multiple partners and more likely to engage in unprotected sex. According to the CDC (1995e), the American College Health Association (ACHA) estimates that 1 in 500 college students is infected with HIV/AIDS. Two studies conducted between 1988 and 1991 found the incidence of HIV infection on participating campuses to be about .2%. The CDC estimates that 1 in 250 Americans, of all age groups including college students, is infected with HIV/AIDS. Sheer & Cline (1994) refer to a Florida study which claims HIV infection among male college students to be 1 in 200. Alcohol and other drug use, lack of maturity and peer pressures are factors that may influence college students to have unprotected sex (NCPADA, 1994). Hence, abandoning safer sex techniques (e.g., failing to use condoms correctly and consistently) can lead to possible infection with HIV/AIDS or other STIs. Also, date rape on many college campuses is associated with alcohol use and may likewise increase the possibility of contracting infectious diseases.

The NCPADA (1994) suggested there may exist a critical relationship between alcohol abuse and increased likelihood of high-risk behavior. The NCPADA

(1994) also points to a number of studies implying a lethal link between alcohol and other drug use, thereby: (1) increasing the likelihood of unplanned intercourse, (2) decreasing the likelihood of condom use, and (3) increasing the likelihood of multiple partners. The NCPADA (1994) further suggests that to understand the powerful implications of this new area of research, a better understanding of alcohol use and sexual behaviors of adolescents and young adults is essential. In a study examining alcohol use and risky sex among college students, data indicated that both genders drank heavily and engaged in risky sexual behaviors. The majority of men and a large number of women did not believe that they could become infected as a result of their sexual behavior (Carroll & Carroll, 1995). Johnson, O'Malley, & Bachman (1989) stated that approximately 80% percent of college students are current drinkers, and 47% reported drinking to intoxication (defined as five or more drinks in a row).

The Role of STIs in HIV/AIDS Contraction

An important indicator for HIV/AIDS is the presence of other STIs. In the United States, the NIH (1989) reports for every seven cases of syphilis there is one case of AIDS, and for every ten cases of gonorrhea there is one case of AIDS. The NIH (1989) also reported that for every 100 cases of chlamydia, one case of HIV/AIDS is certain (Walker, 1989). Gonorrhea rates among Black adolescents 15 to 19 years of age are 26 times greater than for White adolescents. Similarly, the rate of syphilis among Blacks is nearly 60 times that for Whites (CDC, 1996). Louise White, Director of the Leadership in Health Policy Promotion and Prevention Program with the National Association for Equal Opportunity in Higher Education, refers to this phenomenon as the hidden epidemic (personal communication, 1997).

NASPA (1998) points to a recent report released from the Institute of Medicine, entitled: The Hidden Epidemic: Confronting Sexually Transmitted Diseases, which describes sexually transmitted infections as hidden epidemics with enormous health and economic concerns. The report explains that STIs are hidden from public view because many Americans are afraid to openly address sexual health issues.

In other words, understanding the risk level for HIV/AIDS among college students requires examining their rates of STIs. According to the CDC (1996), young adults ages 20 to 24 are at higher risk for acquiring STIs for a number of reasons: they may be more likely to have multiple partners and are more likely to engage in unprotected sexual intercourse. As a result, the consequences of STIs have begun to emerge on college campuses across the country. For example, eight million people under the age of 25 have contracted an STI. In fact, one young person contracts an STI such as chlamydia, gonorrhea, or condyloma (genital warts), every 30 seconds (Gayle, et al., 1990). Without a doubt, the proportion of young women who are sexually active increases with age. In 1993, 31% of ninth grade women had experienced sexual intercourse. The rate rose to 44% in the tenth grade, 55% in the eleventh grade, and 66% in the twelfth grade. In fact, three million sexually active teens or 25% become infected with an STI every year. Women are more likely to be infected than men. In a single act of unprotected intercourse with an infected partner, a woman has a 1% risk of acquiring HIV, a 30% risk of getting herpes, and a 50% chance of contracting gonorrhea (Girls Inc., 1996). In addition, there has been an increase of 17% in HIV/AIDS cases attributable to heterosexual transmission from

1995 to1996. Finally, 86% of all STIs occur among persons 15 to 29 years old (CDC, 1995).

Multiple Partners and High-Risk Behavior

Peterson, et al., (1993) collected data on the prevalence of multiple partners among 2,166 of Blacks living in cities with a high prevalence of HIV/AIDS cases. The data revealed 19% reported having had two or more partners in 1989, the year immediately preceding the survey. More men than women and more single than married adults reported that they had multiple sexual partners. The authors indicate that respondents were more likely to protect themselves with the second partner as compared to the main partner. This report emphasizes that Blacks were more likely than Whites or Hispanics to report having had multiple partners. In fact, higher proportions of Blacks than Whites reported unprotected sex with multiple partners. In addition, Black heterosexual men and women are ten times more likely to be diagnosed with AIDS than are White men and women" (p. 263).

In 1995, Feigenbaum, et al., studied a large northeastern university with 1,825 respondents. They found: 25% of sexually active men and 20% of women had six or more sexual partners; and 22% reported having had anal sex which is high-risk behavior known to increase the risk for HIV/AIDS. In 1997, Patrick, et al. reported that 21% of male and 16% of female California students admitted to having ten or more sexual partners in their lifetime.

In a 1996 survey of New Jersey Youth Risk Behavior, researchers found that almost one in five sexually active youth age 18 and younger had more than five partners. Additionally, 14% of the men and 11% of the women had two or more

sexual partners within the last three months. Stebleton & Rothenberger (1993) conducted a study at a large mid-western university. The survey revealed 36% of men and 21% of women reported being sexually unfaithful to their current partner. A higher percentage of women than men inquired about their partners sexual history before engaging in sexual activity. A higher percentage of men than women reported they lied to their partner or partners about previous sexual experiences (Sherry, 1998).

There continues to be significant increases in the proportion of adolescents who have engaged in sexual intercourse. One such study revealed 48% of females and 61% of male high school students reported having engaged in sexual activity before graduation (Reinisch, et al., 1992). Nationwide, more than half of all high school students 53% reported having had sexual intercourse. According to the Youth Risk Behavior Survey (YRBS), sponsored by the United States Department of Health and Human Services (1995), 56% of males and 50% of females have had sexual intercourse prior to high school graduation. The report stated that 22% of males and 14% of females have had four or more sexual partners by the time they graduate from high school. Using data from the YRBS (1995), researchers at the CDC found approximately 25% of adolescents reported alcohol use during their last intercourse experience, and 5% indicated use of both alcohol and other drugs. Furthermore, close to 22% reported no contraceptive use, or were unsure whether contraception, if any, was used.

Reinisch, et al., (1992) confirm in general, that age at first sexual intercourse and number of partners are positively correlated with the risks of sexually transmitted infections (STIs). In addition, syphilis and chlamydia may also enhance the

transmission of AIDS. According to Walker (1989), sex with multiple partners occurs most among young people 15 and 30 years of age. Therefore, young adults and college students are at high-risk for STIs/HIV/AIDS.

Feigenbaum, et al., (1995) acknowledge that 25% of college men and 20% of college women reported having 6 or more partners; 85% of men and women had experienced oral sex; while 22% had experienced anal sex.

Condom Use and Number of Partners

Johnson, et al., (1992) studied the sexual behaviors of Black male college students. They confirmed that only 40% consistently used condoms; while 20% reported having had a sexually transmitted infection (STI). Their research concluded that consistent condom use reduced the risk of an STI by 9%. Nevertheless, out of a sample of 82 students at the University of Missouri, 51% never used condoms and only 17% used condoms consistently (Simkins, 1994).

Choi, et al. (1993), describe condom-related beliefs and their demographic correlates among United States heterosexual adults age 18-49. This research concluded that promotion for condom use must: (1) counter feelings of distrust by portraying condom use as a caring and responsible behavior for men and ethnicities; (2) use mail-order and door-to-door condom sales persons to reach more women; (3) distribute printed instructions illustrating correct condom use to single, high-school dropouts and members of ethinic groups; and (4) eroticize condom use for men and high-school dropouts.

Caron, Davis & Halterman (1993) conducted a sexual opinion survey using a random sample of first-year students at the University of Maine in order to predict

condom-related behavior. The sample consisted of 330 respondents with a median age of 18; 60% were women, and 77% reported being from a rural community. Overall, 86% had engaged in sexual intercourse, and 34% reported two or more new sexual partners since arriving at college. In one study by (Keller, 1993), 60% of students reported their reasons for taking risks were that the intercourse was unplanned or spontaneous and 50% said that they just knew their partner was not infected with HIV. Sawyer & Moss (1993a) stated that many male students believe that if they have been with a partner for a month or two they can cease using condoms. In a related study, Mickler (1993) found that 80 heterosexual college students perceived their risk for contracting HIV as very low. They likewise believed they were relatively less susceptible to HIV infection than other populations.

Kline & Kline (1992) conducted sixteen focus groups with 134 Black and Hispanic women. Their purpose was to study the effects of health education and the promotion safer sexual practices on decision-making among disadvantaged females. The authors suggest that women retain substantial power to protect themselves if they perceived themselves to be at risk.

Fisher & Misovich (1990) examined 166 students from the University of Connecticut. This study found that 46% of men and 53% of women were sexually active. Further 28% of men and 15% of women were not in sexually exclusive relationships. The study revealed 64% reported unprotected sex while 6% reported anal sex without a condom.

Reinisch, et. al. (1995) found that on average, four years elapsed since the respondents had their first vaginal intercourse. Males reported an average of eight

lifetime vaginal-sex partners and females reported an average of six partners. These numbers indicate rates of at least one or two partners per year. However, more Black students reported using condoms consistently. Butcher, et al., (1991) found that while 87% of students believed that condoms are effective in preventing HIV transmission, only 15% reported using condoms during every sexual encounter.

Freimuth, et al., (1992) also found that while 32% of respondents had ten or more partners in their lifetime, 18% of respondents had five or more partners in the last year. Further, 56% of students did not use a condom during their most recent episode of intercourse. Almost one-third reported using other forms of birth control and assumed a condom was unnecessary. In a multi-site, cross-sectional survey, DiClemente et al., (1990), found that in the past year, 37% of students reporting sexual behaviors never used condoms. Two-thirds of students reporting sexual behaviors used condoms less than half the time. Only 8% of students reporting sexual behaviors used condoms every time. Wiley, et al., (1996) revealed that of 1,148 students from a Texas university who were sexually active, 41% had not used a condom during their last sexual contact. A study of college undergraduates at a northwestern university found that almost half of the sexually active students rarely or never used a condom. Researchers also found that the majority of students were more comfortable discussing contraception than they were in discussing their partner's sexual health and sexual behaviors prior to their relationship (Sherry, 1998).

According to NASPA (1998), a lack of communication regarding sexual behaviors increases the risk of acquiring STIs. Pregnancy prevention is perceived as a greater concern for college students as exemplified by students, discussing

contraception with their partners, rather than discussing their partner's sexual-history. Moreover, college students do not talk about previous sexual partners with their current partner. These behaviors place students at high-risk for sexually transmitted infections. Therefore, college students need more than information. They need to develop communication, decision-making and negotiation skills as well as the ability to recognize and manage high-risk situations.

In addition, NASPA (1998) emphasizes that behaviors that are considered to be the norm for many American college students, are the exact behaviors that place them at high-risk for STIs, unwanted pregnancies and other alcohol- related problems. The report challenges leaders in higher education, student affairs and other academic professionals, to cooperatively provide students with the necessary skills to make responsible and healthy decisions that will decrease high-risk sexual behaviors.

Attitudes and Behavioral Change through Intervention

Flaskerud & Nyamathi (1990), tested the effects of an AIDS education program on the knowledge, attitudes and practices of low-income Black and Latina women. The analysis revealed that the best predictors of knowledge, attitudes and practices were racial/ethnic group, education, and religion. They concluded that a comprehensive audio visual program can positively affect the knowledge and practices of participants; and, that these are retained over time, but that changes in attitudes will take further efforts. Cordova & Norwood (1991) targeted inner city Latina women for training as peer educators in AIDS prevention work. They concluded that a culturally-based program directed at self-empowerment and self-esteem would be a powerful tool if placed in the hands of at-risk women.

DiClemente, et al., (1990), reported that the level of AIDS knowledge was not significantly associated with students HIV preventive behavioral changes, which confirms that knowledge alone does not change behavior.

In their study of 341 students who attended educational intervention programs at the University of South Carolina; Turner, Korpita, Mohn, & Hill (1993) reported: intervention male students increased sexual abstinence; but no change in consistent condom use. Further, intervention female students reported no change in abstinence. The same group reported an increase in consistent condom use. Women who had not received the intervention more frequently reported never using a condom than did women who had received the behavioral change intervention.

Simkins (1995) examined the extent to which infidelity and deceitful interactions with sex partners are characteristic of college students at a mid-western university. Out of 192 students, 37 females and 55 males.182 reported being heterosexual, 8 reported being homosexual, and 2 reported being bisexual. Although no respondents indicated they would lie to their partners about being HIV positive, a few would not tell their partners unless specifically asked. A small percentage indicated that they would have extra relations without informing their steady partner. A small number reported that they might continue to engage in sexual relations even if there was knowledge of HIV infection. The predominant risks reported for this student sample were: the practice of unprotected sex, having multiple partners, and consuming alcohol in conjunction with sexual activity.

The UJIMA project, at Syracuse University, demonstrates that educators can enhance the self-esteem of Black students by providing them with a positive and

affirming space in which to feel safe and receive on-going support for sustaining risk-reducing behavior. More specifically, Syracuse University Health Services trained Black student leaders as Peer Educators to reach other Black students in a traditional workshop setting and also in informal, one-to-one sessions as a means by which to reduce students risk of HIV infection (McLean, 1994).

