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“The Ball Was Always In His Court”: An Exploratory Analysis of Relationship Scripts,
Sexual Scripts, and Condom Use Among African American Women

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Abstract

This qualitative study explored the association between African American women's interpersonal relationship and sexual scripts and condom use with primary partners. Participants were 14 lower to middle-income women between the ages of 22 and 39 involved in emotionally and sexually intimate heterosexual relationships. Relationship types included those that were: stable, emotionally committed; casual, primarily sexual; and unstable, emotionally imbalanced and/or conflict-ridden. Respondents completed a semi-structured interview and a questionnaire about their relationships, sexual, and condom use behaviors. Data analyses identified three interpersonal relationship scripts (i.e., *men control relationships*, *women sustain relationships*, *infidelity is normative*) and two interpersonal sexual scripts (i.e., *men control sexual activity*; *women want to use condoms, but men control condom use*) that may indirectly or directly decrease African American women's condom use with primary partners, and in turn increase their HIV risk. We discuss these interpersonal scripts within the context of sociocultural factors relevant to African American women, heterosexual relationships and communities.

“The Ball Was Always In His Court”: An Exploratory Analysis of Relationship Scripts,
Sexual Scripts, and Condom Use Among African American Women

More than two decades into the HIV/AIDS epidemic, HIV/AIDS continues to rage disproportionately among African American women. Although they represent just 12% of the female population, Black women account for 58% of reported AIDS cases among women (Centers for Disease Control and Prevention, 2001). Since 2000, heterosexual transmission has outpaced injection drug use as the leading HIV exposure category for women of all ethnicities. Heterosexual relationships are thus an important domain for examining women’s condom use experiences and in turn, their HIV risk.

Historically, psychological theories applied to HIV risk have focused solely on individual-level predictors with little or no consideration of the impact of sociocultural context and social inequality on sexual behavior (Amaro, 1995; Zierler & Krieger, 1997). Sociocultural context however, is critical for understanding the experiences of historically oppressed groups such as African American women. Social inequalities in terms of racism, access to resources such as income, education, and health care, and their intersection with other contextual factors such as unequal sex ratios, substance abuse, incarceration, and gender ideologies may also account for the disproportionate incidence and prevalence of HIV/AIDS among this population. This qualitative study focuses on the context of gender ideologies manifest as interpersonal relationship and sexual scripts, and the relationship of these scripts to condom use among African American women.

Scripts are culturally shared social norms that guide relationship and sexual behavior (Simon & Gagnon, 1986). Relationship scripts direct, for example, the types of people we deem suitable for intimate relationships. Sexual scripts influence all aspects of sexual behavior such as appropriate sexual partners and activities. Primarily because of its inclusion of cultural influences, scripting theory provided a compelling theoretical framework for our study. Qualitative methods are also an important component of this study. Though still relatively rare in U.S. psychology,

these methods are ideal for researchers who wish to understand the rich contexts in which peoples' experiences occur (Marecek, Fine, & Kidder, 1997). A constructivist as well as a critical theory epistemological stance informs our methods (see Guba & Lincoln, 1994). Consistent with constructivist paradigms, we believe that there are multiple constructed realities and that researchers and participants mutually create knowledge. Thus, our analyses constitute just one interpretation among multiple interpretations of our interviewees' realities and worlds (Charmaz, 2000). Pursuant to critical theory, we are concerned with issues of power and privilege and how historical realities influenced by myriad factors (e.g., social, political, cultural, economic, ethnicity, gender) intersect to construct social systems. Using semi-structured interview data from a sample of African American women who participated in a study of relationship power and condom use, we explored women's interpersonal relationship and sexual scripts, the sociocultural and contextual factors relevant to these scripts, and the association between these scripts and condom use.

Scripting Theory and African American Women's Condom Use

According to scripting theory, behavior is influenced at three levels: cultural scenarios, interpersonal scripts, and intrapsychic scripts (Simon & Gagnon, 1986). Our study focused on the first two levels. Cultural scenarios are collective instructional guides that direct the performance of roles for the self as well as others. Interpersonal scripts reflect individuals' interpretation of cultural scenarios. At this level, individuals are scriptwriters or adaptors who rely on their socialization and unique experiences to actively shape cultural scenarios into scripts for their own relationship and sexual behaviors.

Like their African American male counterparts, African American women's intimate relationships and sexual behaviors are rooted in the sociohistorical context of slavery and institutionalized racial and economic oppression (Wyatt, 1997). Yet, there remains a dearth of knowledge about the influence of sociocultural factors on African American women's and men's sexual behaviors (Fullilove, Fullilove, Haynes, & Gross, 1990; Wyatt, 1994). Research by

Fullilove et al. (1990) reveals how gendered cultural scenarios for African American women may influence different interpersonal sexual scripts. Traditionally, women's sexuality, regardless of ethnicity and socioeconomic status, has been framed within the context of the Madonna (good girl)/whore (bad girl) role. Yet, whereas the traditional good girl/bad girl dichotomy role focuses on girls and women who have premarital sex, the predominantly low-income African American girls and women in the Fullilove et al. study described "good girls" as those who were serially monogamous within heterosexual relationships. "Bad girls" by contrast, were those who had sex in exchange for money or drugs, had multiple sex partners, or were perceived to be sexually aggressive.

