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FACTORS ASSOCIATED WITH HIV AMONG BLACK WOMEN EXPERIENCING  
POVERTY: EXPLORING THE INTERSECTION OF GENDER, RACE, AND CLASS

by

Robin Nicole Hardin

A Dissertation

Submitted in Partial Fulfillment of the

Requirements for the Degree of

Doctor of Philosophy

Major: Clinical Psychology

The University of Memphis

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## Dedication

This dissertation is dedicated to every Black woman living with HIV. Your voice matters. Your stories matter. Most importantly, you matter.

“Not everything that is faced can be changed, but nothing can be changed until it is faced.” –

James Baldwin

## Acknowledgements

There are many people who helped me along the way. I want to take a moment to thank them for their part in my journey.

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This dissertation would not be possible without the amazing women I interviewed. Thank you for sharing some of your life experiences with me, even your most painful. My sincere hope is that readers will not just see pain or reduce you to an over-simplistic stereotype. Instead, I hope readers are able to see your resilience and all of the many systems that have failed you and be encouraged to do their part in fixing broken systems. I sincerely thank you for being a part of my journey.

“A journey is called that because you cannot know what you will discover on the journey, what you will do, what you will find, or what you find will do to you.” – James Baldwin

## Abstract

More Black women are living with HIV relative to women from all other racial backgrounds, with unprotected heterosexual sex being the primary mode of transmission. There are power dynamics due to gender, class, and race that may increase susceptibility to contracting HIV among Black women with low socioeconomic status. Exploring the sociocultural and contextual factors that contribute to these high rates of HIV among Black women is critical for prevention efforts. Guided by Black feminist theory, which examines the intersectional effects of multiple marginalized identities, we formulated the current study. This study explored how factors embedded in the intersection of race, gender, and class, influence HIV rates among Black women in Memphis, Tennessee who are experiencing poverty. This qualitative study employed grounded theory techniques to explore how the experiences of being a Black woman with a low socioeconomic status contributes to a diagnosis of HIV. Participants included 12 Black women living with HIV. They completed semi-structured, hour-long interviews exploring factors that contributed to their HIV diagnosis. Interviews were transcribed verbatim and grounded theory techniques were used to analyze the data (Rubin & Rubin, 2011). Analyses revealed six themes that emerged as risk factors from the interviews: adverse childhood experiences, substance use, sexual partner concurrency, intimate partner violence, poverty, and relationship imperative. Additionally, religion and finding meaning emerged as protective factors for those living with HIV. Results from the current study highlight how these factors are embedded in the intersection of race, gender, and class for Black women experiencing poverty. Findings provide a foundation for understanding how HIV risk among Black women experiencing poverty begin and is upheld. These results can help mental health professionals in addressing HIV risk within the therapeutic context when working with Black women experiencing poverty.

## TABLE OF CONTENTS

Chapter	Page	
1	Introduction	1
	Black Feminist Theory	2
	Gender Ratio Imbalance	5
	Trauma History	9
	Substance Use	12
	Socioeconomic Status	14
	Current Study	16
	Hypothesis	17
2	Methodology	17
	Participants	18
	Procedures	18
	Measures	20
	Data Analyses	21
	Role of Researcher	23
3	Results	23
	Sample Demographics	23
	Risk Factors	28
	Protective Factors for Living with HIV	44
4	Discussion	49
	Theory Development	49
	Summary of Findings	58
	Implications	59
	Study Strengths	60
	Study Limitations	61
	Future Directions	62
	Conclusions	62
	References	64
	Appendices	
	A. Screening Questionnaire	81
	B. Demographics Questionnaire	82
	C. Interview Guide	88
	D. IRB Approval	92

## Factors Associated with HIV among Black Women: Exploring the Intersection of Gender, Race, and Class

Human Immunodeficiency Virus (HIV) attacks a person's immune system. Specifically HIV attacks the CD4 cells, which are cells that aid the immune system in fighting off infections (Krishnan et al., 2013). If HIV goes untreated, the number of CD4 cells decrease, which increases a person's chances of getting other serious infections or infection-related cancers (Benson et al., 2009). Over time, HIV can destroy enough cells to stop the body from fighting off infections and diseases, eventually resulting in death (Smith et al., 2014). In 2015 in the US, there were 6,465 deaths attributed directly to HIV, and AIDS was the 9<sup>th</sup> leading cause of death for individuals aged 25 to 44 (CDC, 2018).

In the US, approximately 25% of people living with HIV are women (CDC, 2017). In 2015, women accounted for almost 20% of new HIV diagnoses in the US (CDCa, 2018). Regarding race, Black women are infected with HIV at disproportionate rates. Non-Hispanic Black women are 20 and 5 times more likely to be infected with HIV than non-Hispanic White women and Hispanic women, respectively (CDCb, 2018). The rates of HIV are even more alarming in Memphis, Tennessee, the location of the proposed study. In 2015, Black women made up approximately 85% of all new HIV cases among women in Memphis (Shelby County Health Department, 2015).

Heterosexual sex is the primary mode of HIV transmission for women (CDCa, 2018). In Memphis, between 2012 and 2016, heterosexual sex was the transmission mode for approximately 84% of new HIV diagnoses among women (AIDSVu, 2018). Women are more susceptible to contracting HIV than men due to anatomy with the female genital tract being more prone to injury and infection (Quinn & Overbaugh, 2005). Further, there are power dynamics



due to gender, class, and race that increase Black women's susceptibility to contracting HIV, such as a shortage of Black men (given that many Black women date within their race) and high rates of violence for Black women living in impoverished neighborhoods (El-Bassel, Caldeira, Ruglass, & Gilbert, 2009; Whetten, Reif, Whetten, & Murphy-McMillan, 2008). It is through this intersection of gender, race, and class that Black women may be at an economic and social disadvantage, which in turn increases their likelihood of engaging in high-risk behaviors and relationships that could lead to a diagnosis of HIV. The fact that Black women, specifically Black women of low socioeconomic status (SES), comprise the majority of new HIV cases among women every year (AIDSVu, 2018; CDCb, 2018) suggests that there is something unique about the experience of being Black, a woman, and experiencing lower SES that contributes to these high rates. This warrants a deeper exploration and was the catalyst for the current study.

### **Black Feminist Theory**

The current project was guided by Black feminist theory. This theory was used to formulate the research questions, which are focused on exploring how the intersections of race, gender, and class among Black women of all classes, but especially those of lower socioeconomic status, explains the high rates of HIV within this community. Black feminist theory was chosen due to its focus on the intersection of varying identities, oppression related to these identities, and how this intersection impacts Black women specifically. This focus is needed because previous literature suggests there are specific and unique experiences Black women face, which put them at higher risk for contracting HIV relative to White women (Bowleg, 2004; El-Bassel et al., 2009).

During the civil rights movement, many Black women were dissatisfied and disappointed that the main focus of this movement was on the oppression of Black men alone (Collier-Thomas

& Franklin, 2001). Some Black women also described experiences of extreme sexism within civil rights groups (Collier-Thomas & Franklin, 2001). This illustrated that Black women not only dealt with oppressions due to race, but due to being women. The third wave of feminism, which was more inclusive of Black women, emerged due to critiques of second wave feminism by women of color (Gillis, Howie, & Munford, 2004). The biggest critique of second wave feminism was that it did not account for differences among women (Gillis et al., 2004). Audre Lorde, a pioneer for the third wave of feminism, embodies this sentiment and critique of the second wave in her essay entitled: *Age, Race, Class, and Sex: Women Redefining Difference* (Lorde, 2012). “By and large within the women’s movement today, White women focus upon their oppression as women and ignore differences of race, sexual preference, class, and age” (Lorde, 2012, p. 116). The third wave of feminism, which began in the 1990s and sought to challenge the overemphasis on the experiences of upper middle-class White women, really set the stage for the Black feminist movement (Lorde, 2012).

The Black feminist movement emerged from these critiques of overlooking the important differences between the sexes and centered awareness that Black women experience oppression that is uniquely tied to being both Black and a woman (Gillis et al., 2004). This construct, which was later given the name intersectionality by Kimberle Crenshaw in the late 1980’s (Crenshaw, 1989), is the underlying foundation of Black feminist theory. In terms of intersectionality, Black feminist theory highlights other oppressions outside of race and gender, such as class and sexuality (Collins, 2002). Black feminist theory aims to shed light on the intersections of various oppressions that are unique and specific to Black women in order to combat the practices and beliefs that uphold these various forms of oppression (Collins, 2002).

Black feminist theory has additional underlying themes or frameworks. It stresses the importance of focusing on the self-definitions and self-valuations of Black women (Collins, 1986). This includes challenging the stereotypical images of Black women with more accurate portrayals (Collins, 1986). Specifically, some of the stereotypes labeling Black women throughout history include being sassy, angry, hypersexual, and not intelligent (West, 1995). These stereotypes have been used as a way to dominate Black women and treat them as “objects lacking full human subjectivity” (Collins, 1986, p. S18). Focusing on tearing down these stereotypes is crucial due to the detrimental effects these portrayals can have on Black women who may internalize the negative stereotypes and images.

A review article by West (1995) on the historical images of Black women provides some examples of the detrimental effects of these stereotypes including: engagement in risky sexual behavior (e.g., having unprotected intercourse, having multiple sex partners, having an early age of sexual debut, sex work), low self-esteem, low self-efficacy, lack of self-respect and self-worth, substance abuse, and increased likelihood of domestic violence victimization (West, 1995). These stereotypes not only affect how Black women view themselves, but also affect how others view and treat them. Research has demonstrated that Black women are more likely to be perceived as less attractive, having lower education, more likely to be hypersexual, more likely to receive public assistance, and more likely to be earning less income than White women (Goff, Thomas, & Jackson, 2008; Rosenthal & Lobel, 2016). Stereotypes can lead to discrimination in health care and negative health outcomes, which in turn contribute to health disparities (Shavers et al., 2012). Ironically, researchers found that medical students who believed that Black individuals were more hypersexual and more likely to engage in risky sexual behavior than White individuals were less willing to prescribe pre-exposure prophylaxis (i.e., medication used

to prevent HIV transmission among those at high risk for HIV) to Black men than White men (Calabrese, Earnshaw, Underhill, Hansen, & Dovidio, 2014). While this pattern of bias in health care against Black men has been shown in the literature, there is limited understanding of how the intersection of multiple marginalized identities contributes to HIV health disparities among Black women living in Memphis.

The current study explored how these multiple marginalized identities contribute to high incidence rates of HIV among Black women from low socioeconomic status backgrounds. Memphis is an ideal location to explore this intersection due to the high rates of HIV and poverty among the Black population (AIDS Vu, 2018). There have been several variables, including gender ratio imbalance, trauma, substance use, and SES that have been identified in the literature that significantly contribute to the high rates of HIV among Black women (El-Bassel et al., 2009). Identifying and understanding risk factors is important as it highlights potential variables to target in primary and secondary prevention efforts. Primary prevention efforts are aimed at the broad population of individuals who are not living with HIV to reduced their engagement in risky behaviors that could lead to an HIV positive infection (Hobkirk, Towe, Lion, & Meade, 2015). Secondary prevention efforts are aimed at individuals living with HIV to prevent the transmission of HIV to others (Hobkirk et al., 2015). Risk factors that have been found to contribute to the high rates of HIV among Black women will be discussed in greater detail below.

### **Gender Ratio Imbalance**

One factor that has been identified as a reason for the high rates of HIV among Black women is the gender ratio imbalance within the Black community. There is a shortage of Black men in the Black community due to high incarceration and mortality rates (Wolfers, Leonhardt,

& Quealy, 2015). This shortage of Black men can leave Black women at a disadvantage romantically since Black women are less likely to marry outside of their race, with only 9% doing so (Davis & Noll, 2010). While studies have demonstrated that Black women are open to being romantically and sexually involved with individuals from other races; they are least likely to be chosen as potential dating and sexual partners by men of other races, especially White men (Feliciano, Robnett, & Komaie, 2009; Lin & Lundquist, 2013; Robnett & Feliciano, 2011). These limited options might explain why Black women are more likely to date and marry Black men. In the United States, for every 100 Black women who are not incarcerated, there are only 83 Black men (Wolfers et al., 2015). This is the largest gender ratio imbalance among all races (Wolfers et al., 2015). In some cities, this ratio is even more staggering. For example, in Memphis, TN, there are 56 Black men for every 100 Black women (Wolfers et al., 2015).

The gender ratio imbalance is a suggested explanation for why Black men have more concurrent sexual partners than men of other races (Chandra, Copen, & Mosher, 2013). Morris, Kurth, Hamilton, Moody, and Wakefield (2009) found that Black men between the ages of 20 and 38 were 3.5 and 1.9 times more likely to have concurrent sexual relationships than White and other minority race counterparts, respectively. Complicating the HIV risk profile is when Black women are aware that their partners are sexually involved with other people. For example, among 181 Black women in the south, aged 50 and older, 67% reported being in committed, sexual relationships, and 26% of these women reported that their partners were having sex with other women while 12% reported that their partners were having sex with other men (Winningham et al., 2004). Researchers have shown that having multiple concurrent sexual relationships (i.e., simultaneous sexual relationships or sexual relationships that overlap in time) spread sexually transmitted infections (STIs), including HIV, at a faster rate than having the

same number of sexual relationships consecutively (Chandra et al., 2013). Researchers have also found that having a partner who engages in concurrent sexual relationships was a risk factor for acquiring HIV among a sample of Black adults, who were otherwise considered to be at low HIV risk (Adimora et al., 2006).