Willcutts, Fisher, & Misovich (1998) describe their AIDS Risk Reduction for College Students Program as a workshop consisting of three two-hour sessions incorporating information, motivation, and behavioral change strategies for AIDS risk reduction. The information component includes AIDS 101: "a slide show that explains the transmission and prevention of HIV, testing for the virus, and a discussion of the importance of condoms for protection against HIV/AIDS among those who are sexually active. The motivation component is addressed through small-group discussions led by a peer health educator. A video is also shown narrated by a person who contracted HIV through unsafe heterosexual intercourse. Finally, behavioral change and development skills are encouraged through role plays of safer-sex communication. In a field study of the program with 744 college students, participants showed significant gains in knowledge, motivation, and behavior. In particular, sexually active participants were more likely than similar in a control group to purchase and use condoms during a two-to-four-month period following the intervention.

The Center for HIV Intervention and Prevention at the University of Connecticut conducted an AIDS-risk behavior change study from 1989 to 1995. The study targeted heterosexual students who reported high-risk sexual behavior. The

intervention and prevention model, created by Fisher (1989), developed conceptual and methodological data that were empirically tested and repeatedly confirmed (in multiple and diverse student populations) who were at-risk for HIV. The model was applied in intervention and evaluation research, that promoted significant and sustained increases in critical HIV prevention behaviors, including increases in condom use for sexual intercourse and increases in HIV antibody testing.

Johnson, et al., (1994) recommend several ways of addressing specific deficits about the transmission of HIV/AIDS: consistent and correct use of condoms for oral, anal and/or vaginal sex; provide prevention counseling for drug abuse regarding its relationship to negotiating safer-sex; and motivating individuals to reduce and eliminate risky sexual practices such as unprotected sex and sex with multiple partners. The researchers iterate that specific programs should be designed for African-American college students. These interventions should consider the diversity of their behaviors, beliefs, and attitudes. Johnson, et al., (1994), also recommend that specific programs should be designed for African-American college women and these programs must consider the diversity of their behavior, beliefs, and attitudes.

Moore & Blake (1999) reference a 1997 study of African American beliefs regarding HIV/AIDS which found that 26% of respondents agreed that: HIV/AIDS is a man-made virus that the federal government made to kill and wipe out Black people. There were an additional 23% who were undecided regarding the statement's proposed validity. Men who participated in the study were 3.5 times more likely to agree with the conspiracy than their female counterpart. Those who agreed with the idea of the HIV/AIDS conspiracy tended to be culturally traditional,

college-aged Black men who had experienced considerable racial discrimination (Klonoff & Landrine, 1999).

Knowledge of Transmission and Educational Programs

Other pertinent literature reviewed were monographs and reports from national agencies and associations. Harvard University and the CDC (1995) sponsored a conference in 1995, to present a national charge for health care among college students. The participants emphasized the need to build the capacity of post-secondary institutions to implement comprehensive integrated strategies to prevent HIV infection as part of institution-wide health promotion and disease prevention programs for post-secondary students. Similarly, Rutgers University hosted an HIV/AIDS & Higher Education Leadership Forum in 1995. Their recommendations centered around five areas:

(1) ways to make HIV/AIDS prevention more effective.

(2) discovering the links between campus health and the health of the community,

(3) preparing a workforce to be able to manage HIV/AIDS issues,

(4) increasing student involvement in HIV/AIDS education efforts, and

(5) increasing institutional support for HIV/AIDS education.

The Office of National AIDS Policy (ONAP, 1996) issued a report to President Bill Clinton which, in brief, stated that: "additional studies are needed to understand youth and their behaviors" (p. i1). Keeling (1996) provided extensive leadership for HIV/AIDS education in several special reports. In the report, HIV & Higher Education: From Isolation to Engagement, Keeling (1996) describes three

components to an integrated liberal approach for addressing HIV in higher education. They are: politics, experience, and process. Politics refers to fundamental questions of democracy and citizenship and, therefore, to privilege, equity, relationships, and class. The second, experience, is the direct work of reconnecting living and learning through formal and informal partnerships that integrate students and teachers lives. Third, the process of liberal education exploration, analysis, investigation, synthesis, and solutions. In other words, teaching HIV prevention can accomplish teaching biology, epidemiology, geography, and sociology. During the process in which learning relationships are open, and outcomes are felt (where the investment is placed by finding ways to respond to the challenges of HIV) centers us in the mission of higher education (Keeling, 1996).

NASPA's Health Education Leadership Program (H.E.L.P.) funded by the CDC (1997), gathered information by way of focus group discussions with student affairs leaders regarding the status of HIV/AIDS prevention. In brief, they found that:

(a) HIV is not perceived as a hot issue on campus;

(b) students appear apathetic because they have heard about HIV/AIDS for years;

(c) gay and lesbian student groups show more interest in HIV/AIDS prevention;

(d) students have not changed their behavior because HIV is seen as an abstraction;

(e) student STI testing has increased as a way to declare license to have unprotected sex;

(f) some students are on information overload; and

(g) students are aware of HIV but do not feel it applies to them.

The report, states that HIV/AIDS is still seen as a disease of the other person. In addition, HIV is not perceived to be a heterosexual disease. Some administrators admitted that they do not perceive AIDS as a college problem. Other administrators have concern that if they admit there is a problem with HIV/AIDS on campus, then they must do something about the problem, thus, creating other political and moral questions that only add to the already loaded agenda faced by student affairs personnel (Sherry, 1998).

Keeling (1998) reports that current trends on college campuses toward HIV/AIDS prevention include: expanding HIV/AIDS education from being a health center activity to a priority activity for other departments such as counseling, co-curriculum committees, and residence life. The report concludes that on some campuses HIV information is included in on-campus seminars or educational programs that emphasize the prevention of high-risk sexual behavior; or relationship and decision-making skills, as well as information on the effect of alcohol use. Some colleges are using new ways to reach students from condom awareness weeks to sexual jeopardy games. The NASPA (1998) says that one of the most effective efforts has been to involve people living with HIV/AIDS as speakers. The AIDS quilt has been used to create a powerful experience, as well as a silent reminder for students on many campuses. Another tool for HIV education and prevention is the

Peer Educator, which has proven to be one of the most popular types of college prevention programs. Many programs focus on freshman orientation or freshman seminar classes as a means to educate students on HIV/AIDS transmission and prevention. Service Learning is another growing area for HIV prevention and education; as students reinforce and utilize what they have learned on campus to provide a service to surrounding communities.

In 1997, NASPA's H.E.L.P. Project surveyed its member organizations in order to identify successful HIV prevention education programs and the factors that contribute to program success, such as integration into campus life, institutional support and effect on student behavior. The NASPA member organizations nominated various types of health education programs from one-day events to full-scale, comprehensive HIV programming. Almost half of all nominations mentioned peer education or peer-led initiatives. Other components of comprehensive programming included:

> utilizing the AIDS quilt to increase awareness; holding candlelight vigils; sponsoring condom awareness weeks; developing collaboration with community agencies; enhancing campus leadership by developing AIDS task forces and campus policy committees with interdepartmental participation; curriculum infusion in traditional and nontraditional courses; merging HIV with other health related topics such as rape, alcohol, and relationships; HIV testing and counseling; [and] residential life programs and skill-building exercises (p. 8).

The NASPA members selected eight institutional programs for further study. They were: Broward Community College; Creighton Universitys North Carolina School of the Arts; Stanford University; Syracuse University; University of Massachusetts-Amherst; Western Michigan University; and, Western Washington University. In 1998, the NASPA utilized criteria that was developed through a review of the current literature in order to identify the most successful of these programs. The best programs consisted of: a conceptual basis that relates to the particular student population; clearly stated goals that address risks, behaviors, and skill-building; sustained operation over time; comprehensive concepts that educate about HIV in context of other health related risks; outreach to special groups of students; student involvement in educating others; and, program evaluation on a regular basis; receiving support from institutional funds; and consistency of program and institutional value.

Reisser (1995) emphatically states that African-American student social development is not sufficiently illustrated by theories based on White students. Gender differences are satisfactorily analyzed based on theories regarding male students.

A variety of other educational institutions have adopted HIV/AIDS guidelines, policies, or procedures that are clearly aimed at reducing their students' and employees' risks of infection as well as the school's legal liability. Reid State Technical College (1998) emphasizes that administrators will make decisions regarding HIV/AIDs on a case-by-case assesment. According to Gillum (1998) the University of Nevada, Las Vegas, believes the most important goals for colleges and

universities are to increase awareness and to provide education to prevent further spread of infection. In addition, the City College of San Francisco's Health Science Department has had a HIV prevention program since 1991, called Project SAFE (Sexuality, AIDS, Facts, & Education). The training and activities of peer educators are the central focus of campus and community efforts. The university's approach stresses academic studies and service learning. The University emphasizes that they accept students who are entering a career in HIV/STI prevention and individuals currently working in the field. Financial assistance is available to students who qualify. The program consists of classes and related activities which integrate academic preparation with extensive campus and community service learning (Taylor, 1998).

Again, the above examples of institutional policy illustrate how universities are formally addressing the issue of HIV/AIDS on campuses. More importantly, this demonstrates how some universities are preparing themselves in the event that HIV/AIDS cases begin to occur more frequently in campus populations.

Summary

College students who interact among their peers engage in experiencing newfound freedoms, socialization choices and lifestyle exploration. Many adolescent and young adults are often for the first-time confronted with behavioral and situational dilemmas which place them at risk for acquiring HIV/AIDS and other STIs. Surveys among college students from ethnic/racial backgrounds including and not limited to African Americans, Latinos, Asians, Caucasian and American Indians reveal different rates of acquiring STIs through engaging in unprotected sexual

relations. Only 20% of college students are not sexually active. Two-thirds of the 80% who are sexually active do not use condoms. One-half of sexually-active college students have had more than one sexual partner in the last year (Gray & Saracino, 1989). Other factors associated with high-risk behaviors in acquiring STIs include the abuse of alcohol and drugs which may cloud the judgment of college students who encounter vulnerable situations. Piombo & Piles (1996) reported that 70% of female binge drinkers engaged in sexual activities while under the influence of alcohol and other drugs.

Unprotected sexual activity with multiple partners creates extremely high-risks of contracting sexually transmitted infections. Within the last decade AIDS cases among heterosexual African-American women increased most dramatically. Shayne & Kaplan (1991) report that women constitute the fastest growing group (in Oklahoma) of people with AIDS.

Based on the literature reviewed here, AIDS and other STIs are continuing among young people who are economically and educationally disadvantaged. This ignorance is a likely factor that contributes to the epidemic of AIDS and other STIs among all college students. The reviewed literature points to the increased incidences of STIs among college students and strongly suggests that these issues must be addressed by means of public health education. It has been reiterated in the literature of this topic that universities must better meet the educational challenges to adequately address personal responsibility and behavioral modifications to reduce the rates of STIs.

CHAPTER 3

METHODOLOGY

Phenomenology Theory

This study is perspective-seeking research and will be guided by the naturalistic inquiry methodology described in Guba & Lincoln (1985). Lagenbach, Vaughn & Aagaard, (1994) describe this as phenomenology, which is descriptive and interpretive research that studies the human experience. [T]he feature that distinguishes phenomenology from other qualitative research approaches is that the subjective experience is at the center of the inquiry (p. 145). Ross (1998) says phenomenology integrates relevant historical and cultural information in order to give a foundation for understanding the phenomena. Phenomenology is likewise rooted in Tesch's (1998) qualitative tradition, which according to Gall, Borg & Gall, (1996) is an interpretational analysis used to process the close examination of case study data in order to discover constructs, themes, and patterns that can be used to describe the essential issues that serve to shape and/or influence participant's attitudes, motivations and life-circumstances that may contribute to high-risk behavior such as unprotected sexual intercourse with one or more partners.

According to Moustakes (1994), phenomenology is knowledge as it appears to the participant's consciousness, the science describing what one perceives, senses, and knows in ones immediate awareness and experience. Indeed phenomenology is a reasoned inquiry which discovers the inherent essences of appearances. Stewart & Mickunas (1994) explain that an appearance is anything of which one is conscious. In other words, anything that appears to the consciousness is a legitimate area of

philosophical investigation. Gall, et al., (1996) refer to van Kaam (1966) who stated that phenomenological research is experiential and qualitative. Therefore, it can set the stage for empirical investigations by creating less risk for choosing inappropriate methods or categories. This type of exploration complements traditional research methods. To be sure, phenomenological research studies how reality appears to the participant (subjective), rather than the traditional (objective) nature of reality.

Patton (1990) notes that German philosopher Edmond Husserl (1859-1938) discovered phenomenology as a philosophical tradition that developed into a rigorous scientific method that is meant to study how people describe things and experience them through their senses. Husserl's most basic philosophical assumption was that we can only know what we experience by attending to perceptions and meanings that awaken our conscious awareness.

Patton (1990) also describes the phenomenological process as the unique human capacity to make sense of the world. The author writes that the term phenomenology has become so widely used that its meaning has become confused. Sometimes phenomenology is viewed as a paradigm, philosophy or perspective. It is sometimes perceived as synonymous with qualitative methods or naturalistic inquiry. Phenomenological inquiry focuses on the question: What is the structure and essence of experience of this phenomena for these people? The phenomenon being experienced may be an emotion: i.e. loneliness, jealousy and anger. The phenomenon may be a relationship, marriage, or a job. The phenomenon may also be a program, an organization, or culture. The focus of this study includes the examination of sexual behaviors as a specific phenomenon.

Qualitative-Inductive Application: In this research, the qualitative-inductive approach will be used. The investigator will: collect descriptive data in the participant's own words, as well as develop concepts, insights, and understanding from patterns that emerge from the data. The investigator will set aside his own beliefs, perspectives, and predispositions in order to experience the participants' reality as they experience it. Although a list of open-ended questions (see appendixes C& D) will be provided, these questions are to be used as a guide. In order to accomplish the in-depth interviews, the researcher will model interviews after normal conversation, rather than a formal question-and-answer exchange. The investigator will minimize his control by allowing the participants to reflect on their respective perceptions and concepts regarding relationships between men and African-American college women: the maturation process and how that effects a young woman's ability to communicate with the opposite gender; and other significant episodes, events, situations, and life-circumstances that may have influenced the participant's, self-esteem, confidence and values about high-risk behaviors. The researcher will remain sensitive to his effects on the study by interacting with informants in a natural and unobtrusive manner

(Taylor & Bogdan, 1984).

