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# Attitudes Toward Sexuality and Sexual Behaviors of Asian-American Adolescents: Implications for Risk of HIV Infection

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**Attitudes Toward  
Sexuality and  
Sexual Behaviors  
of Asian-American  
Adolescents**

*Implications for Risk of HIV  
Infection*

**by**

**Connie S. Chan**

*September 1997*

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*An Occasional Paper*

INSTITUTE FOR ASIAN AMERICAN STUDIES

September 1997

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Dr. Connie Chan is Associate Professor of Human Services in the College of Public and Community Service and Co-Director of the Institute for Asian American Studies at the University of Massachusetts Boston. Her writing and research focus upon the fluidity of bicultural issues in the development of gender, cultural, and sexual identities for Asian Americans.

*The views contained in this paper are those of the author and not necessarily of the Institute for Asian American Studies.*



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# Attitudes Toward Sexuality and Sexual Behaviors of Asian-American Adolescents

## *Implications for Risk of HIV Infection<sup>1</sup>*

CONNIE S. CHAN

### Introduction

Until 1990, Asian Americans represented an ethnic minority group that was perceived to be at lower risk than African Americans or Hispanics/Latinos for HIV infection, the presumed causal agent for AIDS (Centers for Disease Control, 1989). Reasons cited for this perception include behavioral differences in intravenous drug use (Centers for Disease Control, 1989), sexual behavioral habits (Cochran & Mays, 1988), and underidentification of AIDS cases (Aoki, Ngin, Mo, & Ja, 1989). However, in urban areas such as San Francisco, Toronto, New York, Boston, Los Angeles, and Seattle, where Asians have immi-

grated and settled in large numbers, cases of HIV infection and AIDS have begun to increase dramatically (Aoki et al., 1989), perhaps reflecting the rise in the number of AIDS cases in Asia. In 1994 the World Health Organization estimated the number of adult HIV infections in East, Southeast, and South Asia at 3 million, compared to 1 million in North America.

In San Francisco, Americans of Asian and Pacific Island descent (APIs) represent 33% of the population and, in 1988, recorded the largest percentage increase in reported AIDS cases in comparison to other ethnic minority groups (Mandel & Kitano, 1989). Although the number of Asian-American AIDS cases

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<sup>1</sup>Funding for this study was provided by the Institute for Asian American Studies at the University of Massachusetts Boston and The Center for Education in the Inner Cities at Temple University. Reprinted, by permission, from *Social and Emotional Adjustment and Family Relations in Ethnic Minority Families*, edited by Ronald W. Taylor and Margaret C. Wang (New Jersey: Lawrence Erlbaum Associates, Inc., 1997), pp. 133-144.



was relatively low before 1990, a review of existing data indicates that the number of reported cases is increasing.

There has been little empirical research focusing on sexual behaviors of Asian Americans and their risk for HIV infection and other sexually transmitted diseases (STDs). There is reason to believe that the extent of the AIDS epidemic in the Asian-American community is not well understood and that the actual number of Asian Americans who may test HIV-positive has not been accurately measured. The extent to which cultural beliefs and types of behaviors may contribute to or protect against HIV infection in the Asian-American population is still unknown.

Even less is known about Asian-American adolescents' perceptions of "risky" behavior that leads to HIV infection, the social factors underlying these perceptions, and their knowledge of AIDS (Strunin, 1991). There are several factors which may contribute to this lack of information about Asian Americans and AIDS.

First, the methods by which surveillance data on AIDS have been collected and reported give an incomplete picture of the epidemic among Asian Americans. In most reports, Asians are combined with Pacific Islanders or placed with Native Americans in an "other" category. When there is a category of Asians, linguistically, racially, and culturally different Asian groups are combined into one general category. This general grouping of Asians makes it impossible to distinguish trends, modes of transmission, or other variables in the Asian ethnic groups or communities (Aoki et al., 1989).