The gender ratio imbalance increases the number of alternative relationships that are available for men but decreases the number of alternative relationships that are available for women. This imbalance can lead to an increase in the bargaining power Black men have relative to Black women, and thus may result in Black women feeling increased pressure to engage in uncharacteristic behaviors in order to maintain relationships, even if it puts them at risk for HIV. The shortage of Black men and its impact on sexual relationships between Black men and Black women has become a focus in controlling HIV transmission within the Black community. Black women who are aware of the shortage may be less likely to negotiate safe sex (i.e., using condoms) and support monogamy in their relationships and thus may be more likely to accept infidelity and agree to engage in unprotected sex (Bowleg, 2004; McNair & Prather, 2004). Black women may feel pressure to give their partners whatever they desire due to the fear that their partner might find someone else to do it, if they say no. This concern may prevent Black women from initiating conversations about safe sex practices out of fear that it will threaten their relationship (McNair & Prather, 2004). In a qualitative study with a sample of 24 women aged 45 to 71 of whom 58% were Black, researchers found that some Black women in their sample identified a tolerance for men having multiple female sexual partners (Neundorfer, Harris, Britton, & Lynch, 2005). One woman being interviewed stated, “In the Black race, we are sharing men—dating married men or he is seeing other people.” She went on to say, “I knew that he was probably messing around with women, but I never thought he was messing around with

guys” (Neundorfer et al., 2005, p. 623). This body of research suggests that the gender ratio imbalance found in Black communities can have an impact on infidelity within Black relationships where it might be viewed as an accepted behavior by Black women.

Adimora and colleagues used focus group interviews to explore how contextual factors in communities affected sexual behaviors among Black residents in rural North Carolina (Adimora et al., 2001). The authors found that gender ratio imbalance partially explained the occurrence of concurrent, sexual relationships among unmarried Black individuals in that community (Adimora et al., 2001). In this same study, a group of women aged 25 to 39 shared their beliefs that Black women, especially those who are poor or uneducated, are dependent on men. Comments from Black male and female focus group members demonstrated that the gender ratio imbalance greatly influenced partner selection and engagement in risky sexual behavior for both men and women (Adimora et al., 2001). For example, one 25-year-old Black man stated, “There’s so many black men in prison, strung out on drugs, or dead, that if a decent black lady finds a decent black man, she’s not going to spend a whole lot of time trying to hold him off. She’s gon’ do whatever it takes to get him” (Adimora et al., 2001, p. 73). Similarly, a 35-year-old Black woman shared: “The choices in men are very limited around here. I guess the women put up with the men they have because there aren’t that many” (Adimora et al., 2001, p. 73). These views suggest that when women are aware of gender ratio imbalance in their communities, they may be willing to engage in risky sexual behavior to sustain their relationships. While studies have shown that online dating applications can increase partner availability (D’Angelo & Toma, 2017), it is unclear if this impacts the perception of the gender ratio imbalance in one’s own community.

In another focus group with middle class Black women, researchers found that the women often experienced power imbalances in their relationships and this hindered their ability to negotiate condom use and/or monogamy due to expressed difficulties finding middle socioeconomic status Black men who wanted to be in monogamous relationships (Caldwell & Mathews, 2015). In another study, some Black women reported seeking short-term sexual relationships with men who are often less desirable, younger, and believed to be sexually involved with other women due to the lack of “quality” men in communities where male incarceration rates were high (Dauria et al., 2015). This suggests that the gender ratio imbalance is not just about quantity but also quality of available Black men, which many studies have not simultaneously examined. Researchers have proposed a shortage of “marriageable” Black men, which has been defined as men who possess the social or economic characteristics that Black women are seeking in a marriage partner. The shortage has been linked to Black men having high unemployment rates, being more likely to possess a criminal record, and earning relatively low wages (King & Allen, 2009). More research is needed on how these barriers to dating and marrying impact HIV rates among Black women in Memphis, Tennessee.

### **Trauma History**

Being exposed to trauma is associated with risky sexual behavior and HIV (Abajobir, Kisely, Williams, Strathearn, & Najman, 2018). Previous studies have demonstrated that people living with HIV (PLWH) are more likely to have experienced trauma than individuals who are not living with HIV (Brezing, Ferrara, & Freudenreich, 2015; Whetten et al., 2008). A recent review article showcased that among studies with samples of PLWH, rates of lifetime violent trauma ranged from 10 to 90% (Brezing et al., 2015). Researchers have demonstrated that Black women report higher rates of overall traumatic experiences when compared to White women



(Duncan et al., 2014). Studies have also shown race differences in the association between traumatic experiences and HIV risk. For example, sexual abuse in childhood and adulthood has been linked to increased risk for HIV infection (Abajobir et al., 2018; Bensley, Van Eenwyk, & Simmons, 2000). However, Werner and colleagues found that physical and sexual abuse predicted risky sexual behavior for White women while childhood sexual abuse (CSA) predicted risky sexual behavior for Black women (Werner et al., 2018), illustrating differences by race.

The associations between CSA and HIV-related risk behaviors in adulthood have been well established (Abajobir et al., 2018; Bensley et al., 2000; Koenig & Clark, 2004). Researchers have demonstrated that approximately 40% of women living with HIV have a history of CSA, which is approximately double the rate found in a national prevalence sample of women (Cogle, Timpano, Sachs-Ericsson, Keough, & Riccardi, 2010; Machtinger, Wilson, Haberer, & Weiss, 2012). Researchers also found that 66% of women living with HIV reported a lifetime prevalence of domestic violence (Cohen et al., 2000). Furthermore, a third of these women reported a history of childhood sexual abuse. Women who reported a history of domestic violence or CSA were more likely to have a history of drug use, a partner who was at risk for HIV, more than 10 lifetime male partners, traded sex for money, drugs, or shelter, and been forced to have sex with a person known to be living with HIV (Cohen et al., 2000). Findings from Cohen et al support continuity of risk such that early abuse is related to later abuse and violence, which may then increase the risk of engagement in behaviors associated with a diagnosis of HIV (Cohen et al., 2000).

Women with a history of early and chronic sexual abuse are seven times more likely to engage in HIV-related risk behaviors, such as intravenous drug use, have sexually transmitted infections (STIs), and engage in anal sex without a condom, relative to women without a history

of early and chronic sexual abuse (Bensley et al., 2000). Another study found that Black women who were living with HIV were more likely to report severe CSA relative to White women living with HIV (Wyatt et al., 2002). However, regardless of race, women living with HIV were more likely to report being victims of adult sexual abuse than women not living with HIV (Wyatt et al., 2002). CSA has also been associated with risky sexual behavior including, early sexual debut, decreased condom self-efficacy, inconsistent condom use, and higher rates of STIs (Bensley et al., 2000; Wyatt et al., 2002). Researchers found that women living with HIV were 2.5 times more likely to report CSA than women not living with HIV (Wyatt et al., 2002). Using a prospective cohort study, sexually and physically abused and neglected children were matched with non-maltreated children and followed into adulthood to assess for risky sexual behavior in adulthood (Wilson & Widom, 2008). Researchers found that all forms of abuse in childhood (neglect, physical, and sexual) were associated with sex work in adulthood and having a sexual debut before the age of 15 (Wilson & Widom, 2008). These results highlight the negative effects that child abuse can have on risky sexual behavior.

In a sample of 414 women attending an STD clinic in which 66% were Black, researchers found that sexual, physical, and psychological abuse and neglect in childhood were associated with having more lifetime sexual partners and more episodes of unprotected sex in the previous three months (Senn & Carey, 2010). However, once all other forms of abuse and neglect were controlled in multivariate analyses, only CSA was associated with adult sexual risk behavior. In this study, researchers found little support for an additive model of the effects of the various types of childhood maltreatment (Senn & Carey, 2010), suggesting that the combined effects of multiple traumas and abuse in childhood doesn't put individuals at greater risk for contracting HIV than experiencing CSA alone. Given the association between previous trauma and HIV,

understanding how these variables along with other factors contribute to the HIV risk profile of Black women in Memphis is needed especially due to the high rates of crime (4 to 5 times the national average) in Memphis, specifically in the poorer, Black neighborhoods (Tulumello, 2018).

### **Substance Abuse**

Many women with histories of trauma often turn to substances to help them cope with the trauma they experienced (Liu et al., 2006). In a study of 74 Black women with a history of CSA who were also living with HIV, 83% reported using at least one substance regularly at some point in their lives with the top 4 substances being: marijuana, cocaine, PCP/angel dust, and heroin (Wyatt, Carmona, Loeb, & Williams, 2005). Researchers have shown that Black women with histories of sexual trauma have more serious problems with misusing substances than Black women without this history. Specifically, women with these histories are addicted to more substances and more frequently hospitalized for substance-related problems (Young & Boyd, 2000). Despite some studies finding that the prevalence of alcohol abuse and alcohol disorders is lower for Black women than White women (O'leary, Broadwell, Yao, & Hasin, 2006), the consequences of alcohol use has been demonstrated to be more severe for Black individuals (Chartier & Caetano, 2010). For example, once alcohol dependence occurs, Blacks individuals have a 12% higher prevalence rate of recurrent or persistent alcohol dependence than White individuals (Dawson et al., 2005). Furthermore, Black women with alcohol use disorders are more likely to report having poorer chronic and physical health conditions than White women (Ransome, Carty, Cogburn, & Williams, 2017; Zapolski, Pedersen, McCarthy, & Smith, 2014).

Research has shown that substance use can lead to engagement in risky sexual behavior (Collins, Ellickson, Orlando, & Klein, 2005; Kann et al., 2014). For example, alcohol can

interfere with cognitive processes, which can increase the likelihood of risky sexual behavior because of the lowered perception of risk (Norris, Masters, & Zawacki, 2004). Among a sample of women attending an urban STD clinic, women who endorsed binge drinking (i.e., drinking more than 4 drinks in one day) were more likely to engage in anal sex, test positive for gonorrhea, and have multiple concurrent sexual partners (Hutton, McCaul, Santora, & Erbeling, 2008). It has also been demonstrated that alcohol consumption, especially right before sex, is associated with not using condoms (Scott-Sheldon et al., 2009). There have not been many studies examining the role of alcohol use, at non-abusive levels, on HIV-risk behaviors. Findings from one study of 848 Black women aged 18-29 illustrated that women who consumed any alcohol were more likely to have multiple male sexual partners during the past year, have a risky sexual partner (i.e., recently released from jail, had an STI, used injection drugs, or had a concurrent sexual partner), never use condoms with a casual male sexual partner, and test positive for a STI (Seth, Wingood, DiClemente, & Robinson, 2011), lending support for the detrimental effects of any alcohol consumption on HIV risk, especially for Black women.

Illicit drug use is also prevalent among women living with HIV and has been found to be a risk factor for HIV (Liu et al., 2006; Neundorfer et al., 2005). In a sample of 148 women living with HIV where over half identified as Black, the percentage of women who had ever used non-crack cocaine, crack cocaine, and heroin were 61%, 53%, and 27%, respectively. In that same sample, 45% of women endorsed using at least one illegal drug in the past month (Liu et al., 2006). In a sample of 24 women aged 45 to 71 of which 58% were Black, researchers identified five themes that put women at risk for HIV, with drug and alcohol abuse being the most frequent risk factor (Neundorfer et al., 2005). Almost all of the women in the sample (22 out of the 24) had contracted HIV either directly (i.e., engaging in risky sex after illicit drug use) or indirectly

(i.e., had a sexual partner who abused drugs) from drug or alcohol abuse. Even though none of the women reported currently abusing any substances, 74% reported a history of substance abuse with durations ranging from 8 to 34 years (Neundorfer et al., 2005). Many of these women reported how substance abuse led them to engage in risky sexual behavior. One woman who abused cocaine and alcohol and was diagnosed with HIV at age 36 stated, “Being a drug user, it makes you vulnerable to a lot of men. You need money to get drugs, or you need drugs to be given to you by men. It makes you do things you normally wouldn't do. It makes you cross the line” (Neundorfer et al., 2005, p. 621). Almost half of the women who had a history of substance abuse reported being aware that their behaviors were putting them at risk for contracting HIV, and they placed blame on their substance abuse for interfering with their judgement when it came to sex (Neundorfer et al., 2005). This demonstrates the impact that substance use can have on the high rates of HIV among Black women. However, substance use cannot fully explain why the rate of HIV is so high among Black women since substance use rates have been found to be higher among White women (O'leary et al., 2006). Therefore, more research is needed on the role that substance use (and other factors) has in the lives of Black women who may be using substances to cope with various forms of oppression and trauma.

### **Socioeconomic Status**

HIV disproportionately affects individuals from lower SES backgrounds (CDC, 2011; Holtgrave & Crosby, 2003; Ward, 1993). In a sample of 14,837 heterosexual adults aged 18 to 50, HIV prevalence was 2.3% among individuals with incomes at or below that poverty line compared to 1% among individuals with incomes above the poverty line (CDC, 2011). Like other health disparities, HIV is hypothesized to be rooted in poverty, with poverty being deemed the most important risk factor for HIV among heterosexuals living in urban areas (CDC, 2011).

In 2016, the poverty rate for Black women was approximately 24% in comparison to 10% of White women (Delavega, 2017; Guerra, 2013; Martin, Hamilton, Osterman, Curtin, & Mathews, 2013). In Memphis, the disparity between Black and White poverty is even more staggering and alarming, with the 2016 poverty rate among Black individuals being approximately 32% in comparison to 13% of White individuals (Delavega, 2017). Researchers have demonstrated that there is no statistically significant difference in HIV rates by race among those living in low income neighborhoods (CDC, 2011). Researchers have demonstrated that Hispanic and White individuals living in urban, impoverished areas have similar rates of HIV as their Black counterparts (Denning & DiNenno, 2010).