Human as Instrument. Guba & Lincoln (1985) emphasize the concept of using the human-as-instrument for naturalistic inquiry "because only the human instrument has the characteristics necessary to cope with an indeterminate situation" (p. 193). Similarly, the authors insist that naturalistic studies using humans-as-instruments will more likely implement methods which are extensions of normal

human activities such as looking, listening, and speaking. The authors believe that the human will tend to lean more toward interviewing, observing, and taking account of non-verbal cues.

In addition, Guba & Lincoln (1985) describe the following characteristics that uniquely stand out during the utilization of humans-as-instruments in naturalistic study:

(1) Responsiveness. The investigator can sense and respond to personal or environmental cues that exist and thereby interact with the situation to sense, explain, or describe the event.

(2) Adaptability. The human can collect information about multiple factors at multiple levels simultaneously for multi-purposes.

(3) Holistic Emphasis. The human, more so than any other instrument, is capable of understanding many different aspects of the participant's life in order to view each experience, episode or event within the whole context.

(4) Knowledge-Base Expansion. The human-as-instrument is competent to extend awareness of a situation from knowledge of an event to a description of the participants feelings and wishes.

(5) Human Instrument. The human instrument can process data as soon as it becomes available, generate hypotheses on the spot, and test the hypotheses using the situation created by the participant.

(6) Opportunities for Clarification and Summarization. The human-as-instrument has the capability of summarizing data immediately with quick feedback to the participant for clarity, correction, or emphasis.

(7) Exploration of Responses. The human-as-instrument can explore unusual answers in order to test their validity and achieve a high-level of understanding.

An important concept of qualitative research is trustworthiness. Guba & Lincoln (1985) argue two points in support of trustworthiness. First, trustworthiness of the human instrument can be assessed in the same way as other hard copy instruments. The believability of these data are grounded in Guba & Lincoln's (1985) *triangulation* method. This method calls for a second interview. This process allowed for the study participants to review their answers and change, if necessary, any language that was not clear. "The technique of *triangulation* is the mode of improving the probability that findings and interpretations will be found credible" (p. 307). Second, the human instrument can be modified or refined as other hard copy instruments. Experience and extensive background work in the field is the training prescribed for individuals who are to effectively function within the human-as-instrument concept. Guba & Lincoln (1985) also argue in favor of using the concept of tacit knowledge. Tacit knowledge (everyone's common-sense experience) is described as that which must be experienced in order to be understood, referring to information gathered bit-by-bit from a situation without explicit knowledge on the part of the researcher. The investigator will convert his tacit knowledge into usable, believable, and functional knowledge which the researcher can both explain and then communicate to others.

Ethnographic Research: Ethnographic research is based on a phenomenology oriented paradigm. This paradigm embraces a multicultural perspective because it attempts multiple realities. People act on their individual perceptions; the subjective

reality each individual sees is no less real than an objective defined measured of reality (Fetterman, 1998, p. 5). This insiders' perception of reality is instrumental to understanding and accurately describing situations and behaviors (Fetterman, 1998, p. 20). Documenting multiple perspectives of reality in a given study is crucial to an understanding of why people think and act in the different ways they do (Fetterman, 1998, p. 20).

Investigator's Expertise: The investigator has over 20 years of work experience serving the public as a practitioner in social science and health education fields. Specifically, related to this study; Khepra NuRa Khem (the Investigator) served for seven years as a Community Health Educator with Planned Parenthood of Central Oklahoma. In this capacity, the investigator taught sexuality education classes throughout the State of Oklahoma, including pre-school through college-level courses for both religious and secular organizations. The investigator also provided *Train the Trainer* workshops and seminars for teachers within the Oklahoma City Public School District, child-welfare group-home agencies, and Oklahoma Adult and Juvenile Justice Centers. The curricula consisted of written exercises with lesson plans on contraception, communication, sexually transmitted infections, HIV/AIDS and human anatomy. He is also certified by the Oklahoma Department of Health and the American Red Cross as an HIV/AIDS Prevention Specialist. Related duties include counseling clients on a vast array of sexuality issues. The investigator's experience also includes counseling women and their partners about many relationship and sexuality issues. As a result, the investigator has gained notoriety and credibility for rendering high-quality teaching and counseling; and therefore

became a highly sought after presenter for many different groups on the Norman Campus of the University of Oklahoma. These campus groups include: the Sooner Heat Peer Education Program (formerly sponsored by Goddard Health Center). Alpha Kappa Alpha and Delta Sigma Theta sororities, as well as fraternities such as, Alpha Phi Alpha, Phi Beta Sigma, and Kappa Alpha Psi. Other presentations were made to residents of specific floors in several dormitories being sponsored by Resident Advisors, or the Athletic Department. The investigator's experience also includes: serving on national and statewide planning groups and conducting focus groups that examine high-risk sexual behaviors on many different college campuses in Oklahoma. These campus sites include Langston University, Rose State College and Oklahoma City Community College. Through connections with various community-based organizations such as: the Southeast Area Health Center, the Ahalaya Project (Native American AIDS care center) and Women With Voices (women living with AIDS support group) the investigator has completed four extensive qualitative-naturalistic interviews of women who are living with HIV/AIDS. This project was sponsored by Planned Parenthood of Central Oklahoma. Finally, in addition to being awarded *Graduate Student of the Year* for 1997, and the *100 Black Men's Community Quality of Life Improvement* Award in 1995; the investigator received a paid eight-week internship (funded by the Centers for Disease Control) with the Health Education and Leadership Program of The National Association of Student Personnel Administrators (NASPA), in Washington, DC. The investigator therefore meets the high-standard of experience described by Guba & Lincoln (1985).

Context of the Study

Selection and Description of Participants

This study focused on eight African-American college women who were 18 to 30 years of age. According to Gall, et al., (1996) "the essential criterion for selecting participants is that they have experienced the phenomenon being studied and that they share the researcher's interest in understanding its nature and meanings" (p. 601). Acquiring the sample of participants included several pre-contact hours involving identifying self, discussing the study's purpose and requesting participant cooperation through informed written consent. The African and African-American Studies Program, the Assistant Dean of Students, and the Office of African-American Student Services did agree to allow recruitment of study participants during scheduled presentations of on-campus student-sponsored activities during the Fall, 1999, semester. Key informants emerged to assist in recruiting participants for focus group and face-to-face interviewing. All of the young women in this study were affiliated with the Christian religion, in fact all but one was Baptist, and she was Catholic. Ninety-seven percent of these participants were from rural Oklahoma; two were from major cities in Oklahoma and one was from a major city on the west coast. All but one of these students had attained at least sophomore status; one was a graduating senior. When asked the question: From where do you receive most of your information about preventing STIs/HIV/AIDS? none of these respondents chose the classroom as their answer. The categories of friends (#1) then relatives (#2) were chosen as the source where these students received their prevention information.

Television was chosen as the third source that provided these students with safer-sex information.

Development of Interview Protocol

The investigator's role as a sexuality and health educator/counselor with Planned Parenthood of Central Oklahoma was the initial basis for interest in discovering the factors that contribute to women placing themselves at risk for contracting HIV/AIDS and other sexually transmitted infections. The quantitative data make it clear that women who contract STIs are more likely to endure long-term effects such as: sterility, loss of confidence and/or self-esteem. The investigator perceived the need for greater understanding of this phenomenon in order for women to begin to acquire higher self-esteem and engage in more healthful relationships and as sexual partners to men. The researcher's purpose is to contribute knowledge that will help women have more control in their relationships. Indeed, this study may generate potential solutions to relationship problems between men and women in general, and college students, in particular (Patton, 1990).

Patton (1990) says that the purpose of interviewing is to find out what is "on someone else's mind" (p. 278). Thus, the investigator developed the instrument (see appendix C and D) using the standardized open-ended approach which consists of carefully worded and arranged questions designed to process each participant through the same sequence, asking each participant the same questions with essentially the same words. Ross (1998) stated that this approach should not inhibit the interviewer from asking additional questions by using a conversational style which encourages spontaneity in the exploration of emergent results and issues. As a result, the holistic

aspect of qualitative research will be protected. Patton (1987) confirmed this argument.

Careful consideration was given to the wording of each question. The investigator sought the advice of female colleagues, as well as African-American college women who also served as part of the Planned Parenthood's HIV/AIDS Prevention, Outreach and Peer Education Program. Patton (1990) confirms that the basic purpose of the standardized open-ended interview is to minimize effects by the investigator. The author explains that by asking the same questions of each participant, the interview is systematic. Therefore, the necessity for investigator bias during the interview is reduced. Furthermore, the standardized open-ended interview also makes data analysis easier because it is possible to locate each participant's answer to the same question rather quickly, thus organizing questions and answers. There are two major reasons why the standardized open-ended interview should be used as part of an evaluation: (1) the exact instrument used in the evaluation is available for inspection by decision-makers and information users; and (2) the interview remains highly focused. The participant's time is therefore carefully utilized. In addition, it can be helpful to reduce issues of credibility and legitimacy by carefully collecting the same information from everyone interviewed; thus making data analysis more feasible (Patton, 1990).

Procedures for the Study

Focus Groups and Interviews

As a complement to the individual interviews (see appendix D), the focus group interviews or multiple respondent interviews (see appendix C) are effective in

settings wherein the relationship among respondents is complex and views are diverse. This research technique produces new and additional data because it serves as a stimulus for group elaboration and expression. The phenomenological purpose may better be articulated in the focus group interview because the researcher is able to arrange for a group of participants to meet in a location, free of distractions, within the college-setting which accommodates as many as ten people (Morgan, 1993). Patton (1987) argues that "the focus group process is a highly efficient qualitative data collection technique . . . [which] also provide[s] some quality controls on data collection in that participants tend to provide checks and balances on each other which [may illuminate] false or extreme views" (p. 135). In addition, this form of information gathering reveals differences among perspectives. A formal setting on campus (using structured preplanned questions), will be used to conduct two focus group interview sessions. Lofland & Lofland (1984) suggest using focus group interviews as a supplement to the traditional face-to-face interview. The focus group process allows for clarification on recall and opinion. Furthermore, the focus group interview is an excellent tool for bringing the investigator closer to more participants. Likewise, it is flexible, and allows considerable exploration. In fact, face-to-face interview participants may be selected from the focus groups (Morgan, 1993).

The face-to-face interview was conducted at the on-campus office of the interviewer. The location choice of the interview was advised to be a clinical-office setting by the university's Institutional Review Board. The questions allowed the participants to express their respective realities of external and internal perceptions based on attitude, judgment, experience, and thought. In phenomenological studies,

the investigator abstains from making suppositions of judgments. Therefore, the questions were guided by a reflective process that will permit the individual to construct a description of her conscious experience which will include thoughts, feelings, examples, ideas, or situations that portray her experience (Gall, et al., 1994).

The investigator will identified any emergent patterns regarding attitude, motivation (or other life-circumstances that may arise within the context of family) gender, self-esteem, security or culture. All questions were open-ended and designed to allow the participant to reflect without pressure (Gall, et al., 1994).

Another research method used in this study was the long interview. McCraken (1998) states this method may have the power to take the investigator into the minds and lives of the participants. The long interview allowed the researcher to see and experience the participant's world from her perspective. McCraken (1998) states further that: without a qualitative understanding of how culture mediates human action, we can only know what the numbers tell us. The long, qualitative interview is useful because it helps us to situate these numbers in their fuller social and cultural context" (p. 9). Therefore, this instrument of inquiry is more revealing for descriptive and analytical purposes.

Recording the Data

In order to preserve the information collected in the interviews, the investigator (interviewer) will use an audio-cassette, tape-recorder, which shall be supplemented with note-taking. The audio-cassette, tape-recorder sped up the interview process and allowed the evaluator to jot down key words for later reference. More importantly, the audio-cassette tape-recorder reduced the interviewer's

tendency to make unconscious data selection which might have favored his biases. The investigator carefully explained the purpose of the recording in order to capture each participant's confidence. This minimized negative effects of conducting audio-cassette, tape-recorded interviews (Gall, et al., 1996). The audio-tape cassette-recorded interviews allowed the investigator to conduct lengthy, informal and semi-structured interviews without distraction. In addition, audio-cassette, tape-recorders effectively allowed the capture and retrieval of long, verbatim responses to inquiries resulting in meaningful quotations. In short, the utilization of audio-cassette, tape-recorded interviews was the basis of the investigator's ability to maintain a natural conversational flow during interview processes. Consequently, the tapes can be analyzed over-and-over again. The investigator minimized participant's concerns by means of emphasizing the confidentiality of the data (Fetterman, 1998).

Data Analysis

Ross (1998) suggests the multi-method approach is consistent with naturalistic inquiry and phenomenology. However, the basic approach used in this study was computer-assisted content analysis. Other methods included the editing process as well as pattern-matching as described by Yin (1994). The anonymity of the participants was protected. The data pertaining to the participant were separated and identified using letters and numbers (i.e.: P1, P2, P3, or FGA-P1 or FGB-P2 etc.) in place of the students names. FGA-P1 refers to Focus Group A-Participant #1; and FGB-P2 refers to Focus Group B-Participant #2. The transcribed interviews were stored in locked file cabinets until the process was completed. After completion of

the study, all data collected were destroyed according to University of Oklahoma's Internal Review Board standards.

Content analysis involves identifying coherent and important examples, themes and patterns in the data. The purpose of content analysis is to organize and simplify the data into a manageable form. The investigator looked for quotations or similar observations that served as examples of the same or similar basic idea, issue, or concept. First, the evaluator assembled all the data related to issues of high-risk behavior. Then the data was sub-divided in similar categories, themes and patterns. Labeling the data and establishing a data-index are the initial steps in content analysis (Patton, 1987).