Several studies document the relationship between sociohistorical context and African American women's gender ideologies. Whereas some research has demonstrated that African American women hold more egalitarian gender ideologies than White women or Latinas (Harris & Firestone, 1998), other research has found that African American women are more likely than other groups of women to hold simultaneously expressive (e.g., emotionality, caring for others, etc.) and instrumental (e.g., autonomy, assertiveness, etc.) gender ideologies (Binion, 1990; Bowleg, Belgrave, & Reisen, 2000). These findings suggest that a prevailing gendered cultural scenario for African American women is that they must be traditionally feminine in their intimate heterosexual relationships, and also be nontraditional in terms of their workforce participation.

Relationship and Sexual Scripts

Prevailing cultural scenarios encourage women to establish and maintain intimate relationships at the expense of their own needs (see Golden, 1996). A large literature suggests that cultural pressures for women to value and sustain intimate relationships are universal, though specific cultural scenarios may vary. Indeed, the cultural pressures on African American women to be in heterosexual relationships have been well documented in the feminist and social science literature (see Golden, 1996; Hill Collins, 1991; Sobo, 1995). Sexual scripts are culturally shared directives for sexual behavior that influence all aspects of sexual behavior such

as beliefs about appropriate partners, relationships appropriate for sex, and emotions (Hynie, Lydon, Cote, & Wiener, 1998; Simon & Gagnon, 1986). Sexual scripts do not develop in a vacuum, but rather are shaped by cultural scenarios, particularly those relevant to culture, gender, socioeconomic class, and ethnicity. Traditional gender norms encourage women to perceive sex as appropriate only when it occurs within the context of an emotionally committed relationship or when sex is an expression of emotional intimacy; and to repress their own sexual needs and desires to please their male partners (Holland, Ramazanoglu, Scott, Sharpe, & Thomson, 1990; Hynie et al., 1998). Romantic norms are also linked with sexual scripts. These norms encourage people (particularly women) to perceive heterosexual sex as romantic, spontaneous and unintentional (Gavey & McPhillips, 1999). Romantic scripts also prescribe that women be sexually passive (Diekman, McDonald, & Gardner, 2000), which in turn may preclude women from engaging in indirect HIV prevention strategies such as communicating about HIV before sex or having condoms available.

Our study examined the association of interpersonal relationship and sexual scripts and sociocultural context on condom use among a sample of 14 African American women. Though the sample size is smaller than that of traditional psychological studies, the size is appropriate for qualitative studies. Kvale (1996) recommends that qualitative researchers "Interview as many [participants] as necessary to find out what you need to know" (p. 101) and has observed that interview studies typically include sample sizes of "15 ± 10" (p. 102). Patton (2002) has opined "There are no rules for sample size in qualitative inquiry" (p. 244). Echoing Kvale, Patton notes that a variety of factors such as what the researcher wants to know and available resources will determine sample size.

The study investigated three research questions: (1) What scripts do African American women interviewees articulate?; (2) What sociocultural and contextual factors may be relevant to these scripts?; and (3) How might these scripts be associated with condom use? Our familiarity with the feminist psychology literature on relationships, scripts, and relational theories

as well as much of the psychosocial literature on African American women and HIV/AIDS shaped our expectations for this study. Specifically, we assumed that interviewees would voice a variety of traditional gendered scripts such as the importance of establishing and maintaining intimate heterosexual relationships and being monogamous.

Method

Participants

Participants were 14 women, the female sub sample of a study ($N = 27$) about sex, health, and relationship issues in African American communities. Male participants ($n = 13$) were excluded from this study's analyses. Participants' ages ranged from 22 to 39 ($M = 31.71$, $SD = 5.50$). The sample was almost evenly split between lower and middle-income women, with personal annual incomes ranging from less than \$10,000, to \$50,000 to \$60,000 ($M = \$20,210$, $SD = \$15,110$ based on a mid-point estimate for each income category). Six women had personal incomes below the 2001 national median income for women of \$16,614; eight had incomes above this figure (U.S. Census Bureau, 2002). In the former group, two women were unemployed; one was receiving disability benefits; and one woman did not endorse an option. Levels of education ranged from some high school to some graduate work, with a mean of graduation from high school or high school equivalency degree. A questionnaire item asked all participants whether they had been tested for HIV and their HIV status. Two women indicated that they were HIV positive; another's HIV status was unconfirmed. Interviewee demographics are included in Table 1; relationship demographics are included in Table 2.

Measures

Semi-structured interview. The interview guide included questions designed to elicit rich descriptions about respondents' relationships with primary partners. We asked specific questions about relationship decision-making, financial resources, emotional involvement, sexual behaviors, and condom use. The semi-structured interview format allowed participants to respond freely to questions, and gave them the flexibility to discuss other relevant topics. Sample

interview questions included: "What do you like most about your relationship? Least?" and "Recall the first time that you had sex with your partner; tell me about what happened then."

Questionnaire. Participants also completed a brief self-administered questionnaire that included questions about casual sexual partners, perceptions about partners' sexual fidelity, condom use with primary and other partners, participants' and partners' perceived interest in condom use, and concerns about HIV risk. Demographic questions about age, income, occupation, education level, and description and length of relationship also were included.