Even though the literature has demonstrated that low SES is a significant risk factor for HIV, the path from living in a lower SES bracket to high rates of HIV among Black women is less well-understood. This is partly due to many studies utilizing measures of SES that only captures income and educational attainment (Dahlstrom et al., 2015; Jacobs & Thomlison, 2009; Ransome et al., 2017; Sikkema, Heckman, & Kelly, 2014), which does not fully capture the context in which Black women live. Furthermore, SES is not a definitive risk factor because there are many factors that are associated with low SES that could be responsible for the high rates of HIV among Black women, such as lack of resources and education, reduced access to medical care, homelessness, or higher violence exposure in impoverished neighborhoods. For example, homelessness and unstable housing has been associated with various high-risk behaviors, including sex work, illicit drug use, and having multiple sex partners (Riley, Gandhi, Hare, Cohen, & Hwang, 2007). In a sample of almost 4,000 Black women, income was not a significant predictor of HIV, instead recent or current homelessness and being a Medicaid recipient were significant predictors. Furthermore, there is some evidence that having a higher

socioeconomic status does not fully protect Black women from HIV risk. In a study of Black women aged 25-45 in North Carolina who were associated with middle SES, researchers found that many of the women engaged in risky sexual behavior, such as accepting infidelity from their partner due to various reasons like the gender ratio imbalance within the Black community (Caldwell & Mathews, 2015). These results highlight the need to explore how SES may be putting Black women at risk to be in situations that increases their HIV risk. This is particularly pertinent for Memphis due to the high rates of Black individuals living in poverty in Memphis. Furthermore, more research needs to be done to explore the risk factors for HIV among Black women with higher SES.

### **Summary and Current Study**

Previous literature has identified pertinent risk factors for HIV among Black women that include factors such as gender ratio imbalance, previous trauma, substance abuse, and socioeconomic status (El-Bassel et al., 2009). The majority of the studies cited above include data from focus groups and surveys. Despite the previous identification of risk factors for HIV among Black women, more research is needed to explore how the experiences of being a Black woman living in Memphis, Tennessee contribute to a diagnosis of HIV by taking into account the intersectionality of multiple marginalized identities. Many of the variables reviewed such as previous trauma, substance use, and SES are not just found among Black women. Therefore, more qualitative research is needed to understand how Black women experience these factors in different ways than women of other races, and thus how it drives high HIV incidence rates among Black women, specifically in Memphis, Tennessee. Furthermore, studies utilizing individual interviews are lacking but needed to capture in depth information of the lived experiences of Black women. Accordingly, my research question for this qualitative study is:

How do sociocultural and contextual factors, embedded in the intersection of race, class, and gender, influence the high rates of HIV among Black women experiencing poverty in Memphis, Tennessee?

### **Method**

This was a qualitative study in which semi-structured interviews were utilized with a sample of Black women of low SES, living with HIV. Individual interviews were used over focus groups because they allowed the researcher to hone in on each individual's experience and afforded participants the privacy to share very personal information, which may have been hindered in a focus group setting. Grounded theory was the chosen methodology to explore the research questions. Grounded theory aims to explain a phenomenon instead of simply describing it (Savin-Baden & Major, 2013). It utilizes mostly interviews to build a theory based on the data (Savin-Baden & Major, 2013). Because the focus of this methodology is on generating theory, a specific theory was not used to guide data analyses. However, Black Feminist theory was used in the generation of the research questions.

Grounded theory entails formulating, testing, and redeveloping hypotheses until a theory is developed (Savin-Baden & Major, 2013). Grounded theory was an appropriate fit for this project because the primary researcher aimed to understand potential factors that might explain why Black women have the highest rates of HIV among all women in the US. A key feature of grounded theory is "general method of constant comparative analysis" (Strauss & Corbin, 1994, p. 273). This entailed constantly comparing the data for similarities and differences in order to generate overall themes and ultimately generate a theory. The primary researcher also looked for instances that do not fit in order to expand on the emerging theory. This entailed looking for cases that contradict the emerging themes, in order to fully capture the complexity of the subject



matter. For example, there may be only one participant from a high SES background who discusses how having access to more money and resources led to her diagnosis of HIV. This participant's experience will still be captured to ensure we thoroughly explore factors that contribute to the high rates of HIV among Black women in Memphis.

### **Participants**

We recruited twelve participants who self-identified as Black women. Inclusion criteria was: being a woman who is living with HIV, having contracted HIV through sexual intercourse, being over the age of 18, and understanding and speaking English fluently. Due to the stigma surrounding HIV, the utilization of purposeful sampling was employed in order to obtain a sufficient research sample. Active recruitment involved advertising through organizations serving individuals living with HIV in Memphis including: Hope House and Friends for Life. Exclusion criteria were: women infected with HIV/AIDS via blood transfusion, injection drug use, or vertically from mother to child. These exclusion criteria were chosen because the study explored active sexual behaviors that lead to an HIV diagnosis (see results for additional participant details).

### **Procedures**

After receiving IRB approval, women living with HIV were recruited for the study. Pre-screening questions were administered in person by the primary researcher to determine eligibility (see Appendix A). If women were eligible, interviews took place immediately and were conducted by the primary researcher. It was important that the primary researcher conducted all of the interviews in an effort to eliminate confounding factors of having multiple interviewers (e.g., personality factors, appearance, age, race). Data collection entailed administration of a demographics questionnaire (see Appendix B) and a semi-structured

individual interview using mostly open-ended questions (see Appendix C). In addition, the primary researcher asked probing questions in an effort to add clarification and elicit additional information from participants on a particular topics (see Appendix C). The interviews took place in private rooms at Hope House and Friends for Life, our recruitment partner organizations. Each interview began with the primary researcher orienting each participant to the purpose of the research study and answering any initial questions. After this brief orientation, the primary researcher reviewed the informed consent and explained the woman's rights as a research study participant. Next, the semi-structured interview began and lasted approximately one hour. The interview began with a series of close-ended demographic questions as well as questions regarding the participant's HIV diagnosis (see Appendix B). Semi-structured interviews allowed women to voice their own perspectives and discuss what was important to them as it related to the research topic. The interview questions covered a wide range of topics that included: the availability of romantic partners in Memphis, substance use, previous and current trauma, romantic relationships, sexual history, and their experiences of being a Black woman living in Memphis, Tennessee (see Appendix C).

At the end of the interview, the participant was thanked for her participation and compensated \$20 cash for her time. Previous literature has demonstrated that 12-15 interviews are typically needed to reach saturation (Guest, Bunce, & Johnson, 2006). The current study had 12 interviews, which was sufficient to meet saturation. Specifically, the primary researcher was not obtaining much new information after the tenth interview. All interviews were recorded using two audio recorders (i.e., a second recorder served as a back-up). Additional details of the qualitative analyses process are provided in the data analysis section below.

## Measures

**Demographics Questionnaire.** This questionnaire will include items about participants' age, ethnicity, race, sexual orientation, yearly income, perceived SES, and previous and current romantic relationships (see Appendix B).

**Interview Guide.** The primary researcher developed an interview guide with input from her mentor (see Appendix C). The interview guide started with a few general information questions that helped the primary researcher get to know the participants better. Sample questions included: 'Are you currently working or going to school?' 'Do you like living in Memphis? Why or why not?' Next, questions aimed at exploring factors contributing to participants' positive HIV status were reviewed. All of the main questions were in open-ended format. However, close-ended probe questions that were already devised were used to obtain more information as needed or to clarify points made by a participant. Sample probe questions included: 'Are you aware of any relationship cheating that may have happened?' 'Were you aware that you were at risk for contracting HIV?' See Appendix C for additional probe questions.

General questions regarding participants' HIV diagnosis were explored to determine participants' experience living with HIV and to assess their awareness of HIV risk prior to their diagnosis. Sample items included: 'What has been your experience living with HIV?' 'Tell me what you wish you had known about HIV before you were diagnosed.' Questions about current and previous romantic relationships were asked to assess for risk factors within those relationships that may have contributed to an HIV diagnosis. Sample items included: 'In your romantic relationships, who do you think has most of the power, such as making important decisions within the relationship?' 'Are you aware of any relationship cheating that may have

happened?’ A question exploring participants’ experiences living in Memphis was also asked: ‘What has been your experience as a Black woman living in Memphis?’

Questions exploring trauma, substance use, gender ratio imbalance, and SES were also asked to determine potential contribution to HIV risk. Sample items included: ‘Please tell me about any traumatic experiences that you have experienced in the past and how you think those experiences contributed to your diagnosis of HIV.’ ‘Tell me about your experiences with substances, such as alcohol, marijuana, and other drugs.’ ‘What thoughts do you have about the number of available Black men in your community?’ ‘How do you think your socioeconomic status contributed to your diagnosis?’

### **Data Analyses**

Following completion of the interviews, recordings were transcribed verbatim into a word document by the primary researcher. Each transcript was assigned a participant pseudonym to protect participants’ anonymity. The primary researcher listened to and transcribed the recordings. In further efforts to protect confidentiality, recordings were deleted from both of the audio recording devices following careful transcription. The primary researcher read each transcript at least three times over the span of a couple of days, which allowed time to absorb the data before starting to analyze it.

Data analyses were conducted using Dedoose©, a web-based application used to analyze qualitative and mixed-methods research. The primary researcher along with a trained graduate assistant used line-by-line coding to identify emergent themes in the transcripts. The trained graduate assistant is a third year clinical psychology doctoral student at The University of Memphis. She identifies as a white female, has prior experience collecting and analyzing qualitative data, and has a research interest in factors that increase HIV risk. Coding included

researchers providing descriptive terms that captured the essence of each “data segment” (Savin-Baden & Major, 2013). Coding was used to describe and analyze the data by coming up with themes (Savin-Baden & Major, 2013). Themes are high-level concepts that recur in the qualitative data (Rubin & Rubin, 2011). Constant comparison methods were used by frequently comparing the data for similarities and differences in efforts to combine repeated themes into categories. Only themes relevant to the research questions were identified and common themes were selected across all of the interviews. The primary researcher and graduate student assistant coded each transcript separately, and came together to discuss and agree upon final codes and categories. Memo-writing techniques (i.e., writing down reflective notes or memos during data collection and analysis) were used to expand upon the categories and to draw connections between categories.

### ***Reliability and Validity***

To ensure the reliability of the data, the primary researcher double checked all of the transcripts before the audio was deleted to ensure they were no obvious errors from transcription. Furthermore, the primary researcher ensured there was not a shift in the meaning of the codes during the process of coding by having a set definition for all of the codes in a code book.

In efforts to ensure the validity of study’s findings, an audit trail strategy was employed by the primary researcher. This audit trail entailed keeping and updating a codebook that consisted of all of the themes and excerpts in an effort to have external critiques of the final codes from her dissertation advisor ensuring that the interpretations and findings were coming from the data (Savin-Baden & Major, 2013).

Given that researcher bias has the potential to interfere with the validity of research findings, it is common practice for qualitative researchers to include a description of their role in

the research as a way to shed light on past experiences or identities that may influence the interpretation of study findings (Savin-Baden & Major, 2013). Accordingly, the role of the primary researcher is described as follows.

### ***Role of the Researcher***

As an individual who identifies as a Black woman, the primary researcher has a personal investment in exploring a public health concern that is disproportionately impacting Black women. Given the primary researcher's lived experience as a Black woman who has researched this topic throughout graduate school, she came into the current study with preconceived notions of what to expect. The primary researcher has had meaningful relationships with individuals who have been impacted by HIV/AIDS and who have passed away from AIDS. This experience fuels her commitment to explore the current study topic by immersing herself into the stories shared by each woman participant.

## **Results**

### **Sample Demographics**

The current sample is comprised of 12 participants who self-identified as Black women. Participants ranged in age from 31 to 67 years with a mean age of 48.17 ( $SD = 9.72$ ). In regard to sexual orientation, seven (58.3%) participants endorsed being completely heterosexual, one (8.3%) participant endorsed being mostly heterosexual, two (16.7%) participants endorsed being bisexual, and two (16.7%) participants endorsed being completely homosexual. In regards to formal education attainment, nine (75%) participants endorsed completing high school or above, of which two participants endorsed completing one or two years of an advanced degree, and three (25%) participants endorsed not completing high school. Regarding relationship imperative (i.e., strong desire to be in a relationship), seven (58.3%) participants endorsed having a strong

desire, whereas five (41.6%) participants denied feeling that way. In regards to their partner's race/ethnicity, eleven (91.7%) participants endorsed being romantically involved with mostly non-Hispanic Black individuals, and 1 (8.3%) participant endorsed being romantically involved with mostly Hispanic or Latino individuals. In regard to their partner's age, 6 (50%) endorsed having older romantic partners, 2 (16.7%) endorsed being the same age as their romantic partners, and 4 (33.3%) endorsed having younger partners. In regards to socioeconomic status, nine (75%) participants indicated they either had no income or live from paycheck to paycheck, while 25% reported earning less than \$10,000 per year. Additionally, participants were asked to rate their perceived social status in which they were shown a visual analogue scale that shows a picture of a 10-rung (from A to J) 'social ladder' and they indicated the letter on the rung on which they felt they stood with higher letters indicating higher perceived rank. See Table 1 for their chosen letters and additional sample details.