Second, the diversity of the API group is extraordinary. There is no single "Asian-

American" community in the United States; rather, it consists of many subcommunities of ethnic Asian-American groups such as Chinese, Japanese, Filipino, Indians, Koreans, Vietnamese, Cambodians, Samoans, and so forth. According to the 1990 U.S. Census (U.S. Bureau of the Census, 1992) the "Asian" category covers 29 different groups and the "Pacific Islander" category comprises 20 distinct racial and ethnic groups. Collectively, these groups speak more than 100 languages and dialects. Even within specific ethnic groups—for example, between fifth-generation Chinese and new immigrants—there can be great cultural, social, economic, religious, political, and geographic differences.

Impediments to gathering adequate data on the HIV status of the Asian-American population include the diversity of the population, its relatively small size in this country (3% of the total population), and the inability to make inferences at the national level about the community as a whole. In the few state and local studies that address the health status of Asian Americans, generalizations about the entire Asian-American community cannot be made because of the diversity of the community and differences in their geographic distribution. Moreover, APIs currently comprise the third-largest U.S. minority group, and are the fastest growing community of color, with annual growth rates that may exceed 40% during the 1990s. By the year 2050, it is predicted that the API population in the United States will grow to 41 million.

Of the 242,146 AIDS cases in the United States through September 1992, the Centers for Disease Control (1992) reported that 1,525 (0.6%) were identified as APIs. The male-to-female ratio of AIDS cases and deaths is approximately 11 to 1. Of the AIDS cases in

the API community, 74% were contracted by men who have had sex with men, compared with 58% for all races. The 1992 data resembles data collected at the beginning of the epidemic for other racial groups, leading to speculation that the API communities are still in the early stages of a growing HIV epidemic. Given the relative geographic and psychosocial isolation of many API communities, the effect of an infectious disease may be magnified and spread more quickly once it takes hold. The course of the epidemic in these communities may well begin to resemble that of the African-American and Hispanic/Latino communities, with increases among the heterosexual population, women, and children. It is imperative that culturally aware and effective prevention methods and education be implemented as quickly as possible, especially with adolescent youth who are sexually active.

Even with reports of increased seroprevalence in communities with large API populations such as San Francisco, where it was estimated that 35% (2,034 individuals) of homosexual and bisexual API men are infected with HIV, there has been a sense among local, state, and federal agencies, as well as AIDS organizations, that APIs have lower risk for contracting AIDS. As a result, little attention has been given to APIs regarding AIDS prevention programming, sexual practices, AIDS knowledge, beliefs, and attitudes towards AIDS and sexuality.

### **Asian-American Adolescents**

In 1992, 20% of all reported AIDS cases were in the 16- to 29-year-old age group, and rates among 11- to 24-year-olds have doubled each year (Centers for Disease Control, 1992).

Because the AIDS incubation period is estimated to be from 2 to 7 years, this group is likely to have been infected during adolescence (Strunin, 1991). Surveys of U.S. adolescents demonstrate that approximately 50% of teenagers have had sexual intercourse by the age of 16, and more than 70% by age 19 (Zelnik & Kanter, 1980). Yet all of these sexually active teenagers are not at equal risk for HIV infection and other STDs. Those adolescents who have intercourse at an earlier age, or whose patterns of sexual behavior include more partners and anal sex, those who use alcohol and drugs, as well as those who drop out of school or are of low socioeconomic status (SES) may be at greater risk. Research has demonstrated that the age at which sexual activity begins differs by racial and ethnic background, with earlier sexual experience correlated with higher risk of contracting an STD (Irwin, 1985). Although African Americans have the highest rates for most STDs, and rates for Hispanic/Latinos fall between the rates for African Americans and White adolescents (Irwin et al., 1985), the rates for Asian-American adolescents were not measured in these studies.