In this study, the inductive analysis approach was used in order to arrive at conceptual categories which evolved from the participants or the investigator. In other words, categories of analysis emerged from the data rather than deciding on the categories prior to data collection. The goal was to focus on description and explanation by reconstructing and classifying the data in order to integrate the data into a set of theoretical constructs. This strategy involved scanning the data for categories of phenomena that can be coded for later comparisons. As a result, this procedure permitted universal explanation of the cases studied, as well as new relationships to events, episodes, or situations that may have evolve (Guba & Lincoln, 1985).

Essentially, the investigator condensed the bulk of the data into analyzable units by creating categories through coding procedures that establish links to various data. First, data were defined by a common property or element; thus connecting all

the data fragments to a particular idea or concept. This process enabled the investigator to differentiate and combine the data while reflecting on the information collected. Thus, meaningful data were identified which set the stage for interpretation and conclusions (Coffey & Atkinson, 1996).

Data Analysis Process

The text was coded from six transcribed interviews which includes four individual interviews and two focus group interviews with two participants in each group. The entire text was entered into the software known as NVivo, from the developers of NUD*IST. This software allowed the investigator to build an interactive function whose primary purpose is to code or select text that is closely connected to words or phrases which were manually typed in to reserved cells (containers) in which can then be clicked to call up corresponding text (Denzin & Lincoln, 2000).

Step 1: This process involved automatic coding which was initially directed to twenty-one protocol questions (see appendixes C & D). The entire response was recorded for each question and context was generally not a consideration. In addition, two categories were added to each protocol in order to capture other responses that stood as not relating to the protocol questions. These other responses were opinions, advice and recommendations for Student Affairs and Goddard Health Center.

Step 2: Manual coding was then performed in order to capture the essence and meaning of each sentence and paragraph with respect to the study. Twenty categories

emerged and then were organized into four themes each with its own identifiable patterns:

Theme A: **African-American College women and unprotected sex**

Pattern A1: Competition with White females for Black athletes

Competition with the White female for Black athletes, generated the most responses or data. That is, unprotected sex with Black athletes emerged as the number one reason for this high-risk behavior.

Pattern A2: a) **Fear of losing relationship**

b) Lack of self-esteem

c) Naive

d) Peer pressure or influence

e) Personal choice

f) Please or appease partner

g) Trust that they are in a monogamous relationship

Fear of losing the relationship, with is six sub-categories is explained as the topic that generated the second most talked about phenomena that effected these participants reasons for having unprotected sex.

Pattern A3: **Role of Alcohol and Drugs**

The role of alcohol and drugs, emerged as the third influence on these women to participate in unprotected sex.

Theme B: **Family Influences**

The influence from family members, is listed here as the fourth topic that emerged as the cause for young college age women to have unprotected sex.

Pattern B1: Mother-Father

Pattern B2: Brothers-Sisters

Pattern B3: Morals and values

Theme C: **Student Affairs – Goddard Health Center**

These next two categories emerged through extensive conversation about the experiences of these participants with sexually transmitted infections and their trust of the on-campus health facility know as Goddard Health Center.

PatternC1: Opinion of Student Affairs

Pattern C2: Opinion of Goddard Health Center

Pattern C3: Advice and recommendations

Theme D: **Sexually Transmitted Infections-Safer sex**

Pattern D1: Knowledge about safer sex

Pattern D2: STDs diagnosis and testing

Step 3: Involved manually coding participant responses from the documents directly respective to the research question: Which life-circumstances do Black women perceive have the greatest influence on their attitudes and motivations to participate in high-risk sexual behaviors? This provided an opportunity for a fresh look at the data with a single focus while coding. Even though Step 3 was necessary in this study coding the research question did not reveal any significant data that had not already emerged from step 2.

Limitations to the Process

The success of using computer-assistance in coding data is largely contingent upon the astute insight of the investigator. If the investigator omits vital key words or

phrases, then the research becomes limited to that which was entered into the program. Denzin & Lincoln (2000) fear that these programs over emphasize coding and promote a superficial view. They also note that the mechanical operations are no substitute for the nuance of interpretive analysis. Computerized results allow only fragments of the data to be seen. Consequently, this may not allow the investigator to gain an understanding of the whole story or the whole body of data. Automatic coding captures responses that fall between questions. The process of manual coding therefore assures every responsive word was read. Thus appropriate words, phrases, sentences, or paragraphs were selected and coded to the appropriate research categories.

CHAPTER 4

EMERGENT FINDINGS AND POST REVIEW OF THE LITERATURE

This chapter reports the major to minor themes and patterns discovered by means of interviewing the participants in this study. First presented is a brief outline of the categorized themes and patterns. Next is the issue that produced the most response. The last findings are the most significant issues regarding specific participants. In an effort to best illustrate the study's findings, actual quotes from the respondents have also been provided. Accordingly, a discussion of the relevant literature that supports these findings has also been provided. The research question follows: Which life circumstances do Black women perceive to have the greatest influence on their attitudes and motivations to participate in high-risk sexual behavior?

The following is a list of the major to minor themes and patterns that emerged from conducting individual interviews with four African-American female college students. Also included are emergent themes from interviews with two, 2-member focus groups. There were a total of eight participants in this study.

There are three patterns coded. Theme A: African-American women and unprotected sex. Theme B: Family influences with three patterns. Theme C: Student Affairs and Goddard Health Center with three patterns. Theme D is: Sexually Transmitted Infections-Safer sex; with two patterns.

Theme A: African-American women and unprotected sex:

Pattern A1: *Competition with White females for Black athletes*

FGB-P1: Oh, yeah. It's been brought to me. "No, bro. I can't

do that. You need to get your freaky White girl." But I guess I could see where the competition could come in. But I guess I always felt stronger about myself to do like: No, I can't. I can't do that. You know, I can't be on video. I can't do no group thing. I can't have sex in the room with your home boys over there having sex. I can't do that. So, if you want to be with me, you're either going to do it on my terms, you know, where we're in the room alone or you're doing it with somebody else. Yeah, it exists. Because a lot of people try to keep their man because they don't want them to go to a White girl. I know people who've done made videos and all that freaky stuff because they want to keep their man.

P1: My cousin is an athlete at another university and he said "They've got attitudes". He said "Black girls got attitudes". They don't like the way they act, and they know that they can't get away with what White females will let them get away with, which is why they don't date Black girls...he said usually he can get oral sex and money and sometime they'll let him drive their car.

P3: How do I know? Cause I've seen it. I mean, I know guys . . . I knew a guy on the football team that only dated White girls. I mean, he liked Black girls, but he dated White girls and they have money, let them drive their cars or whatever....

Chapman (1995) writes that men have various reasons that they would rather relate to a White woman, including and not limited to White women are more

supportive, less competitive, easier to get along with, and more sexually liberated than Black women. Black men perceive the stereotype that White women are subservient and are constantly available. Black women are uptight about a variety of sex positions and sex behaviors. Black men believe that Black women will give them more hassle than White women; and not just about sex, but about all matters.

Milligan (1994) author of *Satisfying the Black man sexually* explains why Black men choose White women. She writes that the most critical reason for a White female preference is that Black men continue to measure Black women by the European standard of beauty, values and beliefs. Perceptions of these standards are fed by movies, magazines and advertising which display the White female as the ultimate sex symbol. "The Black woman has been given such titles as: gold diggers, sapphires, male bashers and bitch ... domineering and sexually inhibited" (p. 118). The author asserted that in general, Black cultural thought is that, o*ral sex* or anything out of the *norm* is perceived as things only done by White people. This may be why Black women are reluctant to participate in a variety of sexual-behaviors. I think most revealing is the author's survey results that indicated that whenever Black men requested oral sex from Black women, the Black woman would comply, but only to *please him*. The survey also stated that Black men had to "always request [oral sex] from the Black female whereas with the White woman it was a natural component of making love" (p. 122).

Subira (1994) emphatically rejects the usual reasons *why Black men choose White women*, which are often listed in popular magazines and books on the subject. The author argues that we should not be concerned with the theories that describe:

White women as the *forbidden fruit*; or the *Black man as seeking revenge on the White man*. The reason Black men date White women is that, the women introduce themselves; they are more aggressive than the Black woman in letting him know that she wants to meet him. "It is not necessarily the girls' whiteness that he is reacting to as much as the idea that somebody has voluntarily made and open move toward *him* for a change" (p. 113).

The previous discussion indicates the fact that there are many reasons why Black men choose to have relationships with White women. While these relationship specialists bring an in depth awareness to this phenomenon; it is noteworthy to mention that Milligan (1994) and Chapman (1995) are female and Subira (1994) is male. Thus, a natural inclination for gender bias may be present.

Pattern A2: Fear of losing the relationship which has six (6) sub-category patterns:

A2a) Lack of self-esteem

A2b) Naïve

A2c) Peer Pressure

A2d) Personal Choice

A2e) Please or appease partner

A2f) Trust in a Monogamous Relationship

A2) Fear of losing relationship

FGA-P2: I knew I should have been using condoms because I suspected that he might have multiple partners. But I don't think that I was insistent or persistent enough for him to use them. And then I really didn't want to kind of make him back off because I insisted so

much on using protection. Well, I mean, I really didn't want it to deter him in any kind of way. I just wanted to make sure he was satisfied. So, after I said we need to use condoms. He said "we're not using condoms. You need to be on birth control." Then, I was just like: Well, okay. I allowed him to lay the sole responsibility on me.

FGA-P1: I think some of it has to do with the fear of losing him. Fear of: "if I don't let him have sex without a condom, the next girl will. So in order to keep him, I need to do this to keep him."

P3: Maybe if she wants to keep this person. Maybe they would have unprotected sex. Well, I've had unprotected sex. So maybe if she just wants to keep the person. Just keep the person that they are involved with. When you have sex, you become attached to this person. You give a part of yourself to this person. Or to let them feel you inside of them ...you're going to just say, "Oh, let's not use a condom anymore."

A2a) Lack of self-esteem

P4: I think the main reason is lack of self-esteem and feeling. ... It's a lack of power. Like you feel like you don't have the right to say, " I don't want that." Or, "I don't want to do that." Or, "We're not going to do it unless we do this." Not feeling powerful enough to say that and be firm with the consequences.

FGA-P2: I would say low self-esteem is a reality on this campus, for a lot of women.

FGB-P1: I agree a lot with participant number two and how she was saying, you know, they feel they need a man to make them

whole. And, you know, I mean, I'm in the same boat of her. I have two kids also.

P4: What I think would make a woman to not use a condom. I feel like, lack of self esteem or feeling that she has to always please the man. Like whatever you want doesn't matter. Just what he wants. Or, just really being careless a lot of times. Just not thinking about the consequences. All that combined together makes you careless ... your judgment is not that good. You know, you make a lot of wrong decisions.

A2b) Naive

P3: You know, I just thought he always used a condom. So that's why ... I mean, I just always.... I didn't know that he did not use a condom, but I became pregnant and so evidently he didn't use a condom.

P1: I was fourteen, in the ninth grade when I first had unprotected sex. My boyfriend who was 16 and I was fourteen years old and he was in good with the family, went to church with us, all this stuff. And when I lost my virginity to him, it was unprotected. And the way it happened, I did not expect it. Intercourse was not even supposed to happen. I was not ready, but it just did. I think no matter how old you get, people can still be influenced by their peers.

A2c) Peer pressure or influence

FGA-P1: As far as the students that I know, I think the

circumstances that are most likely to participate in high risk sexual behavior is probably peer pressure or peer influence. If you have a girlfriend that's talking about how much better it feels without the condom, or how anal sex feels, or what oral sex is like, she's more than likely going to want to try it for herself, and see what all the hoopla's about.

FGB-P2: I'm in total agreement with participant number one. The most information comes from your peers and it's pressure. I think it is looking for acceptance from men and women just trying to fit in the norm. Just to say I am in a relationship. And she has multiple partners trying to find that special person.

P3: Well, my mom never talked to me about it, and so, basically, I relied on my friends to tell me about the sex part and stuff. And basically, I don't think I would have done it unless my ... all my friends were doing it. So that is the only reason why I did it.

A2d) Personal choice

FGA-P1: And like for me, I know my first experience was around fifteen years old. I was just starting high school. And, of course, my father was a minister and he preached and talked about sex openly. This is what happens; and he gave the Birds and the Bees story ... meaning don't have sex. But I still did.

FGB-P1: I just think it's all in a person's personal choice.

P4: You're not actually thinking I'm going to take the chance.

You're not thinking that at that moment. Well, I guess you just ... I don't know. There's lots of ways to justify it. I mean, yeah. I mean, you just don't worry about it. Or you go ... you just say, "Well, hey." You know what I mean. I mean, it's just ridiculous when you verbalize it. But yeah, if you discuss it then it might not happen so you don't discuss it.

A2e) Please or appease partner

FGA-P1: I think a lot of it is to please her partner. I think a lot of it leans toward what he wants and not having her best interest in mind. The friends that I have, I think they feel pressure from the men in their life. You know, [he says] "it feels better if I don't wear a condom". Or, you know, she feels like wearing a condom takes the romance out.

P3: The reason I have had unprotected sex is because I just really liked this person and I just wanted to feel something different. And, I don't know, whenever you're with somebody for awhile and you're always using a condom and then you say, "Well, let's not use a condom." It's like it might draw you a little bit closer to them. So maybe you trust them a little bit more.

P4: There's lots of reasons. But I think their main one is not wanting to turn the guy off. Not wanting to somehow push him away. Instead of thinking about what is best for you, you're thinking about: Oh, what is he going to think?

A2f) Trust monogamous relationship

FGA-P1: At that time, this was the man I was going to marry. [laughs] We'd dated for two years, and I guess I put so much trust in him and in the relationship, it just wasn't an issue for us. I think at the beginning of our relationship we may have used a condom. But once we got going ... I was on birth control and it was okay. We were ... well, I was monogamous. I can't speak for him. But it just ... it wasn't an issue. It's like we're together. We'd talked about marriage and about future plans together. It just was not an issue. And I think that that's probably the issue for a lot of people. And that's the reason they don't practice safe sex.