Procedures

Participants were recruited via advertisements placed in a Washington, DC metropolitan area free weekly newspaper targeted to a general audience. A research assistant in Washington, DC also placed approximately 10 flyers at local community-based organizations. Because we believed that the stigma associated with HIV/AIDS might discourage participants, we did not mention HIV/AIDS in the advertisements. The advertisement and flyer invited Black/African American women and men who were unmarried to participate in a confidential study about "sex, health, and relationship issues in Black/African American communities." The recruitment materials encouraged prospective participants to call a 1-800 number in Rhode Island to be screened to determine whether they met the study's eligibility criteria. To participate, respondents had to be Black, unmarried, between the ages of 18 and 44, and have a primary partner of the other sex. We defined a primary partner as a sexual partner to whom respondents felt emotionally closest. Thirty-seven female prospective participants responded. The study's sampling plan included interviews with a total of 36 participants (i.e., 13 women, 13 men, and 10 couples). We met the sampling goals for women and men, but not couples and thus were able to interview an extra female participant. Participants received a \$40 cash incentive. The first author and two trained interviewers, all Black women, conducted face-to-face, tape-recorded individual interviews in Washington, DC. Interviews ranged in length from 45 to 90 minutes and then participants completed the questionnaire.

Data Analysis

Audio taped interview data were transcribed verbatim and edited to remove identifiers. The first and second authors read all of the transcripts thoroughly multiple times to become acquainted with the data and conducted all of the coding independently. Next, we imported the data into NVivo, a qualitative data analysis software package. We analyzed the data via three techniques derived from grounded theory: coding, memo writing, and the constant comparative method (Glaser & Strauss, 1967). Our coding phase of the analysis progressed in three stages: open, axial and selective coding (Strauss & Corbin, 1990). At the end of the coding process, we constructed matrices of our codes to examine the consistency of our interpretations for each woman, and discussed the text that we had interpreted or coded differently until we reached 100% agreement.

For the memo writing analysis, each coder wrote memos at the initial reading of the transcripts and created memos consistently during all phases of analyses to highlight key questions about relationships in the data, to refine categories, and to ensure a close association between participants' responses and emerging analyses. In the constant comparison method stage of the analyses, we systematically compared interviewees and codes for similarities and differences. During the final phase of analysis, the principal author re-read all of the transcripts to ensure that our analyses accurately reflected the context in which women described their experiences and to check the coded data against a summary matrix of key themes.

Trustworthiness of analyses. Qualitative theorists have proposed several criteria for judging the quality, or trustworthiness, of qualitative analyses. We assessed the quality of our analyses via four criteria: prolonged engagement with the data, credibility, transferability, and confirmability (Lincoln & Guba, 1985). First, prolonged engagement involves the investment of sufficient time with the research. We were intensively engaged with the data in terms of conducting multiple reads of the transcripts, numerous reviews and revisions of codes, and many iterative cycles between the transcripts, codes, and our interpretations. Second, we evaluated

the credibility of our findings by examining the extent to which our interpretations were grounded in the data. We also examined exceptions to our interpretations (i.e., negative case analysis) and determined that our interpretations were credible. Additionally, a graduate student with qualitative research experience, but little familiarity with the study or its research questions, evaluated the credibility of our interpretations. She randomly selected half of the transcripts and coded them, and then checked her codes against our interpretations for each script. The rate of agreement between her codes and our interpretations was 86%. The goal of transferability is to assess whether the conclusions drawn from a qualitative study can be compared with other samples or theories. We have provided "thick description" (Geertz, 1973, 1975) to assist others interested in assessing the transferability of our findings. Thick descriptions include, but are not limited to, detailed accounts of the sample and discussion of prior theory. Finally, confirmability refers to the extent to which the study's methods, procedures, process of data collection and analyses, and conclusions have been described thoroughly. We have provided in the results section quotes from participants to support the conclusions that we have drawn. With the exception of some minor edits to improve clarity, all quotes are provided verbatim. To protect the confidentiality of interviewees, we have provided pseudonyms and changed occupations and other identifiers.

Results

A variety of relationship and sexual scripts (e.g., *men as breadwinner, challenge of the emotionally distant partner, love means not having to use a condom, sex just happened*) emerged from the data. We have narrowed our analyses, however, to focus on scripts generated by at least half of the sample (see Table 1).

Relationship Scripts

1. Men control relationships. Traditional heterosexual relationship norms prescribe that men must be heads of the household and have authority over most aspects of relationships (e.g., finances, major decisions, social activities). Consistent with these traditional scripts, 10

women described their experiences of having their partners control various aspects of their relationships. Partners' control of relationships varied in severity. Among the more severe controlling behaviors were: (1) monitoring the women's whereabouts or insisting that women not go out alone ($n = 2$); (2) granting or denying permission for women to socialize with others or regulating the extent of these activities ($n = 4$); (3) regulating women's access to or spending of money ($n = 2$); and (4) restricting women's decision making about household affairs (e.g., repairs) ($n = 2$). Thelma, a 39-year old unemployed mother of six, and Keisha, a 33-year old waitress, described their frustrations about having partners infantilize them by regulating how they spent money or monitoring their whereabouts. Thelma reflected:

The last time we were together, I told him I don't like the way he talks to me like I'm his daughter. And I said, "You can give me the money. I can go shopping by myself." But he be doing it anyway. And I can't shop like I want something. I'm like, "Give me the money, let me go shopping. I'm no little kid."