**Table 1***Sample Demographics*

<b>Pseudonym</b>	<b>Age</b>	<b>Gender</b>	<b>Religion</b>	<b>Yearly Income</b>	<b>Current Relationship Status</b>	<b>Current Sexual Relationship</b>	<b>Sexual Orientation</b>	<b>HIV Med Adherence</b>	<b>Year Started Taking HIV Meds</b>	<b>Perceived Social Status</b>
Ashley	52	Female	Nondenominational Christian	Left Blank	Married	In an exclusive monogamous sexual relationship	Completely heterosexual	100%	2000	F
Brenda	53	Female	Baptist	Under \$10K	Never married (Single and not dating)	Not currently sexually active	Completely heterosexual	100%	1984	B
Carol	46	Female	Baptist	Under \$10K	Single	Sexually active with one person (not in a defined committed relationship person)	Completely heterosexual	100%	2003	D
Donna	50	Female	Nondenominational Christian	Unemployed or Disabled	Never married (Single and not dating)	Sexually active with one person (not in a defined committed relationship person)	Bisexual	Left Blank	Doesn't Know	B



**Table 1 (Continued)**

<b>Pseudonym</b>	<b>Age</b>	<b>Gender</b>	<b>Religion</b>	<b>Yearly Income</b>	<b>Current Relationship Status</b>	<b>Current Sexual Relationship</b>	<b>Sexual Orientation</b>	<b>HIV Med Adherence</b>	<b>Year Started Taking HIV Meds</b>	<b>Perceived Social Status</b>
Eve	54	Female	Pentecostal	Unemployed or Disabled	Divorced	Not currently sexually active	Mostly heterosexual	90%	Doesn't Know	B
Francis	31	Transgender (MTF)	None	Unemployed or Disabled	Single	Sexually active (not in a sexual relationship with one specific person)	Completely homosexual	40%	2017	E
Grace	36	Transgender (MTF)	Nondenominational Christian	Unemployed or Disabled	Never married (Single and dating a few different people)	Having sexual relationships with several people	Bisexual	70%	2009	B
Hope	67	Female	Baptist	Under \$10K	Separated	Not currently sexually active	Completely heterosexual	50%	2002	D
Irene	54	Female	Baptist	Unemployed or Disabled	Divorced	In an exclusive monogamous sexual relationship	Completely heterosexual	100%	2004	D

**Table 1 (Continued)**

<b>Pseudonym</b>	<b>Age</b>	<b>Gender</b>	<b>Religion</b>	<b>Yearly Income</b>	<b>Current Relationship Status</b>	<b>Current Sexual Relationship</b>	<b>Sexual Orientation</b>	<b>HIV Med Adherence</b>	<b>Year Started Taking HIV Meds</b>	<b>Perceived Social Status</b>
Jackie	38	Female	Baptist	Unemployed or Disabled	Never married (Single and involved in a long-term monogamous relationship)	Sexually active with one person (not in a defined committed relationship person)	Completely homosexual	50%	2010	B
Karen	52	Female	Nondenominational Christian	Under \$10K	Never married (Single and not dating)	Not currently sexually active	Completely heterosexual	100%	2013	E
Lisa	45	Female	Muslim	Unemployed or Disabled	Divorced	Not currently sexually active	Completely heterosexual	0%	2018	F

## Qualitative Findings

### *Risk Factors*

Data analyses revealed six themes that help to answer the research question: “How do sociocultural and contextual factors, embedded in the intersection of race, class, and gender, influence the high rates of HIV among Black women in Memphis, Tennessee?” Table 2 below provides a definition of the themes, the number of times the themes occurred, and the number of women who talked about the theme.

**Table 2**

*Themes, Definitions, and Frequencies of Risk Factors*

<b>Themes</b>	<b>Definitions</b>	<b>Total number of times theme occurred</b>	<b>Total number of women who mentioned theme</b>
<b>Adverse Childhood Experiences (ACEs)</b>	Potentially traumatic events that occur before the age of 18 (e.g. experiencing or witnessing violence or abuse). This also includes aspects of the child’s environment that threatens her sense of safety, stability, and bonding (e.g., absent mother, divorced parents, substance abuse by caretaker, parentified child)	38	9
<b>Substance Use</b>	The use of alcohol or drugs by either the participant or her partner	31	9
<b>Sexual Partner Concurrence</b>	Overlapping sexual partnerships or having multiple sexual partners during the same time period	16	10
<b>Intimate Partner Violence (IPV)</b>	Physical, verbal, emotional, and sexual abuse within an intimate relationship	16	9
<b>Poverty</b>	The state of being extremely poor; having very limited finances and resources	16	5
<b>Relationship Imperative</b>	Strong desire to be in a relationship	8	6

### **Adverse Childhood Experiences (ACEs)**

The first theme, ACEs, was defined as potentially traumatic events that occurred before the participant was 18 and also included any aspect of her environment that threatened her sense of safety, stability, and bonding with a caretaker. It was the most prevalent theme as it was mentioned 38 times in nine interviews. Grace provided an example of ACEs and how that potentially shaped her development.

“My parents were very dysfunctional like they argued all the time. My dad was an alcoholic and they were both gamblers. They would always just fight and argue. That’s all I know, so I never had a good relationship with either my mother or father. They weren’t really role models. They didn’t help mold or shape me as a child. I didn’t have that...It’s just that I had a very dysfunctional childhood and upbringing. I basically was a parent to my younger siblings when I was probably around 12 or 13.”

Grace also discussed how seeing IPV in her home as a child affected the types of romantic relationships she had later in life. Grace held the belief that this is the reality for many Black women.

“I think that a lot of Black women, they have the same kind of upbringing as I did... some of the situations from like our parents and how we seen our mothers and how they were treated in their relationships, we turn around and seek those same bad behaviors in men. I know a lot of women who have been in domestic violence relationships and so their kids grow up thinking that it’s okay for their men to do them like that.”

Grace, like several other women interviewed, had undergone more than one ACEs, and she shared how these experiences shaped her sexual behavior as she got older.

“I was molested when I was younger by an older cousin so I’ve experienced all of that...I just think that my experiences, they kind of shaped my sexual behaviors later on in life by being promiscuous.”

Carol discussed the abuse she endured from her great-aunt who raised her.

“Growing up with her, everybody would complement me, everybody we lived around, the neighbors. I grew up in the projects. Everybody would complement me and tell me that I was so pretty, had big legs, and that I was so smart. They would tell me to just hang in there and would say things to motivate me. Every time she would hear that, she would bash me. If somebody would say that I was pretty, she would respond, “aww she ain’t shit”. They would say I had big legs, and she would respond, “oh, she ain’t shit. She ain’t going to be anything but a little hoe”. That was my name until like 1980 until 1991, I was bitch and whore. “You ain’t going to be shit, you ain’t gonna do nothing but have a lot of kids, you gonna have a lot of babies”. That was all I heard my whole life.”

Carol also discussed how the abuse she endured shaped her expectations in her romantic relationships.

“Yeah, she [great-aunt] raised us because my mom lost custody of us. I think my rearing plays a big part in what goes on in my life today. Although, I don’t have to use that as a crutch. I tried, giving my honest heart to God, I tried to put that behind me, but it’s just something that I don’t know won’t let me move past a lot of things, the way she raised me. I try to think maybe she did the best that she could do, but you know the abuse, the mental abuse, the physical abuse, it was no reason...Pretty much when I got older, that’s what I expected from guys, so that’s what type of relationships I was in and that wasn’t

good for me. I had to learn through experience and go through things and know that this is not what I want, this is not what I deserve, so it's been hard."

There were two women who discussed their mothers experience of ACEs and how this can create a cycle of normalcy around partner violence that gets passed on to future generations.

Carol shared,

"My momma told me that my grand momma got killed. She was messing with this guy, and he had a guy friend and he found out about him, and he stabbed her and threw her in the Mississippi River. That's how I was told my grand momma died...it's like a cycle. The cycle isn't being broken because you have a baby and you went through it as a kid, you have a kid, you take your kid through that, your kid then grows up and passes it on. It's a cycle that needs to be broken somewhere. It's a chain, you gotta break that chain. That's what it is, it's the same ole', same ole' cycle repeating itself with just a different person."

Donna shared these same sentiments in regards to her mother being molested as a child.

"My mom, I didn't know until she got ready to transition [pass away] that she had been molested by her uncle. And I can recall she had to take care of this same man. He ended up with prostate cancer, and the other family wouldn't take him in, and my mom ended up taking him in and taking care of him and cooking for him up until the time that he died. So when she told me about it, it was like maybe a month before she died. She was just laying there and crying. She broke down and told me that. So now I see that it was a learned behavior. She got into an abusive relationship with my father, and her grandmother told her to stay because he married her and moved her out and he was paying the bills and all of that, but it was physical and verbal abuse.

Three women discussed their experiences of being neglected by their mothers. Carol stated,

“No, my mom just neglected us. I think she was just into men because I remember men being around. I remember coming home from school and she wasn’t ever there. When she was there, she was drunk.”

Donna reported,

“I think I wanted my mom to be there so bad. I knew I wasn’t going to have her around because when I say she was barely there, she was barely there. Like we may have seen her every three weeks. She would drop us off and we wouldn’t see her for another month...After a certain age, I just got kind of angry with her because I was looking for a relationship with her, and she was acting like she wasn’t looking for one with her children.”

Jackie expressed similar sentiments. She stated,

“Yes, and then it [crack cocaine] was something I was scared of because when I was younger, that’s what kept my mom away from me. It was actual crack cocaine. I was on the same drug that she was on, and I used to go to church and pray for her about it and look, I ended up getting on the drug...The little time before my grandmother finally took over and started raising me, I seen a lot of men beat up on my mom...Oh my grandmother took me when I was in the 3<sup>rd</sup> grade. Because before then, my mom would leave me in the house by myself to go do her drugs. She would bring all kind of men around me.”

A few women discussed being molested by their mothers’ romantic partners and not being believed by their mothers when they shared about their experiences of abuse. Donna expressed,

“So when I experienced her boyfriend touching me, and I went to her and she told me out of her mouth, “oh no, he didn’t do that.” ... it’s not a good experience when your mother or the person that’s taking care of you don’t believe that you’ve been molested by someone they feel like they love. “Oh, that man will never do that; he been around you...blah blah, blah.” When you’re telling a young girl that, it’s like it’s devastating to think you would put a stranger before your own child.”

Karen also shared a similar situation,

“Well I didn’t tell her, I told my brother and he told my mom. Because the last time one of her boyfriends sexually assaulted me, she didn’t believe me so I didn’t tell her. I told my brother... two times with my mommy’s boyfriends; she had two different ones. And then one of my brother’s friends assaulted me, and he had just gotten out of prison.”

Overall, this theme highlights the convoluted nature of the relationship between ACEs and behaviors that have been demonstrated to increase HIV risk (e.g., substance abuse, IPV, concurrent sexual partners). This theme suggests that ACEs does not act alone in increasing HIV risk, but instead, may serve as a catalyst for the engagement in risky behaviors as a way to cope with previous trauma and/or is a learned behavior from childhood.

### **Substance Use**

Substance use was defined as the use of alcohol or drugs by either the participant or her romantic partner. This theme came up 31 times across nine different interviews with the most common substances endorsed including: alcohol, marijuana, and crack cocaine.

When asked to describe what her life was like during the time period she was on drugs, Karen stated, “I didn’t care. I didn’t care about me or anybody else.” Jackie stated she initially started drugs to help cope with things such as having the relationship imperative (i.e., strong



desire to be in a relationship). She shared, “It was like it took everything away. I had got so high that first time, and I wasn’t thinking about trying be in a relationship. All I was thinking about was that high. That drug took me to another level immediately after that first try.” This led to Jackie using drugs to help her get through sex work, and she shared, “I had been doing it [sex work] for so long that I really didn’t have any interest to sell my body but when I got high, that’s when I would get into my sexual mode.”

Hope stated, “I started doing drugs when I met my husband. I smoked my little weed and some cocaine with my weed, and it was okay.” Hope also described how she used drugs as way to cope. She stated, “Sometimes, you have to cope, and I needed it to get through certain things. I would think about my brother who died of AIDS and when my parents died. I would just have to go get a glass of wine and watch tv.” Carol discussed how she started using drugs as a result of IPV and the relationship imperative. Carol was physically assaulted by her partner when she was 19 in which she was beaten beyond recognition. She shared,

“I didn’t think nobody was ever going to want me because I didn’t think my face would ever heal. I just tried the drugs. I rolled up a joint, they call it a primo joint. It’s mixed with cigarette, and I had a sack that I was selling out of, and I just opened the bag up and just tried it because I was like I ain’t got nothing to lose because ain’t nobody ever going to want me because I was looking at my face.”

Carol also shared how drug use led her to engage in risky sexual behavior, specifically exchanging sex for drugs. She stated, “Yeah, because that’s how you kept the high going. If you ain’t have money and you couldn’t buy it, you had to do a sexual act.” Grace endorsed using drugs at an early age. She stated, “I turned to alcohol and marijuana when I was younger and

went to cocaine, so I've definitely had issues with substance abuse." Ashley seemed to be in disbelief now that she had previously had romantic partners who used substances.

R1: What made you stay in those previous relationships?

P2: Because I thought I was in love, but I wasn't. It was infatuation because some of them, oh wow, some of them were using crack cocaine.

Francis shared how her partner's drug use contributed to his infidelity in their relationship. She reported,

"And I know he was still out there having sex with different, random girls because when you're on meth and stuff, that's like a powerful drug. They don't care. He had gotten to the point where he, they said that he wouldn't even take baths or nothing no more. He was just so ready to get high."