FGB-P2: ... Men are unfaithful and females just accept it; and call it trust ... but then I knew he was only with me because he was on the men's basketball team. [When] he was out of town, I was out of town on the same trip. So,
eventually we did stop using protection. Now I have a two yearold son by that same man.

P1: ... I wasn't on any kind of birth control or anything. And so for about almost two months we just talked and hung out and really got to know each other before we even got into a relationship. And so I found out I was pregnant, something just told me to go take a test.

Allen (2001) refers to Rosenberg's (1986) self-esteem theory which contends that all humans possess a great desire to feel self-worth. The author implies that this

need to have self-worth is the *driving force* of self-esteem. Self-esteem is further defined as a people's subjective feeling about themselves. To be sure, this feeling is a result of how each person perceives *what others think of them*. Next, Baer & Jones (1992), point to Barnes (1986) who states that African-American females become exploited by men who plead and beg incessantly for sex; and because these women want to be loved, they allow unprotected sex.

Tolmon (1999) focused on heterosexual decision-making with regard to the realities of who has the *power* in the relationship. Indeed, females may be subtly or overtly denied the power to determine the outcome of their own situational desires. In other words, she may just want to *hug* or *cuddle*, while his interests centers on intercourse. Luker (1975) asserted that the decision to engage in unprotected sex is a result of the female hoping that if she gets pregnant, the male will increase his commitment to the relationship.

Ginzberg, Berliner & Ostow (1988) present two compelling reasons why young people engage in high risk sexual behavior. First, the media and sexually oriented advertising in the Black community causes early sexual activity by youth who then pressure their peers. Second, the media and advertising cause parents and other adult-relatives to be more permissive regarding sexual behavior among younger family members. In fact, this leads to a break down of traditional-family sexual values and moral limits. Third within the Black family, there is a greater tolerance for pregnancy and parenthood outside of marriage. It was argued that perhaps this is a way to identify with the mother; but more than likely it is merely following the example of their peers.

Moore & Rosenthal (1993) explain why young people engage in unprotected sex with multiple partners. Their contention is called the: *trusting of love myth*; which is explained as the reason many young people justify their non-use of condoms. In fact, they believe condoms are not necessary when they are in a long-term monogamous relationship. Further noted, is the interplay between *trust* and *perceived risk* which emerged as the key factors which contribute to a young woman's decision to have unprotected sex. The young female is concerned that the use of condoms create a problem for them because she does not want him to think that she does not *trust* him; therefore she demonstrates her trust, love and commitment by not asking him to wear a condom. The authors explain further that young women found it difficult for them to make demands on their partners, even if that meant that their own needs would go unmet. Likewise, young women reported fear of being labeled a *slut* if she appeared too knowledgeable about sex in general and condoms in particular.

Pattern A3: Role of Alcohol and Drugs

> FGA-P1: As far as alcohol and drugs, a lot of women use that as an excuse. But I think it's just something that you've been wanting to do anyway. And maybe the alcohol and drugs just made you get enough nerve to do it. Because you can use that as an excuse as to why you did it. "Oh, I was drunk, or I was high. I didn't know what I was doing." You know what you're doing. I've been drunk. I knew what I was doing. So, I think a lot of women use that as an excuse to justify their actions.

FGA-P2: It's a small contribution, if any, to a decision to have unprotected sex.

FGB-P1: Well, I think alcohol and drug use have a hundred percent to do with their decision to allow unprotected sex. Because I've known people who, you know, speak: I would never do it. But when they have a few drinks, or they're, you know, smoking a joint, it's just like: Hey, we could just all have fun. And so, I mean, I think that the drug use really alters a person's mental capacity and allows you to lower your behaviors and make some decisions that may not be healthy for you.

P1: Alcohol? No. I do believe it does, you know, alter your senses and stuff in some way. But a lot of chicks blame their actions on alcohol but you are responsive and you do know what you're doing. At least I do. Because I've gotten pretty drunk before, and I'm one who has an extremely low tolerance, and yet I can still tell you what happened that night when I wake up the next morning. P1: Well, I don't really know of anyone that has like any major drug use besides like marijuana. And all I know that weed will make you do is just lay back and probably eat a lot. But that's about it. I mean, you know, never have I heard of an incident from any of my friends or from anybody where they smoked some herb, and then they can't control themselves, or they go jump on somebody, or they can't stop the situation. Because most likely they don't even try to do nothing when

they're smoking. They just lay back and eat. So, I don't think that has a major influence.

P3: I think when you smoke marijuana. . . I mean, it's like a different feeling for everybody else. Like it makes me feel weird. That's why I don't like to smoke it. But some people think that sex is better when they're high. I just think your mind is altered. So, I don't know. I don't agree.

P2: No. I'm going to say that alcohol is not the major contributing factor to having unprotected sex. Alcohol is used as an excuse to justify their high-risk behavior. For example my baby's father tried to say he was drunk the night I got pregnant; and that I should abort the baby but I told him I was not drunk; we don't know when I got pregnant since we had been together at least six months; I also told him, he wanted to use alcohol as an excuse.

Sherry (1998) reminds us that alcohol is the most common drug of choice for college students. The author states that student affairs personnel know that the use of alcohol and other drugs can affect judgment and lead to high-risk sexual behaviors. Kerr (1998) found that alcohol is commonly used in conjunction with sexual activity. The author argues that since impaired judgment with fewer inhibitions result from drinking liquor; then alcohol is a gateway to STI/HIV/AIDS infection. Meilman, et al., (1993) found that the relationship between alcohol and sex is most high for those students who drink five or more drinks in a row or *binge drink*. The author reported the 35% of students engaged in some form of sexual activity that was influenced by

drinking. Almost 18% had engaged in sexual intercourse. Fifteen percent had abandoned safer-sex practices because they were drunk. Anderson & Mathieu (1996) found that percent 32% of men and 17% of women who let themselves drink more than normal in order to make it easier for them to have sex with another. The above data clearly suggest that student affairs specialists must begin to discuss how to prevent sexual behaviors as a result of alcohol use. The report calls for a more comprehensive approach to the relationship of alcohol to high-risk sexual behaviors.

In addition, greater understanding is needed in order to explain the claim by most of the study participants who believe that drinking alcohol is used as an excuse to justify risky behavior. All respondents except one believed that the use of alcohol and drugs is not a major contributing factor to Black females participating in unprotected sex.

Theme B is **Family Influences** which has three patterns:

Pattern B1: Mother- Father

Pattern B2: Sisters-Brothers

Pattern B3: Morals-Values

Pattern B1: Mother-Father

P2: My Mother only mentioned the consequences of sex like getting pregnant or catching an STD. But she never really talked to me about boys' behaviors; she just said virginity was sacred and that I needed to wait until marriage but it was already too late by then; I was sixteen years old and had an older boyfriend who was a senior and we had already had sex. My mother died shortly after that.

FGB-P1: The thug type? Been attracted to a lot of thugs in my life. The whole thug, you know, player, you know, I think that I was attracted to that because that's exactly what my dad did not want. When I came to college I was accustomed to a particular lifestyle that was more of the affluent one with the nice clothes and handbags and shoes and the nice car. And the longer that I was in college, the less my father gave me, the more I had to earn on my own. And a lot of times, that thug man, might have six or seven hundred dollars in his pocket. That was attractive to me because that's what I needed at that time. In my early years, I was trying to rebel against [my father]. But now, looking back on it, he was right the whole time. If I'd of just listened, I'd of probably been in a different situation right now.

FGA-P1. I'm a daddy's girl. So when I look for a man, I do honestly look for some of the qualities that I see in my dad in other men. I mean, that's just me. When I look at a man, I do look at the way he's dressed. And in the back of my head I am comparing that to my father. Because my father is clean-cut. He keeps his hair cut. He keeps his clothes creased and cleaned. And that's what I'm looking for. If my father was like a gangster type, you know, street boy, I'd probably be looking for that man.

Pattern B2: Sisters-Brothers

P1: My brother did not give me a good perception of men at all because I looked at the way he was towards females. And so, I

think when you don't have like a good example of good male role models and things in your life, that's kind of how you start to perceive guys. And so you think, okay, well if my brother is talking to six different girls a night and stuff, then that is how all boys are and that is just how it is supposed to be. My cousin is calling one girl and telling her I love you and then click over on the other line and tell the other girl I love you.

FGA-P1: I had an older sister. She was dating before I was. And listening to her talk about her ex-boyfriends or her ex-male situations or whatever, shaped the way I thought about men. And how I handle the future relationships with men. Because I would base it on what my sister had told me. If your sister is having sex and out running loose, the younger sister tends to follow in the same direction because you're looking at you're older sibling, your older sister. You're sister is having kids at an early age, and it's okay. She still doing what she wants to do. But her younger sister does the same. I know family relations have a lot to do with how African-American women view a man of the opposite sex.

Pattern B3: Morals-Values

P1: I think as far as me and my family, we have a lot of episodes where we did not get along real well and I grew up seeing my parents argue and stuff a lot. And I never really had a real close relationship with my father and so coming from a home like that kind

of makes you want to go out and find somebody that's going to give you attention or make you feel like you are real special. I mean, you are the only person that is important because if you do not feel that way at home, you are going to go off and try to find that attention somewhere or from someone.

P2: Take my sister, for example. When my father was there, she saw them fight a lot. So, in her relationship with her kids' father, she thinks that it is acceptable for them to be physical [with each other]. And then, you know, violent towards one another.

P4: Well, I think that your relationship with your family, especially your parents, has a profound effect on you and how you and how you deal with the opposite sex. Because my mother, she taught me never to pursue a man. Let him come to you; her thing was all about respect. You never want to look like you need a man. Usually you just sit there and wait for them to come to you.

East, Felice & Morgan (1993) found that having sexually active girlfriends or teen sisters who became pregnant was associated with permissive sexual attitudes that may lead to unprotected sex. Indeed, much of the theoretical, as well as the educational literature voice strong concern that young women are having sex in order to: *keep her boyfriend, to fit in with friends, to act out against parental control* or to *relive the poor choices* made by their sisters and mothers who, undoubtedly serve as their primary role models.

Theme C was **Student Affairs-Goddard Health Center** with identified patterns:

Pattern C1: Opinion of Goddard Health Center

Pattern C2: Opinion of Student Affairs

Pattern C3: Advice and Recommendations for both

Pattern C1: Opinion of the quality of Goddard Health Center

FGA-P2: I just think that they need to practice more confidentiality and I just think that the doctors need to be more sensitive to pinpointing whatever may be ailing that person.

FGA-P1: They're not licensed, I don't think.

FGB-P1: I would use Goddard [only] if I knew what was wrong with me.

FGB-P2: I've needed to talk with someone and no one was available. Me and my son's father, we went to counseling to a White woman. She doesn't know how Black relationships work. She don't know how Black people grow up, how our families are. You know, I really didn't know where to turn. I would have liked to come to OU to a Black counselor, somebody who has a degree, who knows the issues that Black families and couples face; but I don't think it was offered. And if it was, I didn't know where to turn to find it.

P2: In my particular situation when I thought I had an STD, I did not go to Goddard because I was detoured from there because I heard that confidentiality is not kept there.

P3: One time I had Chlamydia. I went to the Health

Department. Why didn't I go to Goddard? I would feel very uncomfortable.

Pattern C2: Opinion of Student Affairs

FGB-P2: The only African-American things I know of on campus is the classes that's being offered. And that's just because it's on the internet and I can enroll online. Maybe I didn't look hard enough. But, how hard should I have to look?

FGB-P1: It seems like I used to hear about a lot more programs on HIV and AIDS. And here the last three or four years you really don't hear much.

P1: I would give [student affairs] about a C, and that's probably really good. Because I don't think that people in that department can really relate to what's really going on. I think a lot of issues and things that Black females go through are either overlooked or sugarcoated. And so, I mean, you need to have something happen where you can be in a situation where everything is just out in the open, everything is real and to the point. Show exactly what the deal is and everybody be real because its the campus, you know, we're adults and you want somebody that's going to be honest with you and be able to give you honest answers to questions that you may have about relationships and sex and things like that.

P3: Yes I needed someone to talk to especially Right after I found out I was pregnant. I was really kind of scared ... but I just went

home. I went to a friend because she was in the same situation, and I asked her what she did. Like, I don't really have support as far as me and the baby. I'm kind of different than another college girls.

Pattern C3: Advice & Recommendations for Student Affairs & Goddard Health

FGA-P1: I would probably make a [prevention] seminar mandatory for all incoming freshmen. And, focus on giving them some numbers to deal with instead of just saying that this is affecting our community every day. Give them some numbers. This is what's happening. This is the amount of people who are infected. This is the amount of people who were infected while they were in college, or during their freshman year in school. Give them some realistic, hardcore facts. I'm not saying scare them, but really make it real for them.

FGA-P1: I think [Goddard] should have a second opinion by a practicing physician.

FGB-P2: It needs to be more professional. Confidentiality is the key, and when you're dealing with students, it's the main issue. You know, cause on campus, I mean, you have sexually transmitted diseases going around and people make think they have something, but they're not going to go get checked out so everybody else can know what they have. They will just live with it until, you know, something else happens to where they have no choice but to go.

Theme D: Sexually Transmitted Infections-Safer Sex.

The patterns are identified as:

Pattern D1: Knowledge about Safer-Sex

FGA-P1: I think body to body rub is not realistic for people that's already been sexually active, as number two said. Mutual masturbation, not at all. Now, oral sex with a latex condom, no. I don't see it happening. But as far as vaginal and anal sex with latex condoms, yes. That's realistic. But the oral sex with a latex condom, I don't know too many women that perform oral sex on men and make them have a condom on before they do so.