Sandra, a 35-year old research associate, and Melanie, a 38-year old mail carrier, described their partners' attempts to control virtually every aspect of their relationships. Sandra wished that her partner of one and a half years, "wouldn't be so controlling as far as me making decisions." She recalled a variety of major conflicts in their relationship when she tried to take control over household decisions such as whether to hire a plumber or to sell a faulty VCR. Melanie said that her partner controlled all aspects of their relationship, including sex: "He feel like he pays the bills and I should be very accessible and happy to have sex with him when he chooses to." She noted that although she made more money than her partner and had a college degree, "that still doesn't stop him from wanting to ... from being the person who makes the most decisions. And he wants me to consult him about [all decisions]." Four women noted that their partners had veto power over their social activities. Despite noting throughout her interview that she controlled every aspect of her relationship, Theresa, a 32-year-old administrative associate noted "if he told me he didn't want me to go out, I wouldn't go out."

Yet, while four women indicated that they resented their partners' behaviors, only Thelma described protesting it. More often, interviewees described their silent acquiescence to their partner's actions or justified the behavior. Keisha explained her partner's monitoring of her whereabouts: "He just doesn't want anything to happen to me; which I understand, you know." Sandra attributed her partner's behavior to masculinity norms: "... that's a type of man thing there. I mean they just want to like know that they are leaders. So I try to respect that." La Tonya, a 32-year old firefighter described another strategy for dealing with her partner whom she described as a "control freak [who] was always trying to count my money or trying to regulate what I needed to do with it." She recounted: "I just pacified him and listened to all that stuff. In the end, I guess I do what I need to do."

Other women noted that their partners controlled relationships in subtle ways such as determining when couples would: (1) get together for social or sexual activities ($n = 2$); (2) get engaged or married ($n = 2$); (3) cohabit ($n = 1$); or (4) have children ($n = 1$). Chantal, a 23-year old graduate student who was unemployed and not attending school when she met her partner recalled that the "the ball was always in his court" in terms of deciding when they would see each other. Women often invoked language that omitted their agency in relationship decisions. For example, Denise, a 22-year laundry cashier, opined in response to a question about a time in her relationship where one partner wanted to do something that the other did not: "... There's something he won't change his mind about. Like he's insisting upon marrying me."

II. Women sustain relationships. Consistent with traditional relationship scripts that dictate that women bear primary responsibility for maintaining relationships, eight women described their willingness to tolerate a variety of their partners' undesirable or discomfoting behaviors for the sake of the relationships. Women described their willingness to: (1) tolerate emotionally distant partners ($n = 3$); (2) endure workaholic partners ($n = 3$); (3) endure emotional or verbal abuse ($n = 4$); (4) ignore or deny that their partners had other sexual partners ($n = 3$); (5) privilege their partner's needs to have sex above their own ($n = 2$); and (6) deescalate conflict through

self-silencing or acceding to their partners' demands ($n = 7$). Chantal, involved in a casual sexual relationship with a man whom she described as "someone I could see myself bringing home to Mom and Dad," reflected on her compromises to sustain her relationship:

[In the past] if a guy that I was interested in or whatever, we were dating, and all of a sudden I don't see him for like oh, like more than once a week maybe? He was cut. If he'd say, "Well, I can only see you at 10 o'clock at night. Oh, you're cut. [But with my current partner] I'm like okay well, if I want a serious relationship and he is a professional and I would like to be with a professional. You know, I'm like okay, well there are certain things that I'm going to have to actually be a little more lenient about. ... I've compromised a lot over what I used to tolerate.

La Tonya described having made many excuses about her partner's actions (e.g., his being married, his attempts to control her money, his verbal abuse) in order to maintain the relationship. She recalled, "... Even though Lance is completely crazy, I accepted him. So no matter what he did I found a way to deal with it and put it into perspective." To sustain her relationship, Melanie noted, "I get verbally abused, emotionally abused. I put up with a whole lot of emotional damage just to keep this relationship going." Similarly, Sandra said that she was willing to endure her partner's frequent eruptions of anger for the sake of the child they shared and also out of a sense of "definitely ... [not wanting] to walk away from it all."

III. Infidelity is normative. Eight interviewees said that they suspected that their partners had other sexual partners during the course of their relationships. In contradiction of traditional relationship scripts that prescribe that women be sexually monogamous, nine respondents also reported extra conjugal partners. With the exception of Susan, a 35-year-old mother of seven who reported trading sex for money or drugs, women with other partners tended to describe them as strictly casual. As Melissa (a 36-year-old HIV positive woman on disability) noted of her other partners, "It was just a sex thing. It wasn't no serious thing. It was just sex." Melissa, the fiancée of another man, also knew that her primary partner "has a lady friend that he stay with."

And although LaTonya said that it was her policy to “really stay away from married men” she knew that both her primary partner and casual sex partner were married.

As for partners suspected of or known to have been sexually unfaithful, interviewees responded in ways consistent with the *infidelity is normative* script. Namely, none described having ended a relationship with a cheating partner. Rather, women who suspected or knew that their partners had other sexual partners responded in one of two ways: they continued the relationship with the understanding that the partner would not cheat again ($n = 2$); or they accepted their partner’s infidelity with certain provisos ($n = 5$). Thelma, who suspected that her partner of eight years was having unprotected sex with women, and possibly men, said she was willing to tolerate his cheating “as long as he just don’t flaunt it in my face [and] ...don’t give me no sexual diseases or anything.” Similarly, Melanie (in a seven year relationship that she described as a “living hell”) suspected that her partner was having unprotected sex with other women, but said that she was willing to endure his extra conjugal relationships because her partner was “the type of man who comes home every night.”