Jackie shared that her partner's drug use led to financial problems and IPV. She stated,

"He was a drug addict and alcoholic. I would put him out because he would want to spend all of the money. He didn't care if we had money to pay rent, money to eat with, and I would say no and that we need to save some money and put him out. I had to call the police on him; he kicked my window."

Overall, this theme sheds light on how substances can be used as a way to cope with difficult thoughts and/or emotions while also intersecting with other high-risk behaviors like sex work. This theme also highlights the role that partner substance use can play on HIV risk, as it can potentially contribute to infidelity and IPV within the relationship.

### **Sexual Partner Concurrency**

Sexual partner concurrency was defined as having multiple sexual partners within the same time period. It was brought up by 83% of the women, occurring 16 times across 10 different

<sup>1</sup>R stands for researcher.

<sup>2</sup>P stands for participant.

interviews. Sexual partner concurrency was discussed from the perspective of participants having romantic and/or sexual partners who were engaging in sexual partner concurrency. It was also extremely common for many of the women to have known about their romantic partners and/or husbands having outside romantic partners. For example, Lisa was aware that her husband at the time was having sex with other women and had suspicions that he was also having sex with other men.

P: I have an ex-husband who was quietly promiscuous with females. But who knows? He could have been on the down low, you never know.

R: Did you know at the time he was out with other women?

P: Well yeah, because you know I've been knowing him ever since he was 19.

Carol also endorsed being aware that many of her partners in the past were cheating on her.

R: Were they with other women?

P: Yeah

R: Did you know?

P: Yeah, some of them were really bold.

Francis shared,

R: So it was more of an open relationship?

P: It was an open thing for him. He could do what he wanted to do with me and her.

R: Were you okay with that?

P: Not really, but I just boasted it off.

While Karen did not know for sure if her previous partners had been unfaithful, she reported, "They said they wasn't, but you can tell." Karen also held a belief that all men cheat and witnessed her father cheat on her stepmother, who was also accepting of the behavior. She stated,

“Now my father and my stepmother have been married for quite a long time but their marriage is a lie. He was still out there doing what men do, but she allowed it. She said that as long as he doesn’t allow his mistresses to call the house, it was cool.” Karen also had her first sexual encounter at 13 with an adult married man.

“My first sexual encounter was when I was 13 with a grown man. I lied and told him I was 21. After he broke my virginity, he realized I was lying. He asked me how old I was, and I told him I was 13. He yelled, “Don’t you know I could be thrown under the jail?” I told him it was too late for that and that he had to go because my mommy would be home soon ... I found out that he was my mother’s hairdresser and he was married, that was enough for me.”

Grace discussed how finding out that her partner was cheating led to her cheating before ultimately leaving the relationship.

“I would say about 2 weeks into me moving in with him, someone called the phone and told me that they were the other person on the side...it was so long ago that I don’t even know if I confronted him about it. I just know that I ended up leaving pretty soon, and I started cheating myself after I found that out and ended up breaking the relationship off pretty soon after that.”

Donna was aware that her partner was engaging in risky sex with his outside romantic partners.

“He had different women come into my house while I was at work. I found him in my car sleep with another girl. The car was running. He parked in his momma’s yard, and they just in there knocked out in my car. Oh my God. He got maybe two women pregnant while we was together. So with that being said, he wasn’t using protection.”

While Irene stayed with her husband a while after finding out about his constant infidelity, she did stop having sex with him.

“I told them that my husband at the time said that he been with somebody, and they gave it to him and he told me to go get tested. I didn’t believe him when he told me that. I knew he was out cheating and doing something, and I wouldn’t be sexual with him. I started sleeping in another room, and I thought he said that to make me mad. I was just over everything, so I did not believe him.”

Overall, this theme demonstrates how gender role beliefs and the unequal power dynamics within relationships can serve as contributing factors to women staying in relationships where sexual partner concurrency is occurring.

### **Intimate Partner Violence (IPV)**

The fourth theme, IPV, was defined as physical, verbal, emotional, and sexual abuse within an intimate relationship and engagement in reciprocal violence. IPV came up 16 times across nine different interviews. Lisa provided an example of the IPV she endured one night.

“He used to drag me out to the pool. He dragged me out to the pool one day and the tarp was on top of the pool, and it was freezing. He had handcuffed me to the bed and poured Courvoisier and forced me to drink, and he just drug me out there. See his first wife is still alive, but his second wife, she is a doctor, she died. They found her in the pool dead.”

Karen reported,

“Abusive, the majority of them [romantic relationships]. I’ve been raped several times, smacked around, I’ve been put in the hospital so yeah, all of it. It hasn’t been very good relationships. I thought I had a sign on my back saying, take anything.”

Ashley also reported physical abuse that resulted in her having to seek medical attention. Ashley stated,

“Now in 2000, oh my God, all of this [pointing to jaw] was metal. I have two screws right here and two screws right here. The ex that I was involved with at the time, he attacked me and tried to kill me in front of my children. I don’t know why. He just snapped.”

Carol went through a similar experience. She stated,

“He was younger. He was 16, and I was 19 but he had full facial hair so he looked like he was of age. He was abusive, and he had beat me beyond recognition. My face was to a pulp. Now you see my face, it was literally shifted. Bones were broken and just moved, and I didn’t go to the doctor. Thank God my face healed on its own. He was hitting me so hard that it broke my back teeth. We were selling drugs then too. I looked at my face because I had to sit up and sleep for like 3 days, I couldn’t even lay down because my face hurt so bad. I couldn’t comb my hair for like 6 months, and I had black eyes for like a year. I was really messed up bad.”

Lisa discussed how speaking up in her relationships would result in physical violence. She reported,

“I’ve always had a voice, but I felt like if I spoke up it was always you know that “you talk too much or girl don’t talk to me like that.” I know that a lot of my relationships failed because you couldn’t just make me do nothing. You can’t make me do anything. So I don’t get bopped around, you know jumped on because I’m just not going to allow you to take my voice from me.”

Eve reported how her partner’s drug use resulted in physical violence. Eve stated,

“He would run out of dope, and I would still have my dope. He would try to twist my hand to get the dope out of my hand, but he’s a good guy. It was just the dope thang.” Jackie endorsed being abused and also being the abuser, and she attributed this to her earning more money. She stated,

“I have been the abuser, and I have been the person abused. In early relationships, I have because I am the dominant one. I have always been the one to have the income so if they didn’t do what I wanted, I have put my hands on them or whatever. You know what goes around, comes around, and I ended up getting it. I can say that.”

Carol who described being beaten beyond recognition also indicated that she had intentions to kill that same partner. She shared, “I eventually ended up leaving because I had ended up shooting at him and was trying to kill him, literally.”

Overall, this theme demonstrates the severity of abuse that occurred in participants’ romantic relationships. It also sheds light on the imbalance of power in those relationships, which negatively influences participants’ ability to negotiate safe sex practices due to fear of being abused.

### **Poverty**

Poverty was defined as being extremely poor and/or having very limited finances and resources. The majority of women (75%) included in this study indicated that currently they either have no income or live from paycheck to paycheck, while 25% reported earning less than \$10,000 per year. Thus, the fifth theme of poverty came up 16 times across five different interviews. Jackie described,

“If you can’t get a job to take care of you and your children or just you, it’s hard. I mean it’s some people here in Memphis who have to work two jobs just to find somewhere to

live and hold on to that apartment. Right now, I've been living around there 7 years. I want to move because I don't got clean, but it's still around me. It's hard because that means I would have to get another job so that means I ain't ever gonna have no life. You don't have a life because you get off of one job, you barely get a nap to go to another job.

Carol discussed the role of poverty for a single mother. She explained,

“You have some mothers who want to do good for their kids, but they don't have the means with so many kids and what the system gives them. You can get a job but when you have like four or five kids and making \$7 an hour, it's hard because you're trying to go to work and you have to find somebody to keep those kids. You have some going to school and then you have some that are not going to school. Then you have some that are going to school but what about when they get out of school? You have a schedule. I went through this, that's why I'm saying it.”

Carol discussed how poverty can lead to staying in abusive relationships. She reported,

“That's what causes a lot of women to go through the abuse that they go through because either they are in a stable relationship or for finances and that's the wrong reasons to be in a relationship. Because once a guy finds out that, he is going to take you through it because he knows what your situation is so he knows you are going to put up with his mess. He knows you need that help, and he knows you need it bad.”

When Lisa was asked what kept her from leaving previous abusive relationships, she stated,

“security, money, drugs, the security.” Donna shared a similar perspective:

“Because a lot of times they're not happy. Especially when it comes to relationships and we just stay in them for security and sometimes out of fear. I don't found myself homeless a few times, and you deal with a person because they got a roof over their heads and



they'll let you come in under their circumstance. "Oh, you can stay here but you gotta do X, Y, and Z". And when you see the true colors of them and you're like okay, now what am I going to do? If I leave, I'm going to be homeless again, but I don't want to deal with this. So it's a lot of circumstances and situations that cause women to stay instead of moving forward."

Along those same lines, Grace expressed how poverty can increase one's risk of contracting HIV. She stated,

"I think that when people are in poverty, they turn to a lot of things that can lead them down the road to HIV. They might turn to drugs, women might start carrying or holding drugs for that person, their guy. I know some women who have taken charges for these men and went to jail for these men, and they are put into a system of incarceration and that might lead to their drug use as well. That kind of perpetuates the spread. Also, poverty can lead to prostitution. If you have somebody who is going to give you \$500 and they say they don't want to use a condom, if you're faced with needing a place to stay tonight and not having food, you might take that risk. Definitely with prostitution and different elements of crime and also nowadays there is a lot of sex trafficking, especially with underage girls. So a lot of the poverty, it leads to negative criminal behaviors, and not only just criminal behaviors, but sometimes women will turn to a man to support them if they can't get the jobs that they want. They might not know that their man has HIV or whatever so it leads to different things."

Overall, this theme demonstrates how poverty intersects with other risk factors like IPV, sex work, and substance abuse, and illustrates how staying in unhealthy relationships can increase

participants' HIV risk. This theme also illuminated that Black women experiencing poverty may feel pressure to stay in unhealthy relationship in exchange for financial security and stability.

### **Relationship Imperative**

The relationship imperative was defined as the strong desire to be in a romantic relationship and could explain why some women engage in risky sexual behaviors (like not using condoms) as a way to maintain that relationship. This theme came up nine times across six different interviews.

Donna gave an example of this theme. Donna explained,

“I just felt like women are supposed to be with somebody. You just gotta have somebody. No one taught me that I needed time to heal...I think a lot of times in my situation it was a learned behavior because it was like if you weren't in no relationship, you just had to be in a relationship... But I didn't know how to love myself to even say well okay, I'm not going to sleep with him without protection or no, I'm going to wait a minute because I just got out of a relationship and ain't no sense in me jumping into another one. I didn't know how to love myself so if I knew how to love myself, things would have been totally different.”

Donna also shared her experience witnessing her mother hold the relationship imperative. She stated,

“I think a lot of times in my situation it was a learned behavior because it was like if you weren't in no relationship, you just had to be in a relationship. And my mom, if one relationship didn't work for her, she maybe two or three weeks later, we got a new stepdad or 'it's your uncle'.”

Karen discussed how this desire to maintain a relationship led to her tolerating abuse from partners. She shared, “The verbal abuse, the physical, the mental, it's ridiculous what you'll put

with to keep a man in your life.” Carol discussed how she was able to break the cycle of entering into abusive relationships. She stated,

“I didn’t know the difference between deserving better and just going through this and feeling like I needed it. See I learned the difference between needing a man and wanting a man. Until I learned that difference, I went through that [abuse]. I had to put priorities in line. Hey, I may want you, but I don’t need you. But back then, I felt like I needed a man.”

Overall, this theme highlights how holding the relationship imperative can lead women to engage in risky sexual behavior in an attempt to maintain that relationship. As highlighted by one participant, learning to place less emphasis on the relationship imperative, can decrease one’s chance of experiencing other high-risk behaviors such as IPV and thus may serve as a protective factor.

***Protective Factors for those Living with HIV***

In addition to the risk factors that arose from the data, there were two protective factors relevant to those living with HIV that emerged. Table 3 provides a definition of the themes, the number of times the themes occurred, and the number of women who talked about the theme.

**Table 3**

*Themes, Definitions, and Frequencies of Protective Factors for those Living with HIV*

<b>Themes</b>	<b>Definitions</b>	<b>Total number of times theme occurred</b>	<b>Total number of women who mentioned theme</b>
<b>Religion</b>	The belief in and worship of a higher power or being	16	6
<b>Finding Meaning</b>	The act of creating a new narrative that creates a sense of coherence and purpose about one’s HIV diagnosis	14	7

## **Religion**

Religion was defined as the belief in and worship of a higher power or being, which also extended to being raised within a religious family. This theme came up 16 times across six different interviews. Lisa attributed her strength to her faith in God. She shared, “So, it’s hard for a person to be able to tell me the truth because the only person that can come from is God. I have a strong strength that comes from him. A strong strength.”

Eve’s perspective on what contributed to her HIV diagnosis was her weakened relationship with God. She stated,

“I just figured out that the only thing that happened to me was that I’ve been sanctified all my life and just that I strayed away from holiness and ended up being on the Devil’s side and that’s just point blank to me... I just didn’t stay with the Lord and went on the Devil’s side and when you get on his side, that’s what happens. As they teach us, if you don’t stay with the Lord, your book will be written all the way around it and the wrong way from what God has written it for you.”