Pattern D2: Diagnosis and Testing

P1: Well, I had unprotected sex with an ex-boyfriend and I don't know why but didn't think about the fact that he had just got out of a relationship recently before we started talking again. It was like he was engaged and they had broken up, or whatever. And then we started to talk again. And, uh ... then so all that [infected with trichomoniasis] happened. That was when I was eighteen. And so, I thought that maybe if we get back together everything will get smoothed over and I can act like I don't remember this. I will pretend it never happened. Because I thought, you know, we might get into another relationship: but now I know ... only to get burnt. Yes, I got burnt! I never spoke to him again. I didn't even tell him. I went to his house to tell him, and there was another female sitting over there when

I got there. So I didn't tell him.

P4: Yes. Actually, I am. No. No. No. Wait a minute. Wait a minute. Wait a minute. No. After this [rape] happened to me when I was seventeen, I got Chlamydia.

The American Social Health Association (ASHA, 2001), reports that in the United States chlamydia infects four million people annually while gonorrhea infects 800,000 people annually. Yet 70% of chlamydia-infected women and 50% of the gonorrhea-infected women have no symptoms that often lead to pelvic inflammatory disease or PID; this is the leading cause of pregnancy-related deaths in African-American women.

The Oklahoma State Department of Health (OSDH, 2000) reported chlamydia infection rates for youth age 15-19 with comparisons by race and gender. The report says that out of 3,391 females with chlamydia; Black females comprised 1,102 cases, compared to White females with 1,569 cases, and Hispanic females reported 196 cases. In addition, Native-American females reported 452 cases of chlamydia during the same time period. The same report indicated a total of 464 cases of chlamydia among males. Black males comprised 256 cases, compared to 138 cases for White males; 25 cases for Hispanic males and 38 cases for Native-American males with chlamydia.

Fields (2002) uses ASHA data to report that during 2000, African American ages 20-24 had the highest rate of gonorrhea of all racial, ethnic and age groups. The rates among Black women age 15-19 were 19 times greater than their White peers. The gonorrhea rates among Black men age 15-19 were 50 times greater than White

males of the same age. Among Blacks age 20-24, the rate was 26 times greater than their White counterparts. African Americans comprised 71% of the primary and secondary syphilis cases reported to the Centers for Disease Control in 2000.

We now understand that there is a link between sexually transmitted infections and HIV/AIDS. Studies in Epidemiology repeatedly demonstrate that people are two to five times more likely to become infected with HIV/AIDS, when other STIs are present. Young African-American women, are being infected with HIV at younger ages and at higher rates than their male counterparts. The results indicate that of the 350,000 16-21 year-olds tested, more than 2 per 1,000 were HIV-infected, with rates among Black females exceeding 5 per 1,000. The Centers for Disease Control (CDC) reported that HIV among young Black women is 7 times higher than for young White women and 8 times higher than young Hispanic women. Finally, 38% of all the Black women infected with HIV/AIDS were infected by heterosexual contact. Again, college prevention programs must focus on building and maintaining the self-esteem of female students'. In addition, females need to gain the necessary communication skills that will delay sexual intercourse; while learning to negotiate condom use (CDC, 2000).

Qualitative data suggest that sexual norms prevent women from the initiation safer-sex practices. Women are expected to play the passive role, with all sexual decisions made by the male partner. Other qualitative research suggests that many women at risk do not feel efficacious enough to implement safer-sex practices because they feel they have little power to negotiate sexual behavior-change with their partner. More qualitative research suggests that women expect a number of

negative consequences to occur if they introduce safer-sex alternatives. The reports indicate that women feel that if they mention using a condom, then they will *lose the relationship* because of: partner displeasure, anger, tension, and violent abuse. In fact, these consequences are likely to out-weigh the risk of getting a sexually transmitted infection including HIV/AIDS. The authors refer to Jemmott & Jemmott (1991) reported that if African-American college women associated negative qualities to using a condom. Such as: inconvenience, embarrassment, and loss of pleasure and loss of spontaneity; then these students were more likely to engage in high-risk sexual behavior; than were women with more positive attitudes (DiClemente & Peterson, 1994).

CHAPTER 5

CONCLUSIONS, RECOMMENDATIONS AND FUTURE RESEARCH

The development of appropriate conclusion, recommendations and future research suggestions is important as American colleges and universities are expected to provide the United States of America with leadership that is practical, realistic and intelligently assimilated to promote healthy minds and bodies among all college students. If Black female college students do not possess necessary social skills that empower them to feel as an equal in relationships, then they will continue to lead in the social group which experiences the highest number of deaths from cervical cancer and the highest infection and death rates from HIV/AIDS. In addition, Black babies will continue to lead in all pediatric cases of HIV/AIDS. Furthermore, young adults will continue to lead the nation in syphilis and gonorrhea infection. This topic is important because it may lead to an improved delivery of HIV/AIDS education and prevention for students on college campuses.

The methodology applied in this study was the concept of content analysis that identified and categorized major themes and patterns that emerged through in-depth and structured interviews. The analysis was computer-assisted using the software known as the NVivo qualitative data analysis program.

The following conclusions have been demonstrated in this study. The reasons why African-American college women participate in high-risk sexual behaviors are: competition with the White female for the Black athlete; lack of self-esteem which includes fear of losing the relationship; naïve; peer pressure or influence; personal choice; please or appease her partner; and trust and belief that she is in a

monogamous relationship. Family morality-values and permissive behaviors of family members, will also influence young women to engage in unprotected sex. This is supported by the study-participants; in addition to the literature strongly supporting this thesis. Even though the current literature concludes that the role of alcohol and drugs will certainly influence people to engage in high-risk sexual activity. Most of the study's participants believed that alcohol was used as an excuse to justify irresponsible behavior. However, one respondent did feel that alcohol and drugs had everything to do with whether or not a woman would place herself in high-risk, sexually. Marijuana was the only street-drug discussed by these participants and smoking marijuana was not considered by these respondents, to be a behavior which led to unprotected sex.

In researching the perspectives of African-American college women regarding high-risk sexual behaviors, detailed answers to the following question was sought: Which life-circumstances do Black women perceive have the greatest influence on their attitudes and motivations to participate in high-risk sexual behaviors?

The answers to this question are revealed through the themes and patterns discussed in Chapter 4. The issue which generated the most response was the fact that some Black women feel *competition with the White female for the Black athlete*. Granted, none of the females in this study, acknowledged any personal participation in unprotected sex because they felt they were in competition with White females. All participants strongly felt that the phenomenon existed because they had either been propositioned by athletes for group sex; or they knew of a friend who had made videos or provided oral sex in order to keep her athlete boyfriend; or they knew male

athletes who only dated White women: or that their family members who were athletes, only dated White women in order to obtain money, oral sex, or to drive the White female's car.

There are many scholars who have written about this interracial dating phenomenon. Indeed, all agree Black men do, in some cases, prefer to have relationships with White women: but for a variety of reasons. The literature indicates that some Black men are influenced by the media that reinforces European standards of beauty. Some research indicates that Black men may feel less threatened by White females because they think Black women will hold them accountable for their actions. Research also indicates that Black men are approached by aggressive White women, and Black men favor that approach to being turned down by a Black woman. Competition with the White female for the Black athlete may be a prevalent issue for Black women on college campuses.

The participants in this study confirm that the behavior of family members may also provide motivation to participate in high-risk behavior. Participant #1 said that after observing how her brother who had six different girlfriends, concluded "then that is how all boys are and that is how it is supposed to be." In other words, she expects a non-committed and unfaithful relationship with the men in her life because her brother provided an example of what she thought was normal and permissible behavior. Another illustration comes from Focus Group-A Participant #1 when she stated that her sister "shaped the way she thought about men ... and how to handle her future relationships with men". Indeed the literature supports the notion that, if the sister or mother gets pregnant outside of marriage the younger sibling may

engage in high-risk behavior because it appears to be an acceptable way of life for that family.

This study concludes that the most significant reason for high-risk sexual behavior among these young women in particular, was lack of self esteem; out of which emerged many sub-categories that included: fear of losing the relationship, naïve, peer pressure, personal choice, please or appease their partner and trust that they are in a monogamous relationship. The presence of a father in the home may not prevent his daughter from engaging in high-risk behavior. To illustrate, Focus Group A- participant #1 said: "my father was a minister and he talked openly about sex ... meaning don't have it. But I still did." This is proof that sometimes it is just a personal choice that a young woman will make.

These interviews revealed an intimate look at the thought process of these young women. Uncovered here is what she was thinking when she allowed herself to practice unprotected sex. For example: Focus Group A-participant #2 stated that she "really didn't want to make him back off ... [she] really didn't want to deter him in any kind of way ... [she] allowed him to lay the sole responsibility" on her. Participant #3 indicated that she had unprotected sex to keep the person as a boyfriend. The same person said, after she realized she was pregnant: "I just thought he always used a condom... I didn't know that he did not use a condom, but I became pregnant ... evidently he didn't use a condom". Participant #4 implied that she did not want to "turn the guy away ... push him away. Instead of thinking what is best for you, you're thinking about: Oh, what is he going to think"?

All but one of these women thought that alcohol and drugs had very little to

do with a young woman's decision to engage in unprotected sex. Focus Group A-participant #2 thought that alcohol was: "a small contribution, if any, to a decision to have unprotected sex". The respondent explained that Black women knew beforehand, if they intended to have sex; but used alcohol as an excuse to do what she intended to do in the first place. In contrast, there was one participant who did not agree with this idea. Focus Group-B participant #1 thought that "alcohol and drug use [had] a hundred percent to do with her decision to allow unprotected sex". It is obvious that there is disagreement among the respondents about the influence of alcohol and drugs. However, the research indicates that if alcohol is present, then there is less inhibition to engage in unprotected sex. In fact, if drunk there was strong likelihood that students on a college campus would experience multiple partners.

Bower & Collins (2000) challenged student affairs staff to begin programs that meet the special needs of students living with HIV/AIDS. On the other hand, the literature did not speak about providing parenting education-support, and relationship counseling. However, many respondents expressed a need for culturally competent counseling for relationship problems; they emphasized the need for education and support with pregnancy and parenting issues. In fact, African-American college women who are pregnant or who have children feel that the university does not offer any service that could benefit them in their situation. For example, Focus Group B-participant #1 stated that she "needed someone to talk to ... but no one was available". She continued by saying "me and my son's father, we went to counseling to a White woman. And I mean ... she doesn't know how Black relationships work. She don't know how Black people grow up, how our families are.... I would have

liked to come to OU to a Black counselor, somebody who has a degree, who know the issues Black families and couples face; but I don't think it was offered. And if it was, I didn't know where to turn to find it".

The study-participants thought that prevention and education about sexually transmitted infections including HIV/AIDS was still very relevant. Focus Group A-participant #1 recommended that student affairs "make a seminar mandatory for all incoming freshman ... give them some real hardcore facts ... don't scare them ... but make it real for them". She continued by recommending " a girl talk session with open and honest frank discussion ... just with African-American women and maybe two or three AIDS educators ... [conduct] small sessions with just their peer group like sororities or the basketball team.... Because [if] you are more comfortable, you talk more openly and frankly [when you are around] people you know". The findings in this study agree with Flakerud & Nyamathi (1990) who concluded that women need a culturally-based comprehensive sex-education seminars and workshops which focuses on self-empowerment and self-esteem. These participants suggested that the educational sessions be outside the classroom and its usual academic requirements.

These respondents had great concern over the quality of health care received from Goddard Health Center. There were strong doubts about the ability of Goddard Health Center to keep records confidential. Other concerns were about the medical professionalism and accuracy of diagnoses. Furthermore, only one of the respondents recognized the term *student affairs*; the remainder more readily identified this office as: The Center for Student Life; as it is known on this campus. While this may be true, no respondents were clear about the purpose of The Center for Student Life, and

all participants complained that the needs of Black female students were not being met.

NASPA (1987) states that while most traditional students are maturing intellectually, they are also developing physically, psychologically, socially, spiritually, ethically and sexually. Indeed, Student Affairs staff is expected to establish culturally competent programs that encourage healthy living; and prevention programs that confront abusive behaviors. Higher Education and Student Affairs must provide a forum where values can be tested and solutions sought for problems and persistent issues. To be sure, students learn responsibility when they bear the consequences of their action in a caring supportive environment. Whenever possible, colleges and universities should assist students when troubling circumstances interfere with learning.

Successful students who are able to work through difficult issues while in college must acquire new skills and attitudes that are associated with developing a sense of accomplishment and acquiring skill and knowledge by helping students acquire the necessary skills that will lead to success. The purpose of Student Affairs is to meet the basic needs of all young people. While this may be true, there is no student affairs division in the United States that has sufficient staff to address the overabundance of student needs, wants, and expectations (Komives & Woodard, 1996).

Another conclusion is that African-American college women have a high level of knowledge about safer-sex methods yet they are unwilling to practice most safer-sex methods because the methods are perceived by them to be unrealistic. Even

though vaginal and anal sex with a condom was seen as realistic behavior, most of these participants chose not to use any kind of protection because, they did not feel empowered enough in the relationship to look out for their own best interests. The respondents admitted that intercourse felt better to them, if a condom was not used. They also feared rejection or loss of the relationship if they insisted on the male partner using a condom. In fact, these respondents were willing to *please* their male partner at all costs, in hopes that their male partner would commit to the relationship; even if the behavior resulted in pregnancy. Respondents also noted that they were willing to disregard the fact their partner gave them a sexually transmitted infection. This attitude was motivated by the hope that they would stay together or get back together with their partner. For example: Participant #1 said: "I thought that maybe if we get back together everything will get smoothed over and I can act like this [trichomoniasis infection] ... I will pretend it never happened. Because I thought, you know, we might get into another relationship; but now I know ... only to get burnt" [again].