Others, such as Susan and Melissa, expressed different limits about what they would accept from an unfaithful partner. Although Susan acknowledged that she would be a little hurt if she learned that her partner was cheating, she said that she was most concerned that her primary partner did not have sex with another person in her bed. Melissa noted that she accepted that her partner was sexually active with his live-in partner, but drew the limit at having unprotected sex with him because she feared re-infection. Although she admitted that she did not always use condoms with her partner, she stated that she insisted on condoms as punishment when she “kinda feel that he done been with that other lady.” In a twist on the overt acceptance of cheating theme, all of the women who indicated conditional approval for a partner’s sexual infidelity adhered to the notion that they could not be hurt by what they did not know. Thelma, for instance, said that she would need proof that her partner was cheating in order to be able to convince him to use condoms. LaTonya opted not to ask questions about

cheating because she did not “want to force [her partner] to lie.” Thus, although these women on the one hand accepted their partners’ infidelity, they also, on the other, engaged in denial strategies to protect them, presumably, from the emotional pain associated with the cheating or to maintain the relationships.

Six interviewees did not experience or suspect a partner’s infidelity and four of these stated that they would not tolerate a partner’s extra conjugal relationships. It is noteworthy that all of the women in this group also described their relationships as being with emotionally invested partners. Karen, a 37-year old professional housekeeper, said that she had lodged a preemptive strike against her partner cheating by forewarning him that she would leave him if she caught him cheating or getting high. She declared, “So he knows that I’m coming serious with that and he don’t plan to cheat on me.” Karen, who was HIV positive and in recovery, attributed her unwillingness to tolerate cheating to her self-esteem. Namely, she noted that she valued her life, her sobriety, and her health too much to tolerate a partner who might be engaging in behavior that could reinfect her. Similarly, Sonya, a 28-year old schoolteacher, surmised that her resilience and value for herself would allow her to leave a partner who cheated: “I know that I’m a strong person and I love myself so I know that if anything came up that would compromise the relationship as far as breaking up, I don’t mind being alone because I’ve been alone.”

Sexual Scripts

1. Men control sexual activity. Consistent with traditional sexual scripts that ascribe primary control for a variety of sexual acts to men, most interviewees ($n = 9$) noted that their partners were more likely to initiate or control sexual activities such as: (1) initiating sex ($n = 5$); (2) deciding sexual positions ($n = 7$); and (3) deciding sexual frequency ($n = 3$). Presumably because of the traditional proscriptions against women initiating sex, LaTonya and Thelma said that they often relied on a variety of subtle or nonverbal cues to demonstrate their interest in sex. Denise said that she muted her desires to have sex until her partner initiated sex. Thelma noted that her

partner made his objections about women initiating sex explicit: "[In the beginning of the relationship], I would try to initiate sex lots of times. I would want to and he'd give me a look as if to say, 'Don't go there.' And I kinda [learned that] women don't initiate sex." Male-solely-initiated sexual scripts were not unanimous however. Three women said that they initiated sex most of the time, while five others said that they and their partners shared behaviors such as decision-making about when and how often to have sex.

II. Women want to use condoms but men control condom use. Intricately linked to the *men control sexual activity* script is the *men control condom use* script. Twelve women said that they wanted to use condoms the first time they had sex with their partners. Of this group, seven said that their male partners had controlled condom use either by producing a condom ($n = 4$) or refusing the woman's request to use condoms ($n = 3$). Among those in the latter group were Karen, who said that her partner stated that condoms irritated his genitals; Thelma, whose partner refused because he did not like using condoms; and Stephanie, a 26-year old manicurist whose partner had recently been released from prison and had assured her that he "hadn't been doin' anything." By contrast, none of the women who said that their partners had initiated condom use reported protesting or refusing condom use. Rather, they accepted condom use, as Chantal noted of her partner as "just a thing he does." Likewise, Sandra remembered that before she and her partner had sex for the first time, he informed her, "You know I use protection." Scripts of men controlling condom use were not unanimous however. Three women said that they had initiated condom use and two noted that decisions to use condoms were mutual.

Melanie's initial experience with condom use with her partner bolsters the notion that women may sometimes have more leverage in terms of persuading a partner who is reluctant to use condoms at the beginning of the relationship. Although he now refused to use condoms, she recalled that when her partner protested using condoms the first time that they had sex, she persuaded him to use condoms by informing him that condoms were mandatory if he wanted

to have sex with her. The *men control condom use script* may also extend to women's readiness to purchase or otherwise make condoms available. Only two women, Chantal and Melanie, stated that they had provided condoms the first time they had sex with their partners. As for current condom use, only Denise said that she and her partner shared responsibility for procuring condoms. Others ($n = 4$) suggested that male partners were responsible for making condoms available.

Relationship and Sexual Scripts in Context

To examine the association between sociocultural and contextual factors and relationship and sexual scripts, we systematically compared each interviewee's demographic data, relationship context, and any other contextual information (e.g., substance use history) that we could discern from their narratives (see Table 2). We also conducted negative case analyses to evaluate the contexts of the lives of women who did not articulate specific scripts. First, we examined the relationship between women's incomes relative to their partners' and the types and number of scripts generated. Four women had lower incomes than their partners; six had higher incomes; and four had relatively equal incomes. We found no differences with regard to the types of scripts that the women described. That is, regardless of their relative income status, women were represented across all of the script categories. Women's relative income status, however, did appear to be associated with the number of scripts they generated. For example, women who made lower, higher and equal incomes relative to their partners generated an average of 4.5, 2.8, and 1.5 scripts respectively. Negative case analyses revealed some within-group variance however. For example, Sandra, who made more money than her partner and had a college degree, described four of the five scripts.