Eve also discussed the times she spent doing sex work when she was younger. Despite her relationship with God not being strong during that time, she believed He was still protecting her. She stated, “I still made it pretty good, and God kept on giving me a whole lot of favor when I was out there and stuff because I was a good person.” Brenda discussed a previous romantic relationship with a man who was a pimp and believed that her religion served as a protective factor against harm. She stated, “I had a lot of church women around me, and they weren’t going to put up with him being abusive and pimping me.”

Donna shared how religion helped her cope with her HIV diagnosis. She stated,

“We think okay, well this will be okay and then Jesus going to come and save me. Jesus going to get me out of this, but the word of God says greater works will he do. And I had to realize while I’m praying and waiting on Jesus to work it out, he’s telling me I done gave you all the tools, so you got to put those tools to use.”

Overall, this theme addresses the vital role that religion plays in the lives of the participants and how religion was used as a way to cope with their HIV diagnosis and thus, served as a protective factor.

### **Finding Meaning**

“Finding meaning” was defined as creating a new narrative that provided a sense of coherence and purpose regarding participants’ HIV diagnosis. This theme came up 14 times across seven different interviews. Grace gave an example of this theme. She stated,

“Some people get this virus and they say that it’s going to be a death sentence and sometimes the virus may be a blessing in disguise for you to get your life in order.

I would say this, women sometimes, we are so busy trying to take care of everyone else. I was that person. I was taking care of my sister; I was helping take care of mom who was sick. Sometimes we try to take care of so many different people, but we don’t take care of ourselves. That’s one of the things too, your HIV diagnosis might just be time for you to start taking better care of yourself, self-care.”

Irene attributed her increased strength to her HIV diagnosis. She stated,

“So we were in class and we wrote a letter to HIV and I said, “HIV, at first I was fearful of you but I realized that I could live with you and you made me stronger. Things that I did not see in myself, you allowed me to see it, and you made me feel like I was braver

than what I was at first.” When I told my best friend, she said you always have been brave. I did not see what they said about me. I did not see it.”

Donna shared that her HIV diagnosis started her on a path of self-reflection and discovery. She stated,

“It’s self-love and knowing yourself. That was my problem. I know I was loved. I know I could love. I know could give love, but I didn’t know that it was wrong for me to be loved. I just thought I was designed to be a parent, be a friend, be a wife. I didn’t know that it was wrong for me so it took me all of those lessons and me settling down and dealing with my diagnosis to realize I need to move all this other stuff and focus on me. Let me learn about me. Let me see what’s best for me. I know what I like and I know what I don’t like. But why am I so willing to put up with it. So a lot of it is a learned behavior. A lot of it is society makes us think this is how it’s supposed to be set up. A lot of times that’s not true. so now it’s like with the diagnosis, it makes you think. It’s like wow. A light bulb goes off.”

Several of the participants discussed the work they have done as advocates for primary prevention efforts. In essence, they reported finding meaning in their diagnosis by working to help prevent others from contracting the virus. Eve shared,

“We also went to Nashville and talked to some people up there too. We are trying to get them to change the law for the schools. When you go to schools, you cannot talk about HIV or sex. All you can teach is abstinence, and that is nowhere near good because kids are actually having sex in the fourth and fifth grade now, so they need to be taught all of this. If we can reach the younger group, then maybe we can change it. We have that up as a proposal so that’s what we are trying to get them to do. If you go to a school right now,

only thing you and me can talk about is abstinence. You can't even tell them your story. I think if we can get some of that arranged then maybe it would help."

Eve shared additional ideas for prevention efforts. She stated,

"I would like to get some funding where we can have more stuff on the corners, you know what I'm saying. Some sort of reach out on the corners or something in the summertime, tents, or a building or something where people can go out, like how people go door to door for like voting. That was my suggestion. It needs to be more stuff in communities, not way downtown especially for people who are on drugs and strung out. They're not going too far, but if you offer them some counseling along with a shower, a snack lunch or something, maybe. That's my point of view. That's what I think would reach some of the community because like where I come from, it's the highest rate."

Grace also shared ideas for prevention efforts. She stated,

"It really has to start with outreach. I really think that people should start coming to the schools like in middle school and just start having open conversations about what it is being a woman and just talking about healthy relationships. Not only sex education should be brought back to the school, but I think that they should really get a deeper understanding of healthy relationships because a lot of people have unhealthy relationships and they don't even realize it until they might look at the signs or something and then they're like "oh, this fits me" or "well, my partner doesn't hit me but I'm in a domestic violence relationship", so it starts with just getting outreach out there in the communities. I think that would be a big help."

Overall, this theme demonstrates the resilience of the participants and how they have found meaning in their diagnosis. They expressed how they used their diagnosis as a way to engage in

self-reflection, healing, personal growth, and advocacy. This perspective serves as a protective factor; helping participants cope with their HIV diagnosis.

### **Discussion**

This research study addressed a gap in the literature regarding sociocultural factors that increase HIV risk for Black women experiencing poverty. This research question is crucial given that Black women are disproportionately infected with HIV compared to women of other races (Linley et al., 2019). Grounded theory was utilized to examine the lived experiences of Black women that increase their risk of acquiring HIV. This method was chosen to develop a theory to contribute to understanding reasons for the high occurrence of HIV among Black women, using their own words. While this study's research question was framed to explore risk factors of acquiring HIV, protective factors also emerged from the data. The findings from the interviews revealed the following to be risk factors for HIV risk among Black women experiencing poverty: adverse childhood experiences (ACEs), substance use, sexual partner concurrency, intimate partner violence, poverty, and relationship imperative. Additionally, these protective factors for Black women living with HIV who also were experiencing poverty emerged: religion and finding meaning. Results were consistent with the existing literature with respect to factors that can potentially increase HIV risk for Black women. Findings highlight how much these risk factors are intertwined with each other. Furthermore, the current study suggests that many of the other risk factors for HIV are driven by adverse childhood experiences and appear to be rooted in generational poverty.

### **Theory Development**

Given the purpose of grounded theory methodology to support the generation of theory from qualitative interviews in efforts to explain a phenomenon, the analyses from this study



revealed pertinent information to help explain why the rates of HIV are so high among Black women. The themes that emerged from the data demonstrated the contributions of multiple, co-occurring risk factors (i.e., substance use, IPV, ACEs, relationship imperative, poverty, and sexual partner concurrency) and the cumulative effects of these factors in the context of intersectional identities of Black race, womanhood, and low SES. The data revealed the existence of multiple, co-occurring risk factors and how enmeshed these variables are with each other. While the theory proposed by the current study emphasizes how Black women experiencing poverty are particularly vulnerable to HIV due to the co-occurrence of risk factors, the results also align with Black Feminist theory. Black Feminist theory focuses on the intersection of varying identities, oppression related to these identities, and how this intersection impacts Black women specifically. The participants in this study shared their experiences of being Black, a woman, and experiencing poverty, and how that made them susceptible to engage in high-risk sexual health behaviors that increase vulnerability to HIV. The current study demonstrated how these multiple marginalized identities contribute to high incidence rates of HIV among Black women from low socioeconomic status backgrounds.

### **Adverse Childhood Experiences (ACEs)**

The link between a variety of risky behaviors (e.g., risky sex, substance abuse, partner violence) in adulthood and ACEs has been well established in the literature (Campbell, Walker, & Egede, 2016; Wu, Schairer, Dellor, & Grella, 2010). In the United States, 61% of Black children have experienced at least one ACEs compared to 51% of Hispanic and 40% of White children (Sacks & Murphey, 2018). Given this statistic, it is not surprising that ACEs was the most prevalent theme in the current study. A majority of the women interviewed in the current study described how various adverse childhood experiences influenced other high-risk behaviors.

In the United States, almost half (47%) of Black children are living in a female-headed household (Livingston, 2018). Many of the women in the current study described experiences being raised in a female-headed household, with some being raised by a grandmother or other maternal figure like a great-aunt due to being neglected by their mothers. Several participants attributed this neglect to their mothers' substance abuse and/or romantic partners. These same participants also endorsed other HIV risk factors such as substance abuse, experiencing IPV, childhood sexual abuse, and living in poverty. This is consistent with literature demonstrating that individuals who were raised in single-parent, female-headed household were more likely to live in poverty, be at risk for engaging in substance abuse and risky sexual behaviors, remain in the cycle of poverty, and have an unstable family as an adult (Baker, 2010; Sharpe et al., 2012).

Another common ACEs in the current study was witnessing IPV within the home as a child. Grace attributed this to why she sought "out those same behaviors in men." Research has shown that witnessing IPV as a child can increase one's own chances of being a victim of IPV as an adult (Black et al., 2010). This was highlighted by several participants as they discussed how IPV shaped their romantic relationship expectations because partner violence was the norm. Another common ACEs was childhood sexual abuse (CSA), which has been identified as a significant HIV risk factor for Black women (Lestrade et al., 2013). Black women with a history of CSA have reported higher rates of unplanned pregnancy and are less likely to use contraceptives, including condoms (Campbell, 2016). Grace attributed her promiscuity later on in life to being sexually abused as a child. To compound this, two participants reported that their mothers did not believe their CSA, which may have been another form of trauma. The current study demonstrated how ACEs plays a significant role in increasing Black women's HIV risk by shaping engagement in sexually risky behaviors later in life. Study findings also highlight the

role CSA, in particular, plays in catapulting the co-occurrence of other risk variables, such as substance abuse and IPV.

### **Substance Use**

Research has demonstrated an association between substance abuse and HIV among Black women (Sikkema, Heckman, & Kelly, 2014). The results from the current study shed light on the influence that past traumatic experiences have on substance use among Black women. Hope and Carol discussed how they used substances to cope with past traumatic experiences such as IPV and CSA. This is consistent with research on other samples of Black women (Ullman et al., 2013). Previous research also suggests that Black women with CSA have more severe problems with substances than those without CSA (Asberg, 2012).

The dependence on drugs may lead to other high-risk behaviors such as sex work or trading sex for drugs. This level of dependence may further impair judgements about sex and increase risk-taking behaviors. Jackie who had grown disinterested in continuing with sex work would use drugs as a way to get “into my sexual mode.” Carol discussed her desperation to keep “the high going” that led her to perform “sexual acts” in exchange for drugs. Other participants discussed having partners who used substances and engaged in activities that increased HIV risk. For example, Francis discussed how drug use contributed to her partner having sex with multiple women, and Jackie described how her partner would get violent with her when she wouldn’t give him money for drugs. This is consistent with other studies that have demonstrated partner’s substance use as increasing HIV risk for Black women (El-Bassel & Wechsberg, 2012). Thus, the current study findings highlight the potential pathway that substance use follows to increase HIV risk via other high-risk behaviors like sex work. Furthermore, findings illustrated how

substance use served as a coping mechanism for previous trauma, often experienced in childhood.

### **Sexual partner concurrency**

Sexual partner concurrency (i.e., overlapping sexual partnerships) has been associated with the emergence and facilitation of the spread of HIV within particular populations (Eaton et al., 2011; Neaigus et al., 2013). This has been explained by the higher likelihood of those in concurrent sexual partnerships to transmit STIs to their sexual partners (Adimora et al., 2007). Sexual partner concurrency has been linked to other high-risk sexual behaviors including co-occurrence of substance use and sex, having a higher number of lifetime sexual partners, and inconsistent condom use (Adimora et al., 2011; Frye et al., 2012; Waldrop-Valverde et al., 2012). In regards to race, sexual partner concurrency has been identified as a potential factor in the high rates of HIV in the Black community as Black individuals have been demonstrated to report higher rates of partner concurrency than individuals from other races (Adimora et al., 2013; Kogan et al., 2015). This was also reflected in the current sample of women where 10 out of 12 of the women discussed having experienced sexual partner concurrency at some point in their lives. Furthermore, several of the women discussed how they stayed in their relationships/marriages for a while after finding out their partners were engaging in concurrent sexual relationships. Jones & Oliver (2007) found that some Black women even continued to engage in unprotected sexual intercourse despite knowing about their partners' concurrent relationships.

In a study of 20 Black men seeking care at an STD clinic, researchers found a general consensus among the men that having more than one sexual partner was both normative and acceptable because it is consistent with family modeling and community norms, and is “in a

man's nature." (Carey et al., 2010, p.5). This was also reflected in the current study in which many participants held the belief that "all men cheat." Karen's belief came from witnessing her father constantly cheat on her step-mom, who was aware and "allowed it...as long he doesn't allow his mistresses to call the house." Karen then described her first sexual encounter at age 13 with a married man. This highlights how seeing sexual partner concurrency as a child can normalize the behavior as an adult. Findings from this study demonstrated the impact of childhood experiences and caregiver messages on intimate partner relationship decision-making in adulthood. These findings also highlight what to expect and/or deal with in future relationships and thus may provide avenues for future intervention.

### **Intimate Partner Violence (IPV)**

Researchers have demonstrated that Black women report higher rates of lifetime IPV victimization and perpetration than White and Hispanic women (West, 2012). In the current study, IPV was brought up in 75% of the sample. IPV has been established in the literature as a risk factor for HIV and engaging in HIV-risk behaviors (Hess et al., 2012). Research has shown that women reporting IPV in their lifetime were more likely to endorse multiple sexual partners, inconsistent or non-use of condoms, past or current STI, and having a partner with known HIV risk factors like drug use (Wu et al, 2003), all of which were endorsed in the current sample of women. For instance, Eve described how her partner would physically assault her in an effort to get drugs out of her hand. There is a known association between IPV and risky sexual behaviors like infrequent condom use and difficulties with condom negotiation among Black women (Morales-Alemán et al., 2014; Stockman et al., 2010). Many HIV intervention programs include skills to improve condom communication and negotiation skills (Peragallo et al., 2012; Sales et al., 2012); however, if women are experiencing IPV, their fear of prompting abuse may impede

their ability to negotiate condom use (Raiford et al., 2009). Lisa discussed how speaking up in relationships would result in physical abuse. Several participants also discussed how seeing their mothers experience IPV led to them being victims of IPV in adulthood. The results from the current study illustrated the influential role that witnessing IPV and/or experiencing abuse during childhood have on experiencing IPV later in adulthood.