As infection patterns among college students compared to the larger population are the same or similar, college administrators must be diligent in consciousness raising tasks and educating all students, as all students may be subjected to the dangers of HIV/AIDS. Responding to these challenges requires comprehensive strategies designed to reach entire campus communities. Strategies directed toward educating a specific demographic group, (i.e. African Americans) will work best when it is embedded in a broader campus effort. That effort must be

sensitive to the unique culture of each campus and super sensitive to the culture of the African American college students (Moore & Blake, 1999, p. 2).

There is at least one extraordinary challenge presented when undertaking educating African American youth about HIV/AIDS. It is based on the history of the Tuskegee Experiment. This has resulted in African Americans perceiving a suspicion about the motives and goals of educators, specifically, fears of governmental conspiracies against the African-American community. Moore & Blake (1999) reference a 1997 study of African American beliefs regarding HIV/AIDS which found that 26% of respondents agreed that: HIV/AIDS is a man-made virus that the federal government made to kill and wipe out Black people. There were an additional 23% who were undecided regarding the statement's proposed validity. Men who participated in the study were 3.5 times more likely to agree with the conspiracy than their female counterpart. Those who agreed with the idea of the HIV/AIDS conspiracy tended to be culturally traditional, college-aged Black men who had experienced considerable racial discrimination (Klonoff & Landrine, 1999).

When encountering suspicions of conspiracy, one should not be dismissed as being irrational, especially when there is a perceived strong historical foundation that legitimizes the belief. Conspiracy fears are exacerbated by widespread rumors from governmental infiltration of Black protest movements to *disclosures* of government support of distribution of crack cocaine in central cities (Black Issues, 1998, October 29). Despite the fact that such fears may not be openly expressed among students, the fears can certainly impede successful action due to passive responses to information regarding risks associated with HIV/AIDS. Educators are further challenged by the

resentment and/or resistance among students who fear becoming stigmatized from negative connotations of race and substance abuse, in addition to being potential carriers of a life-threatening disease. Other obstacles for educators include beliefs that HIV/AIDS is a gay disease among White men. This perception combined with homophobic sentiments create patterns of denial of the disease's existence among Blacks. While homophobia is not unique to Black communities, when it is combined with conspiracy fears, governmental agency suspicions and racial discrimination, homophobic sentiments become a formidable barrier to health promotion efforts to counter HIV AIDS (Moore & Blake, 1999, p. 2).

Moore & Blake (1999) as faculty, administrators and authors are contemporaneously committed in uniting academic and student affairs in a comprehensive program of HIV/AIDS education. They also work with staff in campus leadership programs, residence halls, and other forums with the purpose of extending HIV/AIDS awareness into every phase of students' lives. One unique approach to overcome challenges unique to the African-American college student population might include building such educational programs around unique features of Black student culture through entertainment programs also sponsored by African-American fraternities and sororities. One such strategy in program development may include *Step Shows* which are derived from unique creativity exhibited in chants, lyrics and choreography. Other approaches may take advantage of today's contemporary popular cultures, (i.e.: hip-hop and/or rap groups) which spontaneously evolve among student populations, may prove to be a significantly more effective means of communications in such prevention program efforts. Other approaches may

include the development of competitions, (i.e. poetry slams) designed to combine academic and co-curricular efforts around the subject of HIV/AIDS education and prevention (Moore & Blake, 1999, p. 4).

The focus of such educational programs should include considerations designed to increase student involvement in their educational and social lifestyles. These programs are most effective when promoted as part and parcel of larger comprehensive efforts within the educational institution. Educational leaders should therefore see specific efforts as a series of concentric circles that start with a clear statement of purposes and goals. Within these circles there can be special programs that reach out to all the constituencies on campus (Moore & Blake, 1999, p. 4). Based on the preceding historically-based fears and perceptions, and strategies designed to specifically reach African-American college students as well as larger college student populations regarding the crises of HIV/AIDS in American society, academic administrators are therefore charged to develop a specific vision in their higher-education based leadership protocol (Moore & Blake, 1999).

Discussed in Chapter 1 is the conceptual framework which describes a set of epistemic assumptions or *ways of knowing* that are prevalent among college students. There is absolute knowing (certain of knowledge); transitional knowing (uncertainty in some areas) and independent knowing (uncertainty in most areas). Chickering's 1969 guide to *identity development* is particularly relevant because establishing identity encompasses all other areas of development. Establishing an identity is at the root of balance and security. Emphasis is placed on recognizing the importance of the knowledge-of-self before a young woman can understand the perspective of a

future male partner. In fact, a woman's sense of self becomes centered around being able to build and maintain relationships. Therefore she must be able to conquer what Chickering (1969) described as *managing emotions*. Special emphasis is placed on the student's ability to control sexually aggressive behavior while managing romantic attraction, fear, guilt or anxiety. Finally developing purpose helps young women clarify goals. Similarly, developing integrity which means she will personalize her values to a level that shifts away from harmful destructive behavior. In other words, if a young woman is able to develop a strong and positive sense of self, purpose, and integrity, then she will be able to balance her need to develop relationships with the opposite gender, because she will be centered on her personal growth and development (Reisser, 1995).

This study affirms DiClemente & Peterson's (1994) research that concludes that women often fail to implement safer-sex because young females hold attitudes and beliefs that are incompatible to initiating safer-sex practices. For example, Focus Group-A participant #2 explained that she suspected that her boyfriend might be having multiple partners; however she "really didn't want to make him back off because [she] insisted so much on using protection ... [she] just wanted to make sure he was satisfied". Behavioral change studies explain that there are four interrelated concepts which guide the behavioral change process. (1) if she feels susceptible or vulnerable to contracting a sexually transmitted infection; (2) if she perceives some severe consequence of her behavior; (3) if she believes one behavior out weighs another and (4) if the negative consequence of contracting and STI is great enough to change the level of risk she is willing to take. While this may be true, participant #1

admitted she was willing to forget that her boyfriend had given her Trichomoniasis, if this meant that they might get back together. It was only after she had been infected a second time that was she willing to stop having unprotected sex with him.

The literature review warned us that sexually transmitted infections including HIV/AIDS is among the African-American student population. In fact, of the reported cases among adults 20-24 African-American females made up 41.4% (Moore & Blake, 1999). Further, the Oklahoma rates of syphilis, gonorrhea and chlamydia rates were highest among Blacks who were 20 to 24 years old (OSDH, 1993, 1997, 1998). In 2000, the CDC informed us that African-American women represented 38% of all the HIV/AIDS cases acquired due to heterosexual contact. This growing population of students who are living with HIV/AIDS has presented a challenge to campus officials, that until now, have been unwilling to face. There are many studies that document college student sexual activity; more importantly, there are several studies that document warned us that of multiple sex partners among 18 to 25 year old heterosexual men. NASPA (1998) clearly states that alcohol use has led to unintended intercourse and date rape. Also noted is the fact that alcohol weakens the immune system which makes it easier for infection to occur. Kerr (1998) called for educators begin to discuss the relationship between alcohol and sexual behavior. As far back as 1989, the National Institutes of Health reported a connection STIs to HIV/AIDS. For every seven cases of syphilis there is one case of AIDS, and for every ten cases of gonorrhea there is one case of AIDS. For every 100 cases of chlamydia there is one case of AIDS.

Johnson, et al., (1994) confirmed that there was a specific connection to

syphilis and HIV/AIDS. Their study found that of the students who were infected with HIV/AIDS; many of those same students had previously been treated for syphilis. Indeed, the African Americans who were living with HIV/AIDS in this study, had a very low-level of knowledge about the transmission of STIs/HIV/AIDS. On the other hand, this is not the case for students in this study. The level of knowledge on how to prevent infection was adequate among the women in this study. However, the respondents indicated that they felt like they had to please their partner; so out of fear of losing the relationship (in some cases), they consented to unprotected sex. In fact, African-American females become exploited by men who plead and beg incessantly for sex; and, because these women want to be loved, they allow unprotected sex (Baer & Jones, 1992).

The results of this study demonstrate that these college women were able to continue with their academic life even though they had children in most cases, and in some cases had encountered a sexually transmitted infection such as trichomoniasis, chlamydia and gonorrhea. The women in this study continue to be full-time students. Even though becoming a parent gave these students more responsibility; it appears to have also provided them the needed purpose in life to continue their academic quest. Without a doubt, this study confirms Elliot et. al. (1997), who reported that college students who conquer their social-problems have more success in adapting to the demands of academic life.

This study confirms Ishii-Kuntz, et al., (1990), who also interviewed heterosexual college students and found as this study did, that *trust* and belief that they are in a monogamous relationship was a significant reason why these females

had unprotected sex. For example, after the couple has been together for a couple of months, they stop using condoms and she may stop using birth control if she thinks that getting pregnant will commit him to the relationship. Participant #3 stated the reason she "had unprotected sex is because I just really liked this person and I just wanted to feel something different". She continued by confessing that "when you're with somebody for awhile and you're always using a condom and then you say, well, lets not use a condom, its like it might draw you a little bit closer to them".

The NCPADA (1994) suggested that there is a critical link between alcohol and high-risk sexual behavior. Certainly, it has been acknowledged that drinking alcohol lowers one's inhibitions and may have a devastating effect on a woman's vulnerability. However, only one participant agreed that alcohol has *everything* to do with her having unprotected sex. Most women in this study argued that a woman knows if she wants to have sex with that man beforehand and she only uses the alcohol as an excuse to do what she wanted to do anyway.

The literature suggests that consistent condom use reduces one's chances of obtaining a sexually transmitted infection. Other studies found that young men are twice as likely to have multiple partners as young women. While this may be true, the findings in this study suggest that the issue of condoms and communication about number of previous partners was non-existent. Most participants would not even bring the subject matter up because she perceived that her partner would think that she was a *slut*. Another prevailing attitude emerged from this study, that is: if she asked about condoms, then she reasoned that this would suggest to the male partner, that she was unfaithful. Likewise, if she inquired about the number of his previous

partners. then she reasoned that he would think that she did not trust him. To illustrate further. another participant *just thought* her partner *always used condoms.* Indeed. she was very naïve because did not know that her partner did not use a condom. until after she became pregnant. Another conclusion is women must feel as if they have enough power in their relationships if they are to be confident enough to insist on her partner using a condom.

This study confirms NASPA's (1998) findings that college students need more than information. Students need to develop communication and decision-making skills. In addition women especially need to develop their negotiations skills especially about using condoms. This study also confirms DiClemente. Forest & Mickle (1990) who stated that knowledge alone does not change behavior. The pre-focus group interviews indicated that the study participants had adequate knowledge about how to protect themselves from pregnancy and STIs; however the underlying motivation was *fear of losing the relationship.* Hence. the study participants. allowed their male partner to have control over their behavior.

CONCLUSIONS. RECOMMENDATIONS AND FUTURE RESEARCH

The following are some of the conclusions:

- Study participants stated that women need culturally-based sex-education focusing on self-empowerment and self esteem;
- The women in the study expressed the lack of relationship counseling by African-American professionals;
- Participants suggested prevention education about Sexually Transmitted Infections (STIs);
- Participants identified Parenting –Education and Support. as a critical need;
- Analysis of data suggested to integrate a sustained campus-based prevention

by building partnerships between Student Affairs and all other campus departments:

- Comments by participants suggested that *safer-sex* methods were perceived as unrealistic:
- Students were reluctant to use on-campus health facilities because of concern over privacy and accuracy of medical diagnoses, and finally
- Becoming a parent appeared to provide female-students with responsibility and a purpose in life.

More research is needed on the African-Centered approach to problem solving by investigating how connecting to one's African Identity and self–concept development can empower people to take control of their sexual health.

Moore & Blake (2001) conclude that the dramatic rise of infection rates among African-American communities, along with increased knowledge of the disease and fears of infection, has created a critical opportunity for the university. The conditions are extremely favorable for programs that will promote healthy sexual behavior designed to prevent HIV/AIDS and other sexually transmitted infections. The authors conclude that creating effective programs will require campus leadership that has a clear vision and an extraordinary level of sensitivity and understanding. Cooperative programs should be built among faculty, students and external community groups. To be sure, African-American and other college women will greatly benefit from a program that is designed to increase her ability to feel confident and powerful in her relationships; if this can be accomplished behavior change is imminent.

In conclusion, the trends of sexually transmitted infections and HIV/AIDS among young African-American women in the United States clearly indicate that colleges and universities must take ownership of their responsibility to provide

African-American students with a culturally competent outreach, prevention, education and counseling program. At its center, the program must focus on improving the self-efficacy of its participants. In other words, increase the notion among women that they have the personal power to control their level of high-risk behavior.

Moore & Blake (2001) recommend that the most effective way to prevent STIs/HIV/AIDs is to integrate a sustained campus-based prevention program into the entire campus. Therefore it will be necessary to build partnerships between student affairs units and other campus departments or constituencies. The National Association of Personnel Administrators (NASPA), provide counsel and guidance to campuses through the Health Education and Leadership Program (HELP) recommend the following partnership development in order to integrate HIVAIDS prevention campus-wide:

1: **Academic**--the Successful combination of credit bearing courses with HIV/AIDS prevention at its center can enhance longevity as well as effectiveness. In these courses professors always introduce a unit on health in multicultural communities, with emphasis on the increase of HIV/AIDS. Students have the opportunity to learn more about the epidemic as a part of their overall learning expectations.

2: **Greek-letter organizations**--have made HIV/AIDS prevention a central issue by sponsoring workshops, speakers, discussion groups and some organizations have rapping and rhyming contests; while some organizations incorporate prevention messages in their

performance and step-shows.

3: **Women's student groups**--can help spread the prevention message to its constituencies in a variety of ways through poetry readings or motivational speakers: these groups would be the perfect mechanism to address: *self-esteem issues for women only*. Surely, this could be a place where students with children might feel welcome to attend if a genuine effort was made to accommodate their needs.

4: **Community organizations**—whose mission is to promote sexual health and responsibility should be contacted and encouraged to offer their prevention and empowerment messages to students. Campus leaders will have to reach out and build coalitions with such groups. Indeed, greater access of the academy to the general community will strengthen the university's presence and give validity to its authority to lead.