Although some studies of adolescents suggest that knowledge concerning transmission of HIV is increasing, few adolescents in the early years of the AIDS epidemic (1986–1989) considered themselves at risk for contracting HIV—nor did they report changing their behavior to reduce the risk of contracting the virus (Di Clemente, Zorn, & Temoshuk, 1987; Strunin, 1991; Strunin & Hingson, 1987). In Strunin and Hingson's survey of 860 Massachusetts adolescents, 54% were not worried about contracting AIDS and 61% did not think that it was likely that they would get AIDS in their lifetime. Only 15% of sexually

active adolescents reported changing their sexual practices to avoid contracting HIV. In 1988, Weisman and colleagues found that 90% of a sample of 400 adolescent girls knew that "unprotected sex" was a high risk activity for contracting the AIDS virus, but fewer than 40% of the girls had used condoms the last time they had had intercourse. However, as AIDS awareness and education have increased both in the public view and in some educational settings, adolescents today may be more knowledgeable about AIDS risks.

Racial and ethnic differences in knowledge and perceived risk were found by Di Clemente in a 1988 sample of 261 White, 226 African-American, and 142 Hispanic/Latino students. The adolescents who knew less about AIDS transmission were more likely to perceive themselves at higher risk for contracting the virus, with white adolescents the most knowledgeable and Hispanic/Latino adolescents the least knowledgeable about AIDS.

Although it is sparse, research on Asian-American adolescents' knowledge of AIDS transmission and perceived risks, their attitudes towards sexuality, and reported sexual activity indicates that Asian-American students may be less knowledgeable about AIDS than their non-Asian peers. A 1987 survey of San Francisco-area high school students found that Asian-American students were the least knowledgeable racial group of students regarding AIDS information (Di Clemente et al., 1987). Telephone and high school surveys, conducted in Massachusetts in 1988 with more than 2,000 adolescents, demonstrated that ethnicity was an important predictor of knowledge about AIDS (Strunin, 1991). Strunin's study found that Asian-American adolescents knew significantly less about the

ways in which the virus can be transmitted sexually, and about drug-use transmission of the HIV virus, than did White, African-American, or Hispanic/Latino adolescents. Although the percentage of Asian-American respondents in the survey was very low (3% of the total sample), this study found that significantly more Asian-American adolescents (94% compared to 73% of Whites and Hispanics/Latinos, and 69% of African Americans) were worried about getting AIDS. This finding is even more remarkable in that significantly fewer numbers of Asian Americans reported having heterosexual intercourse in the past year—only 19%, compared with 61% of Hispanics/Latinos, 63% of Whites, and 74% of African Americans. Strunin suggested that because the majority of her Asian-American sample consisted of recent U.S. immigrants, they may adhere more closely to ethnic cultural expectations of abstinence, and may not have been exposed to AIDS education in school or at home.

Indeed, some research indicates that cultural pressures may result in reduced behavioral risk for HIV, as it describes a "sexual conservatism" among Asian-American young adults. Research has reported that Asian Americans are significantly less likely to talk about sex than Whites, African Americans, and Hispanics/Latinos (Erickson and Moore, 1986), and are more disapproving of marital infidelity (Christensen, 1973). However, as Cochran et al. (1991) commented, not outwardly expressing one's sexuality is not necessarily the same as not engaging in HIV-related risk behavior. Cochran's study of 153 Asian-American college students at the University of California, Los Angeles (UCLA) found that previously reported sexual conservatism within this ethnic group may be limited

to the initiation of sexual activity. Once sexually active, sexual behaviors appear to be similar to that of their non-Asian counterparts. They found that Asian-American students were practicing sexual behaviors that were risky, including low rates of condom use (11%), and sexual behaviors that would transmit the HIV virus if present. According to the study, Asian-American college students at UCLA are at the same risk for transmission of HIV as are their non-Asian counterparts. If this is true, the potential transmission of HIV within the Asian-American population is likely to be greater than previously assumed.

Any discussion of sexuality and sexual behaviors within Asian-American cultures is complex and problematic. There is no one Asian-American culture but, rather, many separate and distinct ethnic and cultural groupings within the Asian-American community. Even if one were to believe that Asians share a common cultural expectation that reinforces sexually conservative behaviors due to the traditional Asian values of family unity and the desire to not bring shame on the family, the extent to which these cultural values affect Asian-American adolescents who are also exposed to the hegemonic American cultural values is unknown and must be taken into consideration. In addition, lumping all Asian-American subgroups into one is not useful in measuring AIDS knowledge and sexual behaviors, which may differ dramatically depending on ethnicity, length of stay in the United States, socioeconomic status, and education, among other factors. Future research measuring attitudes, knowledge, risk factors, and behaviors of specific Asian-American ethnic and cultural groups rather than combining all groups into a single Asian category would be more applicable to AIDS education strategies.