Next, we examined the influence of relationship type (i.e., stable, casual) and the degree of intimacy in the relationship (e.g., emotionally invested, conflict-ridden) on the types of scripts that interviewees' articulated. We found that of the eight women who reported stable, emotionally invested relationships only one had generated the *infidelity is normative* script.

There was, however, no clear pattern with regard to the stability of one's relationship and other relationship and sexual scripts.

Because the majority of the sample articulated the *men control relationships script*, we conducted a negative case analysis of the four who did not generate that script to examine what we could learn from their relationship or life contexts. Among those in this group were Faye and Stephanie, who were in stable relationships and who were employed full-time. Faye, a 28-year old postal supervisor, attributed her egalitarian ideals to her middle-class upbringing. She noted that her parents had owned their own business and that it had fostered a sense of independence characterized by her not liking "... to depend on anybody and especially a man." For Stephanie, her status as primary breadwinner may have explained why she did not articulate the *men control relationships script*. Moreover, she noted that she was not at all shy about telling her partner "whatever I want to say; I say whatever's on my mind." Alternatively, Melissa said that her partner's relationship with the woman with whom he cohabited limited the amount of control he exerted over her: "He don't have too much to say in [our] relationship because of the situation that he in. So he ain't got too much to say cuz he really can't tell me where to go and who to go with." Susan said that she did not love her partner and explained that she was with him for shelter only. She appeared to relish her independence: "I'm my own woman. I come and go as I please and do what I want to. By me being a woman, I can make more money than he makes, doin' a job or not a job [i.e., doing sex work]."

Finally, we examined other contextual factors that may be relevant to the relationship and sexual scripts that women discussed. Among them were five women's discussions of the impact of cultural scenarios on their perceptions of relationships, such as messages from parents and society encouraging women to marry men who were financially secure; and to remain with partners through good and bad times. For example, despite noting that she was not "really ready to settle down," Susan articulated the impact of cultural scenarios about marriage: "... but I'm 35 and see, a woman of my age should be settled down, married and stuff like that."

Keisha traced her notions about relationships to her mother: "... that's how I was raised. My mother said once you find your soul mate or the person you think is going to be your life partner... [you're] together until they say, 'until death do us part.'."

Condom Use

Condom use frequency, wanting to use condoms, and concerns about HIV. The study's questionnaire asked participants about their condom use frequency during the last six months and the last month, how much they wanted to use condoms with their partners, and their concerns about contracting HIV from their partners. Reported frequencies for condom use in the last six months and last month were identical: never ($n = 7$), sometimes ($n = 4$), always ($n = 3$). Five interviewees said that they definitely wanted to use condoms with their partners. Others responded: definitely not ($n = 3$), kind of not ($n = 4$), and kind of ($n = 2$). Women rated their concern about contracting HIV from their partners as: not at all ($n = 6$), a little ($n = 2$), neutral ($n = 1$), very ($n = 4$), and extremely ($n = 1$). There was little association between concerns about contracting HIV from a partner, desire to use condoms, and condom use. For example, although Stephanie noted that she was "extremely" concerned about contracting HIV from her formerly incarcerated partner, she was nonetheless one of three women who noted that she "definitely did not" want to use condoms and reported inconsistent condom use. Of the four women who said that they were "very" concerned about contracting HIV from their partners, only Melanie and Melissa said that they "definitely wanted" to use condoms. Melanie reported no condom use because of her partner's refusal to use condoms. Melissa reported inconsistent condom use based on her own volition. LaTonya and Thelma were ambivalent about wanting to use condoms and both reported never having used condoms with their partners.

Condom use and relationship type. To examine the association between condom use and relationship type, we compared the condom use frequency data from the questionnaire with interviewees' narratives about their relationship types. Relationship types included those that were: stable, emotionally intimate ($n = 8$); casual, primarily sexual ($n = 3$); and unstable,

conflict-ridden ($n = 3$). All of the women in unstable conflict-ridden relationships reported no condom use in the last six months or month. Melanie and Thelma explained that their partners refused to use condoms, and Susan said that she used condoms with her clients, but not with her primary partner. For women in stable and casual relationships however, our analyses found no clear pattern between condom use and relationship type. Women in stable, emotionally intimate relationships were represented across each of the condom use frequency categories: never ($n = 3$), sometimes ($n = 3$), and always ($n = 2$). Sonya and Keisha, two of the three women who were in stable relationships with no condom use in the last six months or month, cited issues of trust and communication as central to condom use. Sonya noted that although she and her partner had used condoms "all the time" in the beginning of their relationship, they discontinued condom use after they had both tested negative for HIV. She explained, "... I think we both trust each other not to bring anything [like a STI] home. ... We've talked about it and laughed about it. We're like, 'That's not going to happen.'" Keisha said that she and her partner had never used condoms because, "... [from] the first day we met, it wasn't about sex. We didn't talk about sex, we talked ... for like a month before we even had sex. We just talked, communicated, got to know each other." Karen, by contrast, recalled that her partner had refused to use condoms the first time they had sex because he said that condoms irritated his genitals. As for current condom use, she said that she had never asked her partner to use condoms since his initial refusal and that her partner believed that condoms prevented him from "actually feel[ing] me" during intercourse.