5: **Gay, Lesbian, Bisexual and Brothers on the *Down-low*:** The campus-community must not forget about students who are not heterosexual. However, this is a delicate matter. In the Black community; the general thought is that you can be homosexual but do not flaunt your preference in public or you might be thought of as an embarrassment. Therefore, if we are to reach these brothers and sisters then it must be through programming that is mainstreamed within the messages given to all other Black students.

Fields (2002) recommends that today's institutions offer a variety of student

support services focusing on sexual health and sexual responsibility. If programs are to be effective then they must offer a variety of prevention techniques including: condom distribution, birth control and emergency contraception; and education workshops designed to prevent HIV/AIDS and other sexually transmitted infections. The author emphasizes that sexual health and responsibility should be covered in a required freshman seminar class because reaching students early with information about appropriate sexual behavior is the key to preventing infection among students. In addition, the university must form relationships with community healthcare providers who can come on the campus and conduct HIV/AIDS, pregnancy, and mammogram testing or screening. Finally, it is recommended that the division of Student Affairs coordinate with the campus health center, residence halls staff, campus police and Greek letter organizations in the establishment of a relevant and culturally competent peer-counselor program that focuses on improving male responsibility and women's self-esteem.

Asante (1980) described the African-centered philosophical approach to problem solving as using the multi-disciplinary approach which is a comprehensive application to problem solving. This philosophy recognizes that there is no separation from the student's social, spiritual and material world. Hence, beliefs and values; prevention and education resources; as well as, fear and self-efficacy all function together. I agree with Asante that students will not be able to accomplish absolute behavior-change without a realization of their spiritual connection to their creator, working in conjunction with their knowledge, resources and values. In other words, if young women begin to realize that God lives inside of them, perhaps they

will begin to honor the best in themselves. As a result, meaning and substance will be added to their lives. Therefore young women and men will begin to value themselves and regard life as a precious gift. If this occurs then perhaps the female college student will be empowered enough whereby she can effectively communicate, negotiate and control her level of high-risk behavior.

More research is needed on the African-Centered approach to problem solving. In addition, scholars should investigate the connection between how African identity and self-concept development can empower people to take control of their sexual health. Thompson & Chambers (2000) point to Baldwin (1985) who argues that a positive African self-consciousness is a prerequisite for optimal health among African Americans. Nobles (1986) contend that accepting our African-identity does influence how we respond to our concrete condition. Likewise, Akbar (1995) stated that self-acceptance is the beginning for all positive social activity. The author states further that self-knowledge acquaints a person with the best of their human potential. In fact, DiClimente & Peterson (1994) support the need for more studies that will contrast the effects of the African-centered approach to intervention with other culturally sensitive prevention techniques. Future research should focus on male sexual health, and responsibility; we need to know Black-male perspective on why Black athletes choose to date White women.

Other research is needed in order to understand more about date rape and why women are reluctant to report date rape. Finally, we should study what benefits women receive by revealing their deepest sexual-secrets. There is value added to her existence because she is able to tell her story; we should readily investigate how

telling her story empowers her to change her behavior.

APPENDIX A

Focus Group Pre-Survey Questions
PLEASE CIRCLE THE ANSWERS THAT APPLY TO YOU

1. My age is: 18 19 20 21 22 24 25 26 27 28 29 30 over 30.

2. From where do you receive most of your information about preventing STIs/HIV/AIDS? (a) Television (b) Radio (c) Newspaper (d) Classroom (e) Relatives or (f) Peers/friends.

3. The best way to keep from getting a sexually transmitted infection is: (a) only have one-partner (b) always use a condom (c) always use a diaphragm (d) get tested before participating in sexual intercourse or (e) do not have intercourse.

4. The best kind of condom to use to protect yourself from STIs/HIV/AIDS is: (a) plastic (b) latex (c) rubber (d) polyurethane (e)natural (f) lambskin

5. The two most likely body fluids that will infect a person with HIV/AIDS are: (a) breast milk (b) blood (c) vaginal fluid (d) semen/sperm (e) sweat (f) saliva (g) tears

6 Which infections cannot be cured: (a) Syphilis (b) Trichomoniasis (c) P.I.D. (d) Lice
(e) Scabies (f) Hepatitis-B (g) HIV/AIDS (h) Herpes (i) HPV/Condyloma (j) Gonorrhea

7. Do you think of yourself as being: (a) Gay (b) Lesbian (c) Straight (d) Heterosexual
(e) Homosexual (f) Bisexual?

8. (a) Wet kissing is: Low-risk medium-risk or high-risk

(b) Protected anal intercourse is: Low-risk medium-risk or high-risk

(c) Protected vaginal intercourse is: Low-risk medium-risk or high-risk

(d) Oral intercourse is: Low-risk medium-risk or high-risk

9. Please complete the following statement on the back of this sheet. African-American college women are most likely to change their behavior from high-risk to low-risk if. . . .

APPENDIX B

Demographic Profile Focus Groups and Individual Participants

1. How old are you?
2. What is your religious affiliation?
3. Do you attend church regularly?
4. If your father has an occupation outside the home, what does he do?
5. If your mother has an occupation outside the home, what doe she does?
6. How many brothers and sisters do you have?
7. At what age did you have your first menstrual period?
8. Did you attend and urban, suburban or rural high school?
9. How many students were in your graduating class?
10. How many credit hours have you completed at Oklahoma University?
11. What is the highest educational level completed by your mother?
12. What is the highest educational level completed by your father?
13. Who else in your family has a college degree? What level?

    AA; BA; MA; Ph.D; JD; _____other

APPENDIX C

Focus Group Questions

1. Do family relations with parents and siblings affect a young woman's perception about the opposite sex? If so explain how?: If not, why not?

2. Explain how the maturation process (puberty) affects a young African-American woman's ability to communicate with the opposite sex?

3. The guidelines for safer-sex include: Anal, Vaginal, and oral sex with a latex condom or barrier, monogamous relationships, mutual masturbation, and body to body rubbing. Are these guidelines realistic for you, and the students you know. Why or why not?

4 What do you consider to be the sexual behavior that is the greatest risk: vaginal intercourse, anal intercourse, or oral penetration?

5. Regarding the students you know, under which circumstances are they most likely to participate in high-risk sexual behavior? Explain how much influence alcohol and drug use contribute to a woman' s decision to allow unprotected sex?

6. How much influence do family values have on a students likelihood to participate in high-risk behavior?

7. What are the physical, mental, social, and sexual qualities in men that cause African-American college women to feel increased self-esteem, confidence, desire, love, or hate?

8. Are there students you know who have contracted a sexually transmitted infection such as: gonorrhea, syphilis, lice (crabs), chlamydia, trichomoniasis, herpes, or condyloma (warts)? If so, how did this affect their social or academic life?

9. Where do students receive information that has the most impact on their decision to practice safer-sex behavior?

10. If you were responsible for Student Affairs on this campus how would you implement an HIV/AIDS prevention program? a) How do the prevention messages address African-American culture on campus? b) What messages have the greatest influence on Black women?

11. What is the best method to motivate Black males on campus to practice safer-sexual behavior? How about Black women?

APPENDIX D

Individual Interview Questions

1. Reflect on what constitutes an ideal relationship between men and African-American college women?

2. Explain how the maturation process (puberty) affect a young African-American woman' s ability to communicate withe the opposite sex?

3. What significant moments do you remember most about your maturation process? Explain why it is significant?

4. How do family relations with parents and siblings affect a young woman's perception about the opposite sex? If not, explain why not?

5. How do family life-experiences affect an African-American college woman's attitude toward relationships with the opposite sex? If not, explain why not?

6. Are there family experiences that occur and influence young women to seek-out relationships with males? If so, describe the experience? If not, explain why not?

7. What are the physical, mental, social, and sexual qualities in men that cause African-American college women to feel increased self-esteem, confidence, desire, love, or hate?

8. Are there episodes, events, situations or circumstances that exist with males that cause African-American college women to feel recognized, accepted and/or valued? If so, explain why not?

9. Do life-experiences influence an African-American college woman's attitude and motivation to participate in unprotected sex? a) If so, describe which life-circumstances may have the greatest influence? b)Describe which life-circumstances have the least influence on a young woman's attitude and motivation to participate in unprotected sex?

10. Are there factors that make it difficult for an African-American college woman to control the level of risk she will allow with a male partner? If so, what are those factors that have influence on a young woman's attitude or motivation to participate in unprotected sex?

APPENDIX E

Informed Consent for Individual Interview Participants

This research is being conducted under the auspices of The University of Oklahoma. The principal investigator is Khepra NuRa Khem who is a doctoral student in Educational Leadership and Policy Studies Department of the College of Education. This document is evidence of informed consent.

The title of the research is High-Risk Sexual Behaviors of College Students: Perceptions of African-American College Women. The purpose of the study is to develop insight and understanding with regard to why African-American college women participate in high risk sexual behaviors. Related to this central concern are questions of life-history, personal experiences and other life-circumstances that contribute to decisions to engage in high-risk sexual behavior. The investigator will record and examine through focus groups and face-to-face interviews those factors that may have placed the participants in high-risk sexual behaviors.

I understand that life-history questions dealing with me will occur during the interview process and that my participation in this research project is completely voluntary. I also understand that I may choose to discontinue my participation without penalty of any sort. **I also understand the interview will take no longer than four hours and will be audio taped.** I have been informed that I must be 18 years or older to participate in this study.

Benefits

I understand that this study may assist college women in developing stronger negotiation skills with respect to limiting their involvement in high-risk sexual behaviors.

Risks

If you experience any negative emotional feelings as a result of this project and feel the need to talk with someone other than the researcher please contact: Michael Daves at Goddard Health Center Counseling Services, 325-4611.

I understand that my personal risks are very minimal. **I also understand that there might be some personal distress, as I discuss some personal experiences.**. I also understand there will be no mention of my name, major, hometown, or names of my sexual partners. I agree to be identified only as 'P' which stands for participant; with a corresponding number such as P1, P2, P3, or P4, etc.

Participant's Assurances of Minimal Risks

I understand that any information collected is strictly confidential. I am assured that this information will not be shred with anyone in any way which could reveal my personal history. **I also understand that third person will observe the process in order to minimize all personal risk.**

I want to have the opportunity, if necessary, to read, re-read, and make final suggestions to modify any information pertaining to myself.

I understand and agree that **all data collected will be stored in locked file cabinets, and will be destroyed upon completion of the study.**

Contacts for Questions

Dr. Dorscine Littles, Human Relations	405-325.1756
Dr. Rosa Cintron, Educational Leadership	405.325.3521
Dr. Jerome Weber, Educational Leadership	405.325.3629
Khepra NuRa Khem	405.858.0758

Questions regarding your rights as a research participant should be directed to the office of Research Administration at (405) 325-4757 or email at irb@ou.edu

My signature below indicates **that I am at least 18 years old**. As **an individual interview participant** my permission is given to Khepra NuRa Khem to include only approved information regarding my interview. **I agree to the presence of a third person during the interview.** I agree that the data collected for this research become the property of Khepra NuRa Khem. However, I reserve full rights and privileges regarding the dissemination of personal information with explicit scrutiny by me or my legally authorized representative.

_____ _____

(Participants's name) Date

_____ _____

Khepra NuRa Khem Date

APPENDIX F

Informed Consent for Focus Groups

This research is being conducted under the auspices of The University of Oklahoma. The principal investigator is Khepra NuRa Khem who is a doctoral student in the Educational Leadership and Policy Studies of the College of Education. This document is evidence of informed consent.

The title of the research is High-Risk Sexual Behaviors of College Students: Perceptions of African-American College Women. The purpose of the study is to develop more insight and understanding with regard to why African-American college women participate in high risk sexual behaviors. Related to this central concern are questions of life-history, personal experiences and other life-circumstances that contribute to decisions to engage in high-risk sexual behavior. The investigator will record and examine through focus groups and face-to-face interviews those factors that may have placed the participants in high-risk sexual behaviors.

I understand that life-history questions dealing with me will occur during the interview process and that my participation in this research project is completely voluntary. I also understand that I may choose to discontinue my participation without penalty of any sort. **I also understand the interview will take no longer than four hours and will be audio taped.** I have been formed that I must be 18 years or older to participate in this study.

Benefits

I understand that this study may assist college women in developing stronger negotiation skills with respect to limiting their involvement in high-risk sexual behaviors.

Risks

If you experience any negative emotional feelings as a result of this project and feel the need to talk with someone other than the researcher please contact: Michael Daves at Goddard Health Center Counseling Services, 325-4611.

I understand that my personal risks are very minimal. **I also understand that there might be some personal distress, as I discuss some personal experiences.**. I also understand there will be no mention of my name, major, hometown, or names of my sexual partners. I agree to be identified only as 'P' which stands for participant; with a corresponding number such as P1, P2, P3, or P4, etc. **I also understand that other participants may not keep the information confidential.**

Participant's Assurances of Minimal Risks

I understand that any information collected is strictly confidential. I am assured that this information will not be shared with anyone in any way which could reveal my personal history.
I want to have the opportunity, if necessary, to read, re-read, and make final suggestions to modify any information pertaining to myself.

I understand and agree that **all data collected will be stored in locked file cabinets, and will be destroyed upon completion of the study.**

Contact for Questions

Dr. Dorscine Littles, Human Relations	405-325.1756
Dr. Rosa Cintron, Educational Leadership	405.325.3521
Dr. Jerome Weber, Educational Leadership	405.325.3629
Khepra NuRa Khem	405.858.0758

Questions regarding your rights, as a research participant should be directed to the office of Research Administration at 405 325-4757 or email at irb@ou.edu

My signature below indicates that **I am at least 18 years old. As a Focus Group participant** my permission is given to Khepra NuRa Khem to include only approved information regarding my interview.

____Yes, I agree to allow the focus group to be audio taped.
____No , I do not want the focus group audio taped

_____ _____
(Participants's name) Date

_____ _____
Khepra NuRa Khem Date

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