### **Implications for AIDS Education**

Because Asian cultures have a tradition of keeping issues of sexuality, sexual expression, and sexual identity within the private realm and discouraging discussion of sexuality in public forums, the majority of Asian Americans may not consider themselves as having a sexual identity such as homosexual, heterosexual or bisexual (Chan, 1994). This lack of a sexual identity, combined with the taboo of not discussing sexual activity or sexuality in public, may contribute to the perception that Asian Americans are at lower risk for HIV infection and other STDs.

This chapter assesses Asian-American adolescents' knowledge about AIDS transmission, their attitudes about AIDS, their sexual behaviors, and explores whether there are differences between a Cambodian group, which comprises half of the sample, and an "Other Asian" group, which is comprised of adolescents from Chinese, Vietnamese, and South Asian backgrounds. Although the original design called for equal numbers of each ethnic group, in this pilot study we were unable to survey large enough numbers of Chinese, Vietnamese, and South Asians to do analyses by separate ethnic groups. Thus, these three groups are combined into an "Other Asian" category in comparison with a Cambodian group comprised of participants in a youth project. In addition to ethnic and cultural differences, there is a difference between the groups with regard to socioeconomic class (the Cambodian group is based in Revere, a working-class city north of Boston, whereas the "Other Asian" group comes from more varied socioeconomic backgrounds in the

Boston metropolitan area).

## Method

Questionnaires were completed by 80 adolescents (40 boys and 40 girls) in the Boston and Revere geographic areas from July through December, 1994. Participants were recruited from a neighborhood youth program called ROCA-Revere, and from two Asian-American youth programs in the Boston area. Approximately 17% were born in the United States, 49% in Cambodia, 13% in China, 6% in Vietnam, and 5% in Thailand. The length of time this sample group had lived in the United States ranged from 1 year to 17 years (since birth). An overwhelming majority (90%) of this sample speak a language other than English, with 60% speaking Khmer (the language of Cambodia), 13% Cantonese, 5% Vietnamese, and 4% Korean. Participants ranged from 14 to 19 years old (median = 16.1), and all were enrolled in high school (median grade = 10.1).

## Procedure

Questionnaires consisting of 35 items were administered to 96 high school students of Cambodian, Chinese, Vietnamese, and Indian descent. The items included demographic data collection, and assessed AIDS knowledge, attitudes towards AIDS, and personal sexual behaviors, including frequency of sexual contact with males and females, use of condoms, and prior sexual experiences of the respondents. All questionnaires were completed anonymously and on a volunteer basis. Ninety-six questionnaires were distributed, 16 of which were discarded because the respon-

dents did not complete at least half of the questions, or provided obviously false data (such as giving their age as 50, or listing 500 sexual partners in the past year). Eighty participants, comprising the sample group, completed the entire questionnaire with valid data.

The questionnaire included questions from two AIDS awareness and attitude surveys conducted previously in Massachusetts high schools and among adolescents (Strunin, 1991), and by adding additional questions concerning sexual behaviors (regarding anal and oral sex), as well as questions concerning ethnicity and primary language.

One-way ANOVA tested the significance of differences in responses among the Cambodian Americans and the other Asian American groups. The one-way ANOVA also evaluated any significant differences by gender in the other variables.

## Results

### Knowledge of HIV transmission

As a group, this sample of Asian-American adolescents was generally knowledgeable about AIDS and how it is transmitted, although there are some gaps in their knowledge. Table 1 summarizes the knowledge about HIV transmission of Cambodian and non-Cambodian Asians.