### **Poverty**

It has been established in the literature that HIV disproportionality affects individuals of lower SES (Doyle et al., 2020; Gibson et al., 2018; Williams & Prather, 2010). Like other health disparities, HIV is hypothesized to be deeply rooted in poverty in which Black individuals are overrepresented relative to Whites (DeNavas-Walt, 2010). The majority of participants endorsed having either have no income or living from paycheck to paycheck. Research has established that children who come from families with low SES have worse adolescent and adult outcomes (e.g., not completing high school, teen pregnancy, and inconsistent employment as an adult) than children from families with higher incomes (Ratcliffe & McKernan, 2010). Black children are almost three times more likely to experience poverty and seven times more likely to spend half of their childhood living below the poverty line than their White counterparts (Ratcliffe & McKernan, 2010). Carol and Jackie discussed the burden of being a single mother living in poverty and raising children; further emphasizing the impact of generational poverty.

In regard to risky sexual behavior, low SES has been associated with Black women's vulnerability to acquiring HIV and difficulties negotiating condom use (DiNenno et al., 2012). Black women with higher income may have more opportunities to protect themselves from risky relationships and partners because they are not dependent on their partners for financial security. Carol, Lisa, and Donna discussed how they all stayed in risky relationships for financial security.

Grace discussed how poverty can lead an individual to engage in risky behaviors such as sex work. These findings are consistent with previous literature (Biello et al., 2010). In a sample of unmarried Black and White women, Black women (21.6%) were more likely than White women (10.5%) to endorse starting a relationship because of economic considerations and trading sex for money and/or resources with someone who was not a regular partner (13.1% vs. 2.9%). One study found that being with a male partner who was unfaithful was sometimes overlooked when that partner contributed income to the household (Goparaju et al., 2012). Results from the current study demonstrates how poverty, which could be seen as another adverse childhood experience, can increase HIV risk. This highlights how the co-occurrence of multiple high-risk behaviors (e.g., sex work, IPV, sexual partner concurrency) is deeply rooted in poverty, more specifically generational poverty, for these Black women.

### **Relationship Imperative**

Placing significant importance on being in a romantic relationship at all times has been shown to be associated with risky sexual behavior (Foreman, 2003; Raiford et al., 2013; Raiford et al., 2017; Scott et al., 2011). In the current study, Carol discussed how holding the relationship imperative led her to tolerate abuse in past relationships. She attributed her ability to change her pattern of getting in unhealthy relationships to learning the difference between “needing a man and wanting a man.” Similarly, another study found that their Black women participants reported a willingness to accept unfaithful partners due to loneliness and the desire for a relationship (Paxton et al., 2013). In this study, Donna and Karen reported that their mothers held a relationship imperative as they constantly saw their mothers in relationships and attributed their own relationship imperative to being a “learned behavior.” This highlights how experiences in childhood influence decisions making about relationships later in life. This aligns with the

proposed theory as it demonstrates how the co-occurrence of risk factors may be propelled by traumatic events and messages heard in childhood.

### **Religion**

The relationship between religion and HIV risk has been examined with mixed findings (Shaw & El-Bassel, 2014). A plethora of studies have found that religiosity is a protective factor against adversity (e.g., Dowshen et al., 2011). Some studies have found that participants who endorsed greater religiosity also endorsed lower levels of sexual risk (Dowshen et al., 2011; Iles, Boekeloo, Seate, & Quinton, 2016). However, there have been other studies that have found no association between religiosity and sexual risk (e.g., Muula et al., 2011), while others still have shown an association between religiosity and increased sexual and HIV risk (e.g., Golub, Walker, Longmire-Avital, Bimbi, & Parsons, 2010). Almost all of the current participants (91.6%) self-identified as religious and aspects of religion emerged in the interviews. Eve attributed her HIV diagnosis to the fact that she “didn’t stay with the Lord” as she emerged into adulthood. While not protective against HIV, Eve and Brenda believed their faith and religion protected them against other forms of harm such as death and IPV. Other participants like Donna used their religion as a way to cope with their HIV diagnosis. This is consistent with previous studies that demonstrate the positive effects of religion on coping with HIV (Doolittle, Justice, & Fiellin, 20018). The results from the current study demonstrated the vital role that religion plays in the lives of participants and how they use religion to cope with their diagnosis and find strength.

### **Finding Meaning**

While it did not emerge as a risk factor, finding meaning emerged as a protective factor and highlighted the resiliency of the women in this sample. Meaning or benefit finding has been



associated with more positive outcomes for individuals living with HIV, such as having better psychological adjustment (Fekete, Chatterton, Skinta, & Williams, 2016; Lee, Nezu, & Nezu, 2014). Finding meaning has also been positively associated with increased medication adherence, greater likelihood of having a lower viral load or being undetectable, and with fewer depressive symptoms (Cruise, 2014). A few of the participants discussed how their diagnosis prompted self-awareness and self-growth. Grace mentioned how her diagnosis prompted her to engage in better self-care, while Donna was prompted to start thinking about what she truly deserves in relationships and reflect on why she tolerated less positive treatment in previous relationships. Thus, this study illustrated protective factors within this sample of women living with HIV and how they have been able to find meaning through their diagnosis.

### **Summary of Findings**

Findings suggest potential variables to target in both primary (i.e., interventions to reduce HIV risk for individuals not living with HIV) and secondary (i.e., interventions to reduce HIV transmission for individuals living with HIV) prevention efforts with Black women. Given that all of the participants were experiencing generational poverty, findings illustrate the influential role poverty has as a catalyst for engagement in behaviors that may lead to contracting HIV. All of the risk factors identified in this study can be viewed as stemming from the limited social capital of participants. Social capital would have allowed women to gain access to resources such as services, money, information, and accurate expectations of how they should be treated by others through engagement in social relationships (Ramlagan, Peltzer, & Phaswana-Mafuya, 2013). Findings suggest that individuals experiencing poverty may lack the social capital that could help protect against engagement in risky behaviors. For Black women already living with

HIV, findings demonstrate that religion and finding meaning through HIV are protective factors that could reduce transmission of HIV.

## **Implications**

### ***Intervention***

Researchers have demonstrated that the most effective HIV interventions take into account the underlying sociocultural and contextual factors existing in the population (El-Bassel et al., 2009). Participants shared their ideas for interventions aimed at decreasing HIV rates. One idea focused on working to change the policies in schools to allow for a more comprehensive sex educational program that teaches safe sex practices, healthy relationships, and supports candid conversations between youth and individuals living with HIV to share personal stories and deter students from making similar choices. Another idea was to focus on street outreach to individuals living in poverty by disseminating knowledge about HIV and risk factors, and setting up testing sites in low income communities. Because religion emerged as a prominent theme for participants living with HIV, the church could be an ideal setting to reach Black women and implement both primary and secondary intervention efforts. The current findings highlight that interventions should focus on fostering and increasing resources and power among Black women experiencing poverty as a way to increase their social capital. Strategies such as setting up a mentorship program, providing education on financial literacy, and linking women to resources in the community could be beneficial.

### ***Clinical***

The results from this study shed light on important areas for clinical intervention. This study can serve to assist clinicians working with Black women who have experienced an adverse childhood event or young girls as they experience adverse experiences as a way to inform

treatment. Given the abundance of negative outcomes that can result from ACEs including acquiring HIV, clinicians should address trauma in treatment and teach healthy coping skills. Because generational poverty was so pervasive and seemed to drive the experiences of many of the participants, clinicians should explore the effects of poverty in the lives of Black women in an effort to mitigate high risk behaviors. Furthermore, connecting Black women experiencing poverty with case manager services in an effort to increase their financial stability may be warranted.

Given the data that emerged, clinicians should also provide psychoeducation on what healthy relationships look like since children who have experienced ACES may not be aware and thus may continue to seek unhealthy behaviors in their romantic partners. For clinicians working with Black women who are engaging in other high-risk behaviors, such as substance abuse, and staying in relationships where IPV and partner concurrency are happening, the risk of HIV should be explored and communicated to the client. For clinicians working with Black women living with HIV, faith/religion and finding meaning should be explored as a way to promote psychological well-being and resilience. Clinicians should also be aware of the intersection of race, gender, and social class and how these identities uniquely impact clients within the therapeutic context and thus may place them at high risk for HIV.

### **Study Strengths**

A major strength of this study is the focus on the intersection of race, gender, and class and the impact these intersectional identities have on HIV acquisition among a sample of Black women experiencing poverty and living with HIV. This study highlighted factors unique to the participants due to these intersectional identities, and provided space for Black women living with HIV to express their experiences via their own worldview and lens in their own words.

Another strength of the study was using a semi-structured interview guide, allowing for greater exploration of ideas as opposed to forced choice answers in a quantitative study. Further, all interviews were conducted by one person in an effort to reduce confounding variables associated with having multiple interviewers.

### **Study Limitations**

**Sample-related limitations.** The current sample was not representative in age, socioeconomic status, or geographical region of all Black women living in the United States. Over 75% of the sample consisted of women aged 45 or older who endorsed either living from paycheck to paycheck or having no current income. At the point of data saturation, an adequate amount of information had been obtained from the interviewees to answer the research question but not all groups of Black women across age and social statuses had been interviewed. However, because the aim of this study was to create a starting point for the development of a theory on the lived experiences of Black women, generalizability was not a top priority of the study but still presents as a study limitation. An additional study limitation was that participants were drawn from a convenience sample of women receiving services at organizations serving individuals living with HIV/AIDS. Thus, there may be something about this sample of women seeking services that is different from women who are not currently seeking HIV-related services which this current study was unable to capture.

**Methodology-related limitations.** Because a grounded theory approach was selected, an attempt was made at offering some theoretical explanation for the data that emerged from the interviews. These explanations should be understood as subjective and likely to change over time. It is reasonable to assume that others may interpret the data in a different way due to their personal and professional backgrounds that shape their own interpretations. Further, this study

employed a semi-structured interview conducted in-person. Even though these interviews were conducted one-on-one with the researcher in hopes to increase comfort level, some women may have felt uncomfortable discussing such sensitive topics in great detail to someone they just met resulting in some level of censorship. A limitation of using the constant comparative analysis is the subjective nature of this approach. It is possible that other individuals reading the interviews and using this approach would find different themes than were found by this author.

### **Future Directions**

Future studies should continue to explore how the intersection of race, gender, and class impact the high rates of HIV among Black women. This should include expanding the sample so that it is more representative of Black women in the United States. Specifically, researchers should make an intentional effort to include Black women who vary in age, socioeconomic status, and geographical region. Because poverty was identified as a risk factor for the current sample, recruiting Black women living with HIV who come from families with higher and middle SES would offer needed perspectives into risk and protective factors that may not be rooted in poverty.

Furthermore, because the current study aimed to develop a theory that would offer an explanation for the high rates of HIV among Black women, future studies should focus on developing interventions that address all six themes identified to assess their impact on reducing HIV risk and promoting protective factors.

### **Conclusions**

This study supported a developing theory about how co-occurring risk factors contribute to high rates of HIV among Black women experiencing poverty. The results demonstrated multiple HIV risk factors of adverse childhood experiences, substance use, sexual partner

concurrency, intimate partner violence, poverty, and relationship imperative. The interconnectedness of these variables were highlighted by participants, illustrating that not one of them stood alone in increasing HIV risk but rather that they collectively contribute to a disproportionate burden of HIV in this population. Aligning with Black Feminist theory, the lived experiences of participants showed how their gender, race, and socioeconomic status intersected and placed them at high risk for engaging in risky behaviors. Protective factors of religion and finding meaning were also revealed from the sample and shed light on the strength and resilience of these women. Through the lens centering the intersectionality of marginalized identities, findings provide a foundation for understanding how HIV risk among Black women experiencing poverty and other co-occurring adversities begins and is maintained.

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## **Appendix A**

### **Screening Questionnaire**

#### **Introduction**

Thank you for expressing interest in the study. My name is Robin, and I am a graduate student at the University of Memphis conducting a research study exploring what contributes to the high rates of HIV in Memphis among Black women. If you are eligible and decided to enroll, we would schedule a day and time that works best for you to complete an interview that will consist of me asking you a series of questions about what contributed to your HIV diagnosis? You will be interviewed one time in-person and the interview will last about one hour. You will be compensated \$20 for your time.

Are you at least 18 years of age or older?

- a) Yes
- b) No

Are you fluent in English?

- a) Yes
- b) No

In terms of your race, do you self-identify as Black or African-American?

- a) Yes
- b) No

Have you ever received a diagnosis of HIV?

- a) Yes
- b) No

To the best of your knowledge, did you contract HIV through having sex with someone who is living with HIV or through injection drug use?

- a) Yes
- b) No

**If participant answered no to ANY of the above questions, the participant is not eligible for the study.**

Interviewer: I am sorry but based on the answers you provided, you are not eligible for the study. I appreciated your interest in the study. Thank you so much for your time.

**If participant answers yes to ALL questions, she is eligible for the study.**

Interviewer: Wonderful! You are eligible for the study. When would be a good time for you to schedule the interview? We can do the interview at the University of Memphis or I can come to your home, which ever would be more convenient for you. If you have another place in mind, it is possible that we could do the interview there like the library or a community center.