Issues of trust and sensation were also key to women in stable relationships who reported sometime condom use ($n = 3$). Sandra said that she and her partner trusted each other, preferred sex without condoms, and had ceased condom use after both tested negative for HIV. Stephanie said that she stopped using condoms with her partner after "I got to know him, and I got trust in him and everything." Faye, however, said that she used condoms when she was menstruating only. Finally, contraception was the primary reason that two women in stable

relationships reported consistent condom use. Trust also factored into Theresa's decision to use condoms, albeit in a manner different from Sandra and Stephanie. Theresa said that she also used condoms for STI prevention because, " ... even though he says he's the only that sleep with me ... he could be lying, you know. I'm not with him 24 hours a day so I don't what he's doing." As for women in casual relationships, LaTonya explained that she had never used condoms with her partner because, " ... I love intimacy but I swear I hate condoms." Melissa, who said that she used condoms "the majority of the time" stated that she was more likely to use condoms when she suspected that her partner had been sexually active with "anybody," and less likely to use them when "we get to playing around and I gettin' hot and I be wanting [sex] right then." Finally, Chantal attributed her consistent condom use to the fact that her partner always used condoms.

Condom use and the men control condom use script. As reported previously, we found that the majority of women ($n = 12$) said that they wanted to use condoms the first time they had sex with their partners. By contrast, our analyses of condom use frequency in the last six months and month demonstrated that women were less interested in using condoms with their partners currently than they had been at the start of their relationships. Only 5 women reported that they "definitely wanted" to use condoms with their partners presently. Women articulating the *men control condom use script* ($n = 7$) were represented across each condom use frequency category: never ($n = 3$), sometimes ($n = 3$), and always ($n = 1$). A clear pattern, however, emerged between those who wanted to use condoms and those who did not, and condom use frequency. All three of the women who generated the *men control condom use script* and reported no condom use in the last six months or month, stated that although they wanted to use condoms, their partners had refused to use condoms. By contrast, all of the women in the sometimes condom use category who generated this script stated that they did not want to use condoms. Finally, only Chantal, who stated that she "definitely wanted" to use condoms, and whose casual partner used condoms always, reported consistent condom use.

Discussion

This qualitative study explored the association between relationship and sexual scripts, sociocultural and relationship context, and condom use among a sample of 14 African American women. Three relationship scripts (i.e., *men control relationships*, *women sustain relationships*, *infidelity is normative*) and two sexual scripts (i.e., *men control sexual activity*; *women want to use condoms, but men control condom use*) emerged in our analyses. These scripts may indirectly or directly decrease women's condom use with partners, and in turn, increase their HIV risk. The *women want to use condoms but men control condom use* script may be most directly related to sexual risk because these scripts specifically influence condom use. Our findings demonstrated that when men initiated condom use at first sex, women readily accepted the use of condoms, often, as Chantal noted, as "just a thing he does." Men also controlled current condom use in terms of initiating or refusing condoms, regardless of whether women wanted to use condoms.

With its focus on cultural scenarios and interpersonal directives about how women and men should behave in sexual relationships, relationship and sexual scripts provide a contextually grounded approach to women's condom use behaviors. Our findings suggest that understanding the influence of relationship dynamics such as conflict, power, and communication on condom use is critical. Yet, empirical studies of these phenomena remain scant. With regard to relationship conflict and condom use, our study's findings that all of the women in unstable conflict-ridden relationships were concentrated in the group of women that never used condoms is consistent with findings of previous research demonstrating an association between relationship conflict and lower condom use among a sample of HIV positive women (Kline & VanLandingham, 1994). Communication and negotiation about condom use also play a central role in African American women's condom use (Wingood, Hunter-Gamble, & DiClemente, 1993). Though most of the focus group participants in the Wingood et al. study expressed comfort with communicating about safer sex, few of them

reported being able to negotiate condom use with their partners. Among the women in stable, emotionally intimate relationships in our study, communication between partners about condom use was associated with decisions to use condoms at the start of the relationship, or in Keisha's case, to not use condoms. Communication was also related to ceasing condom use when partners determined that they had achieved a level of trust in the relationship, and in the case of Sonya and Sandra, after both members of the couple had tested negative for HIV. These findings suggest that more research is needed to understand how women in stable, emotionally intimate relationships communicate about and negotiate safety with their partners.

Our study's findings that men control condom use not only at the start of the relationship, but present condom use echo Amaro's (1995) posit that condom use is a distinctly different behavior for women than it is for men. That is, whereas wearing the condom is the focus for men, for women condom use involves more complicated behaviors such as persuasion, opting not to have sex with a partner who refuses to use a condom, or as was the case with several of the women in our study, engaging in unprotected sex despite concerns about HIV risk or wanting to use condoms. Consistent with a relationship power perspective on women's HIV risk, more research is needed to understand how factors such as emotional and financial dependence diminish African American women's relationship power with regard to condom use (Amaro, 1995; Amaro & Raj, 2000; Bowleg, Tschann, Lucas, & Burkholder, 2003).

Finally, our study highlights an important reality about condom use that is virtually invisible in much of the theoretical and research literature on women and HIV prevention: women's non-condom use is not always a function of their relationship context. Some women simply do not want to use condoms. Perceptions that condoms diminish sexual pleasure and disrupt intimacy were two of the most commonly cited reasons for non-condom use in our study. The fact that the majority of women in our study did not want to use condoms with their partners, suggests that theory and research on women's condom use must consider how individual as well as interpersonal factors influence women's condom use.