To measure overall knowledge about HIV transmission, we calculated a "knowledge index" score, a composite score of the number of correct answers to the items in Table 1. The mean scores for each group, by ethnicity, as well as the results of a test to measure differences between groups, are summarized in Table 2.

The results show that Group 1, the Other

Asian group, scored higher than Group 2, the Cambodian youths. Although the difference is not highly significant ( $p = .074$ ), the difference in mean scores does indicate that Cambodian adolescents are less knowledgeable about HIV transmission than other Asian-American adolescents.

### Discussion of AIDS and Sexual Behavior

This sample of Asian-American adolescents has a much better knowledge of the methods of AIDS transmission than did the Asian group in Strunin's 1991 Massachusetts study (data gathered in 1988). It seems that AIDS education and knowledge about AIDS overall has increased over the past 7 years among high school students. One reason may be that AIDS is discussed far more openly now than it was 6 years ago. When asked if they had ever discussed AIDS with anyone, 72% responded "Yes", and 28% responded "No". The former were asked to indicate with whom they had discussed AIDS (e.g., teacher, friend).

This finding indicates that adolescents are receiving their information about AIDS in schools and from counselors in teen programs, but that there is little discussion about AIDS (and, perhaps, sex) with their parents.

In addition to finding out whether they discussed AIDS, we were interested in how open the adolescents were in talking about sex and sexual behavior with their friends. Thirty-three percent responded that they do talk about sex and sexual behavior with their friends, although 67% said they do not. These results suggest that there is, among this group of Asian-American adolescents, more openness about discussing AIDS in a structured setting, such as in school or in a group program, than there is about discussing sex and

sexual behavior with their friends.

### Concern about Getting AIDS

Because we wanted to explore whether adolescents felt that they were at risk for AIDS and, if so, how high, we asked them a question regarding their perception of risk (Table 3).

These data indicate that there is quite a range in terms of individual worry about personal risk for AIDS; half the sample is quite concerned about getting AIDS, while the other half is only marginally or not at all concerned. To determine whether those who responded positively to being sexually active in the past year were more concerned about getting AIDS, a one-way ANOVA was calculated on this question with sexual activity defining the two groups. No significant difference was found between these two groups. The individuals who reported being sexually active in the past year were no more likely to worry about getting AIDS than those who were not sexually active. Perhaps those who had not been sexually active in the past year abstained from sexual activity because of their concerns about AIDS.

### Behavior Changes Due to AIDS Awareness

In response to a direct question as to whether they had changed any of their sexual behaviors because of concerns about getting AIDS, 45% of the overall sample responded "Yes" (40% of the Cambodian group and 50% of the Other Asian group). Those who responded positively to making behavior changes reported changes in the categories listed in Table 4.

### Risky Behaviors for HIV Infection

Because other studies have found that knowl-

edge about AIDS does not necessarily lead to changing behaviors to reduce the risk of transmission of the virus (Cochran et al., 1991; Strunin, 1991), it was important to find out about the adolescents' past and current sexual behavior (Table 5). One-way ANOVAS measuring differences between groups showed significant differences in some sexual behaviors between the Cambodian and Other Asian groups. Overall, the number of those who indicated that they had engaged in sexual contact in the past year made up 33% of the entire group.

These results show that 26 adolescents, almost one third of the total sample, reported having sexual contact in the past year. The data demonstrate a significant difference between the Cambodian group and the Other Asian group, with the Cambodian group being notably more active during the previous year. The Cambodian group's mean age for first becoming sexually active was 15.4; for the Other Asian group the mean was 16.1. Twelve out of the 26 adolescents who were sexually active (46%) reported using condoms during sexual contact, a higher percentage than reported in previous studies of sexually active Asian-American groups. There were no significant gender or ethnic group differences with regard to condom use.