**Appendix B**  
**Demographics Questionnaire**

**1. What is your age in years?**

\_\_\_\_\_ YEARS

**2. What is your gender?**

- Male
- Female
- Transgender (MTF)
- Transgender (FTM)
- Other, please specify: \_\_\_\_\_

**3. What is your religion?**

- None
- Agnostic
- Anglican
- Atheist
- Baptist
- Catholic
- Jewish
- Methodist (including African Methodist Episcopal {AME})
- Muslim
- Nondenominational Christian
- Pentecostal (including Church of God in Christ {COGIC})
- Presbyterian
- 7<sup>th</sup> Day Adventist
- Other: \_\_\_\_\_

**4. Please indicate your ethnicity:**

- Hispanic or Latino
- Not Hispanic or Latino

**5. What is your racial heritage? (Please select all that apply.)**

- American Indian or Alaska Native
- African-American or Black
- Asian
- Native Hawaiian or Other Pacific Islander
- White or European American
- Biracial or Multiracial: \_\_\_\_\_
- Some Other Race, please specify: \_\_\_\_\_

**6. If you chose b in the previous question, how do you specifically identify?**

- African
- African-American or Black
- Caribbean
- Other, please specify: \_\_\_\_\_

**7. Approximately what is your yearly income?**

- a. Unemployed or disabled
- b. Under \$10,000
- c. \$10,000-20,000
- d. \$21,000-30,000
- e. \$31,000-40,000
- \$41,000-50,000
- \$51,000-75,000
- \$76,000-100,000
- \$100,000-200,000
- over \$200,000

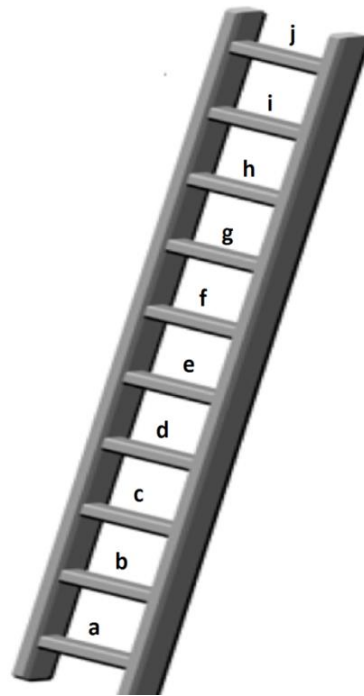
**8. What is the highest level of education you have received?**

- Grade School: 1
- Grade School: 2
- Grade School: 3
- Grade School: 4
- Grade School: 5
- Grade School: 6
- Grade School: 7
- Grade School: 8
- High School: 9
- High School: 10
- High School: 11
- High School: 12
- College: 13
- College: 14
- College: 15
- College: 16
- Graduate School: 17
- Graduate School: 18
- Graduate School: 19
- Graduate School: >20

**9. Which of these phrases best describes your socioeconomic status?**

- I live very well.
- I live comfortably.
- I live from paycheck to paycheck.
- I don't have a steady income.
- I have no current income.

10.



Think of the above ladder as representing where people stand in the United States. At the top of the ladder are the people who are the best off - those who have the most money, the most education, and the most respected jobs. At the bottom are people who are the worst off - who have the least money, least education and the least respected jobs or no job. The higher up you are on this ladder, the closer you are to people at the very top; the lower you are, the closer you are to people at the very bottom. Where would you place yourself on this ladder? Please, select the letter for the corresponding rung in which you think you stand at this time in your life, relative to other people in the United States.

- A
- B
- C
- D
- E
- F
- G
- H
- I
- J

**11. What is your current relationship status? (Choose one.)**

- Married
- Separated, not divorced
- Divorced
- Widowed
- Engaged
- Never married. Single and involved in a long-term monogamous relationship (more than 6 months).
- Never married. Single and living together but not married (less than 6 months).
- Never married. Single and dating/hanging out with one person.
- Never married. Single and dating a few different people.
- Never married. Single and not dating.
- Other, please describe \_\_\_\_\_

**12. What is your current sexual relationship?**

- In an exclusive monogamous sexual relationship
- Not currently sexually active with another person
- Sexually active, but not in a sexual relationship with one specific person
- Sexually active with one person but not in a defined, committed relationship
- Having sexual relationships with several people
- I have never had sex.

**13. Which one of the following best describes your feelings?**

- Completely heterosexual (attracted only to persons of the opposite sex)
- Mostly heterosexual (mainly attracted to persons of the opposite sex and slightly attracted to persons of the same sex)
- Bisexual (equally attracted to men and women)
- Mostly homosexual (mainly attracted to persons of the same sex and slightly attracted to persons of the opposite sex)
- Completely homosexual (gay/lesbian, attracted to persons of the same sex)
- Not sure

**14. What is the race/ethnicity of most of the individuals you have been in a romantic/sexual relationship with?**

- American Indian or Alaska Native
- Non-Hispanic Black or African-American
- Asian
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- Non-Hispanic White or European American
- Biracial or Multiracial: \_\_\_\_\_
- Some Other Race/Ethnicity, please specify: \_\_\_\_\_

**15. My romantic/sexual partners tend to be:**

- A lot older than me (5 years or older than me)
- Slightly older than me (less than 5 years older than me)
- The same age as me
- Slightly younger than me (less than 5 years younger than me)
- A lot younger than me (5 years or younger than me)

**16. Having a partner at all times is important to me.**

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

**17. Who knows about your HIV status? (Check all that apply.)**

- Child/Children
- Partner
- Immediate family
- Extended family
- Close friends
- Acquaintances
- Primary care doctor
- Dentist
- No one

**18. Are you currently prescribed any HIV medications by your doctor?**

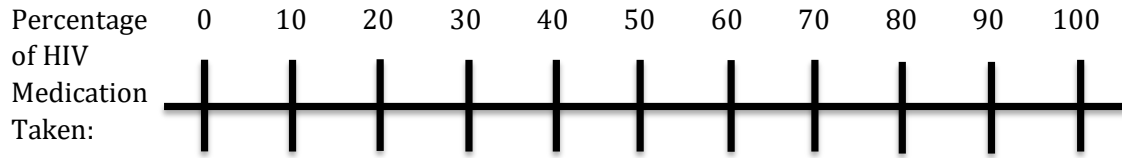
- No; Why not? \_\_\_\_\_
- Yes

**19. What month and year did you begin taking these prescribed HIV medications (MM/YYYY)?**

- The month and year was: \_\_\_\_\_
- Don't know
- Refuse to answer

**20. On the line below, please indicate the point that shows your best guess about how much of your prescribed medication you have taken in the LAST MONTH.** We would be surprised if this were 100% for most people. Examples: 0% means you have taken no medication; 50%

means you have taken half of your medication; 100% means you have taken every single dose of your medication.



**21. Do you ever forget to take your HIV medication?**

- No
- Yes

**22. Sometimes if you feel worse, do you stop taking your HIV medication?**

- No
- Yes

**23. Did you miss taking any of your HIV medication over the PAST WEEKEND?**

- No
- Yes

**24. Thinking about the PAST MONTH, on average, how would you rate your ability to take all your HIV medications as your doctor prescribed?**

- Very poor
- Poor
- Fair
- Good
- Very good
- Excellent

## **Appendix C Interview Guide**

*Start by giving an introduction:*

Thank you very much for taking out the time to speak with me today. I'd like to let you know that your responses to my questions will be used as data for a research study, but I will NOT record your name to ensure that your responses remain anonymous. If at any point during the interview you need to take a break, please let me know so that we can take one. Also, please keep in mind that you do not have to answer any questions that make you feel uncomfortable. Just let me know if you feel uneasy, and we can move on to another question. Are you ready to begin the interview? [*Wait for verbal affirmation, then turn on the recorder*]

### **General Information**

Before we get started with the main part of the interview, I would like to learn more about you.

- A. Are you currently working or going to school?
  - If working, what kind of work do you do? Is it full-time or part-time?
  - If going to school, what is your major? Are you in school full time or part time?
  
- B. What area of Memphis do you currently live in? Where are you from/where places have you lived outside of Memphis?
  
- C. Do you like living in Memphis? Why or why not?
  
- D. Are you currently in a romantic relationship right now? Tell me about it.
  - How long have you been together?
  - How did you meet?

Thank you for sharing! Now I would like to ask you some questions regarding your HIV diagnosis.

\* Probes: [*optional, if conversation is not flowing*]

- 1. What has been your experience living with HIV?
  - a. Probe: How long have you been living with HIV?
  - b. Probe: How did you learn about your diagnosis?
  - c. Probe: What lead you to get tested?
  - d. Probe: What was it like receiving a positive diagnosis?

2. What do you wish you had known about HIV before you were diagnosed?
  - a. Probe: Were you aware that you were at risk for contracting HIV?
3. If comfortable, please share with me how you contracted HIV.
4. [***If sexual contact was the answer to #3***] Tell me about the relationship with the person you contracted HIV from.
  - a. Probe: How long was the relationship?
  - b. Probe: Were you aware your partner was HIV positive?
  - c. Probe: How did your partner contract HIV?
  - d. Probe: Are you aware of any relationship cheating that may have happened?
  - e. Probe: When it came to making important decisions in the relationship like financial decisions, who made most of the decisions?
  - f. Probe: How often did you use condoms with this partner?
  - g. Probe: Please tell me about any abuse or violence, whether it was sexual, physical, and/or emotional abuse, that you experienced in that relationship.
  - h. Probe: In what ways were you able to express your needs and wants to your partner in that relationship?
5. Please tell me about all other romantic relationships you have been involved in. What were those relationships like compared to the one with the partner with whom you contracted HIV?
  - a. Probe: Have you ever been romantically involved with anybody outside of your race? [**If no**] Why not?
  - b. Probe: What thoughts do you have about the number of available Black men to date or even to marry in your community?



- c. Probe: Many people in relationships put up with more than they would like to, in order to keep that relationship alive. Have you ever felt like you have done that?  
If so, tell me more about that.
  - d. Probe: How many abusive and/or violent relationships have you ever been in?
  - e. Probe: In your romantic relationships, who do you think has most of the power, such as making important decisions within the relationship?
  - f. Probe: In general, do you feel like you have been able to communicate your needs and wants to romantic partners? [*If no*] Why not? [*If yes*] what helped you do this?
6. How has your diagnosis impacted your relationships with others such as children (if any), family, friends, and/or romantic partners?
7. Please tell me about any traumatic experiences you have had in the past and how you think those experiences may or may not have contributed to your diagnosis of HIV.
- a. Probe: This can be any childhood abuse such as rape, emotional, and/or physical abuse, as well as any of these experiences during your adult years.
  - b. Probe: What do you think can be done for other women who may have had similar experiences in order to prevent them from contracting HIV?
8. Tell me about your experiences with substances such as alcohol, marijuana, and other drugs. [*For women who endorse any experiences, continue on with probes*]
- a. Probe: Prior to your diagnosis of HIV, were there any substances such as alcohol, weed, or other drugs that you were using on a regular basis?
  - b. Probe: How long have you been using \_\_\_\_\_ (*fill in with the substance(s) they endorsed; probe for each substance reported*)?

- c. Probe: What were/are some reasons that you engage/d in substance use?
  - d. Probe: Do you ever use substances before having sex? Why or why not?
  - e. Probe: How do you think substance use contributed to your diagnosis of HIV, if at all?
9. What has been your experience as a Black woman living in Memphis?
- a. Probe: Were you born in Memphis?
  - b. Probe: How long have you lived in Memphis?
  - c. Probe: Tell me about your experiences dealing with discrimination because of your race, gender, social class, or other aspects of your social identity.
  - d. Probe: How do you deal with discrimination?
  - e. Probe: About 85% of the people living with HIV in Memphis are Black. Why do you think the rates of HIV are so high among people in the Black community in Memphis?
10. On the questions I had you fill out earlier (*demographic questions*), there were questions about your socioeconomic status. How do you think your socioeconomic status contributed to your HIV diagnosis, if at all?
- a. Probe: Do you live in a neighborhood where there is a lot of crime and drug use?
  - b. Probe: How do you think crime and drug use affects the HIV status of people in your community?
11. If you were going to share your ideas with women in your community who were not HIV positive, what would you tell them to keep them from getting HIV?
12. What advice would you give to women in your community who are living with HIV?
13. Is there anything else you would like to share about your experiences living with HIV?

**Appendix D**  
**IRB Approval**

The University of Memphis Institutional Review Board, FWA00006815, has reviewed your submission in accordance with all applicable statuses and regulations as well as ethical principles.

PI Name: Robin Hardin  
Co-Investigators:  
Advisor and/or Co-PI: Idia Thurston  
Submission Type: Initial  
Title: Exploring Factors that Lead to HIV in Black Women  
IRB ID : #PRO-FY2018-675

Expedited Approval: March 8, 2019

The University of Memphis Institutional Review Board, FWA00006815, has reviewed your submission in accordance with all applicable statuses and regulations as well as ethical principles.

Approval of this project is given with the following obligations:

1. When the project is finished a completion submission is required
2. Any changes to the approved protocol requires board approval prior to implementation
3. When necessary submit an incident/adverse events for board review
4. Human subjects training is required to be kept current at [citiprogram.org](http://citiprogram.org) every 2 years

For additional questions or concerns please contact us at [irb@memphis.edu](mailto:irb@memphis.edu) or 901.6783.2705

Thank you,  
James P. Whelan, Ph.D.  
Institutional Review Board Chair  
The University of Memphis.