Psychosocial theories of risk abound in the psychological literature on women and HIV/AIDS. Absent from many of these theories, however, are “contextual social factors relating to gender that shape the reality of risk and potential for risk reduction among women” (Amaro, 1995, p. 440). Sociocultural context may explain the seeming paradox between the financial independence of most interviewees (most had incomes equal or greater than their partners) and their espousal of the *men control relationships* script. Binion (1990) attributes African American women’s “psychological androgyny” to historical realities of slavery and institutionalized discrimination that necessitated that African American women work outside the home to support themselves and their families, while simultaneously maintaining traditional gender beliefs “in order to sustain meaningful relationships within their domestic network; especially with men” (p. 550). Thus, our findings of the *men control relationships* script may reflect prevailing gendered cultural scenarios for African American women that dictate that women must be traditionally feminine in their intimate heterosexual relationships (i.e., allow men to control relationships), and also be nontraditional in terms of their workforce participation. An alternative explanation is that women, recognizing the mundane racism that their male partners experience, “allow” men to control some aspects of relationships as a way to compensate for the fact that their partners fall short of hegemonic masculinity ideals such as economic and professional prowess.

Consistent with other calls to bring sociocultural context and social inequality to the forefront of theories of HIV risk (see Amaro, Raj, & Reed, 2001; Zierler & Krieger, 1997), our study demonstrates that African American women’s condom use and HIV risk cannot be isolated from the sociocultural contexts in which they live. Women like Thelma and Melanie, presumably because of their financial and emotional dependence on their partners, perceived that they had no other alternatives than to endure the prospect that their risky partners might infect them. Their decisions to stay in risky relationships presumably because the alternatives are less desirable may be relevant to unequal African American sex ratios. Namely, it is possible that some African

American women tolerate their partners' undesirable, and in these cases, risky behaviors because they perceive that their chances of finding other partners are slim (Mays & Cochran, 1988; Sobo, 1995). Several of the low-income women in the study also had at least one child, a fact that increased their financial dependence, and in the case of Melanie, her willingness to sacrifice everything, including her health, for the sake of her child. Although only Stephanie reported having a partner who had recently been incarcerated, this experience too is an important factor that frames the context of intimate relationships for African American women (Comfort, Grinstead, Faigeles, & Zack, 2000). As such, our findings echo Reid's (2000) admonition that HIV/AIDS research on women of color not focus solely on intimate relationships and love to explore HIV risk among women of color, but also examine the influence of factors such as poverty and racial discrimination.

In comparison to psychologists in other countries, many U.S. psychologists have been reluctant to embrace qualitative methods on the fallacious grounds that these methods are unscientific, not rigorous, or more subjective than quantitative methods (Marecek et al., 1997). Yet, our findings demonstrate that qualitative methods are invaluable for exploring the depth, complexity, and contradictions of women's intimate relationships and condom use. Nonetheless, our study has several limitations. One is that our study design did not provide interviewees with the opportunity to review our interpretations about their relationship and sexual scripts. Doing so would have allowed participants to dissent or challenge our interpretations (Fine, Weis, Weseen, & Wong, 2000) as well as inform us whether our interpretations of their experiences had emic resonance (Landrine, Klonoff, & Brown-Collins, 1992).

Another limitation is that the study focused on the influence of relationship and sexual scripts on condom use. Most respondents, however, did not want to use condoms currently and so our findings must be interpreted with caution. This finding also suggests the importance of first assessing interest in condom use rather than presuming that participants want to use condoms and cannot. Moreover, our assessment of condom use included forced-choice responses (i.e.,

never, sometimes, always) that precluded understanding of the context of condom use. It is likely that an item focused on a variety of HIV risk domains such as types of sexual behaviors, partners, and actual condom use frequency within a recent time frame may have provided a more valid and comprehensive assessment of condom use and HIV risk. Another limitation of our study is that since our analyses of relationship and sexual scripts were primarily exploratory, our analyses focused on data that emerged from the narratives rather than on responses to structured interview questions. Our analyses focused on women who discussed, either explicitly or implicitly, experiences and perspectives relevant to the focus of our analyses. The absence of interview questions designed to elicit responses specific to relationship and sexual scripts is a limitation of our study.

Our study also has implications for HIV/AIDS interventions targeted to African American women. The *women want to use condoms, but men control condom use* script echoes a chord sounded in much of the feminist theory and research on women and HIV prevention: women do not control condom use; men do. Thus, it is critically important that HIV interventions target men who have sex with women to educate and encourage the correct and consistent use of condoms to prevent the transmission of HIV and other sexually transmitted infections. Our findings about contextual factors relevant to women's lives such as their incomes, relationship types, and substance use and mental health histories also imply that comprehensive interventions that address a variety of aspects of African American women's lives (e.g., employment, relationships, education, etc.) may prove more effective than those that focus solely on HIV, particularly when other life realities supersede concerns about HIV (Brown, Jemmott, Mitchell, & Walton, 1998; Wyatt, 1994). Ideally, such interventions would provide a forum for all women who are at increased risk to learn self-affirming strategies from women such as Sonya and Karen who said that they loved themselves too much to endure relationships that would jeopardize their health.

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