## Discussion

In the few published studies measuring AIDS knowledge and sexual behaviors of Asian-American adolescents and young adults, this population has been found to be less knowledgeable about AIDS, to discuss sex and sexuality less, and, in some studies, they are found to be less sexually active than their White,

African-American, and Hispanic/Latino counterparts. The results of this study reveal that some of these previously held assumptions about Asian-American adolescents may no longer be accurate. As AIDS awareness and educational efforts increase, Asian-American adolescents are much more knowledgeable about how AIDS is transmitted and discuss AIDS more frequently with their friends and adult educators and counselors. Greater numbers of Asian-American adolescents seem to be translating that knowledge into behavioral change in terms of reducing risky behaviors during sex (with increased use of condoms)—although, of the youths who have been sexually active in the past year, only 46% use condoms during oral, anal, or vaginal intercourse.

The results of this study show that a sample of Cambodian adolescents from Revere, Massachusetts differ from their Chinese, Vietnamese and South Asian counterparts from the metropolitan Boston area only in sexual activity, where significantly more Cambodians report being sexually active in the past year. Possible explanations for this difference are ethnic cultural beliefs, immigrant status, and SES. Cambodian culture, with younger ages for marriage in traditional Cambodia, may—if not openly sanctioning sexual activity at earlier ages—not be as prohibitive as the other Asian cultures.

Although there were no significant differences between groups in terms of immigration status, the majority of both groups were first-generation immigrants who would be expected to adhere more closely to traditional cultural expectations than would more "Americanized" adolescents (i.e., those born in the United States or living here longer). Socioeconomic class may also be a factor in understanding the difference in level of sexual

activity between groups. Research has demonstrated that lower SES is correlated with higher behavioral risk for HIV transmission, and the Cambodian group is from a working-class community. However, because AIDS knowledge and attitudes toward AIDS were similar between groups, this socioeconomic factor may play less of a role in this study than in others where low socioeconomic class results in less knowledge about AIDS.

Finally, as this is a pilot study, and these are preliminary results, we expect that a larger sample group which allowed comparison between the three largest Asian ethnic groups in Massachusetts (Cambodian, Vietnamese, and Chinese) would explore these factors in greater contextual depth.



**Table 1**  
**KNOWLEDGE OF HIV TRANSMISSION**

Can you get AIDS from (% responding correctly):	Cambodian (n= 55)	Other Asian (n= 25)
Toilet seats	91%	95%
Sharing eating utensils	85%	86%
Kissing	82%	85%
Germs in the air	92%	91%
Being in the same room with a person who has AIDS	94%	98%
Sex between two men	100%	100%
Sex between a man and a woman	100%	100%
Male semen	97%	98%
Female vaginal fluids	82%	80%
Giving blood	88%	90%
Injecting drugs	84%	87%

**Table 2**  
**KNOWLEDGE INDEX BY GROUPS**

	N	M	SD	SE	t	df	2-tail prob
Group 1 (Other Asians)	25	15.41	2.765	0.564	1.82	51.65	0.074
Group 2 (Cambodians)	55	14.10	3.281	0.442	1.82	51.65	0.074

Note: Composite groups score—Number of items answered correctly (perfect score is 16).

**Table 3**  
**PERCEPTION OF RISK**

How much do you worry about getting AIDS?	Cambodians	Other Asians
A great deal	24%	31%
Somewhat	20%	26%
A little	31%	20%
Not at all	25%	21%

**Table 4**  
**BEHAVIOR CHANGES**

Behavior Change	Cambodian (n=16)	Other Asian (n=20)
Use condoms	50%	60%
Abstain from sex	25%	20%
Check partner out more carefully	25%	30%
No anal sex	25%	0%
Stay with one partner	25%	40%

**Table 5**  
**SEXUAL BEHAVIOR**

Number and Percent Resp. "Yes" to:	Cambodian	Other Asian	Total	F-Values
Sexual contact in the past year	20 (50%)	6 (15%)	26 (33%)	8.01 **
Anal sex	10 (25%)	2 (5%)	12 (15%)	5.97**
Oral sex	14 (35%)	4 (10%)	18 (22%)	5.15*
Having sex with someone of the same gender	2 (10%)	0 (0%)	2 (5%)	

Note: \*p <.05 and \*\*p<.01.

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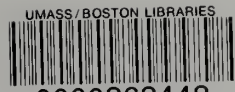
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