Exploring The Relationship Between Intimate Partner Violence And Hiv Risk Propensity In African American Women

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EXPLORING THE RELATIONSHIP BETWEEN
INTIMATE PARTNER VIOLENCE AND HIV RISK PROPENSITY
IN AFRICAN AMERICAN WOMEN

by

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A dissertation submitted in partial fulfillment of the requirements
for the degree of Doctor of Philosophy in Public Affairs
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Major Professor: Eileen Abel
ABSTRACT

This study explored the relationship between Intimate Partner Violence and HIV Risk-Propensity in African-American women. Current literature on HIV reveals that one of the groups most seriously impacted by the continued scourge of HIV is African-American heterosexual women.

An anonymous questionnaire was completed by a community based sample of 200 African American women with a varied history of intimate partner violence to (1) explore whether a relationship exists between Intimate Partner Violence and sexual coercion in African-American women (2) determine whether a relationship exists between sexual coercion and HIV Risk in African-American women (3) determine if the frequency of intimate partner violence impacts the HIV-risk of African-American Women (4) determine if the ability of African-American women to negotiate condom use is affected by being in a violent relationship, and (5) determine if there is a relationship between Intimate Partner Violence and increased HIV-risk propensity among African-American women.

Various statistical techniques, including structural equation modeling (SEM), bivariate correlation analyses and ANOVA were used to examine the data. A strong positive
correlation was found to exist between sexual coercion and Intimate Partner Violence. Specifically, the frequency of physical abuse, and feeling frightened by what a partner says or does were found to be highly correlated with sexual coercion. Moderate levels of correlation were also found between sexual coercion and frequency of being emotionally abused. Statistically significant regression weights indicate that when Intimate Partner Violence increases, sexual coercion also increases.

Moderate and high correlations were also found between sexual coercion and ability to negotiate condom use. Statistically significant standardized regression weights indicate that as sexual coercion increases HIV Risk also increases. Moderate correlations also exist between being in a violent relationship and being able to negotiate condom use. Standardized regression weights reveal that as IPV increases HIV Risk also increases.

The frequency of Intimate Partner Violence was also shown to impact the levels of sexual coercion, likelihood of having a partner with a STD, and the likelihood of have a partner who uses intravenous drugs. In the effort to fortify prevention strategies, and reduce the rates of HIV infection in African-American women, additional factors that impact disease
transmission were discussed and suggestions for future research were made.
This dissertation is dedicated to my siblings Sherill “Sister Dawn” Lewis, Sharon Josephs-Green, Aleen Josephs-Clarke, Wayne Josephs, Alicia “Lisa” Josephs, and Ricardo “Ricky” Josephs, and most of all to my mother Pearl I. Josephs. Though we suffered a tremendous loss on 4-13-1991, we continue to persevere. This is a testament to Mummy whose strength ensured that we did not drown in our sorrows. I also dedicate this dissertation to my father Clifford E. Josephs, who departed this earth much too soon. You inspired us all to be ambitious and never to settle for mediocrity. Finally, I hope that the completion of this project will be an inspiration to the next generation: Andre Josephs-Clarke, Clifford Clarke, Brandon “Badu” Clarke, Danya Clarke, Raquel Green, Dillion Farquharson, Jason Josephs, Matthew Josephs, LeeAnna Josephs and all Josephs’ yet to arrive.
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>CCC</td>
<td>Citizen’s Commission for Children (Orange County, Florida)</td>
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<td>Centers for disease control and prevention</td>
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<td>HSI</td>
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<td>IDU</td>
<td>Intravenous Drug User</td>
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<td>IPV</td>
<td>Intimate Partner Violence</td>
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<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>NCF</td>
<td>Neighborhood Centers for Families</td>
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CHAPTER ONE: INTRODUCTION

Since the onslaught of the HIV/AIDS epidemic, African Americans have been disproportionately affected (Kaiser Family Foundation, 2003; Anderson, 1990; Brown, Mitchell, & Williams, 1992; Thomas & Quinn, 1994). Over time, the disparity has worsened (Ibid). Even though African Americans account for only 13% of the U.S. population, they represent more than 50% of all new estimated HIV infections in the United States (Centers for Disease Control, 2004a). African-Americans comprise the largest group of AIDS diagnoses, and represent the largest group living with AIDS, (CDC, 2004a; Glynn, 2005).

African-American teenagers are also disproportionately impacted by HIV/AIDS. Although they make up only 15% of the teenagers in the United States, African-American teenagers represent an astounding 65% of the new AIDS cases reported in 2002 (CDC, HIV Surveillance in Adolescents; 2003). While the incidence of HIV in the United States has leveled off over the past decade, diagnoses of AIDS in the African-American population increased by 7% between 1999 and 2003 (CDC, 2004). During this same time period AIDS diagnoses in the general
population decreased by 3% among White Americans (CDC, 2004).

![Proportion of AIDS cases of adults and adolescents by race/ethnicity and year of diagnosis](image)

Figure 1: Proportion of AIDS cases of adults and adolescents by race/ethnicity and year of diagnosis

Source: Centers for Disease Control “HIV/AIDS Surveillance by Race/Ethnicity Slide Series through 2003”

**Significance of the Problem**

The CDC reports that almost between 850,000 and 950,000 people in the United States are currently infected with HIV; an additional forty thousand infections occur each year. While incidence of HIV infection in the United States has leveled off over the past decade there are increasing numbers of people who...
are living with HIV and the face of AIDS in the United States has changed significantly (CDC, 2002).

In the 1980’s HIV/AIDS, was a little known disease, and was largely confined to populations of Homosexual Caucasian Males (Aragon, 2001). However, HIV is increasingly being transmitted through heterosexual contact and AIDS is now the most catastrophic disease ever (UNAIDS, 2002).

![Figure 2: Percentage of new HIV infections by Race/Ethnicity](image)

When viewed by race, 54% of new HIV infections occur in African-Americans, 26% in Whites, 19% in Hispanics and 1% in other groups (CDC, 2001). Of the new HIV infections in women each year 67% occur in African-American women (CDC, 2003).
The HIV/AIDS Surveillance Report released by the CDC in November 2004 revealed that African-American women had an AIDS case rate of 48.2 per 100,000 population. This rate is 23 times greater than the rate of white women (2.1 per 100,000). These astounding statistics make HIV infection, among the four leading causes of death for African American women between 25-54 years of age, and the leading cause of death for African American women aged 25-34 years (Anderson & Smith, 2005).

**Top 10 Regions with AIDS**

Over 50% of African-Americans with AIDS reside in the Southern United States (Kaiser Foundation, 2004). The top 10 regions, from highest to lowest, for African-Americans living with AIDS in the United States are:

1. New York
2. Florida
3. California
4. Texas
5. Maryland
6. Georgia
7. New Jersey
8. Pennsylvania
9. Illinois, and
10. The District of Columbia (CDC, 2004).

**What is HIV?**

According to the National Institutes of Allergy and Infectious diseases (NIAID) (2001), Human Immunodeficiency Virus (HIV) was first identified in 1983. However, studies conducted with samples of previously stored blood revealed that HIV entered the United States population in the late 1970’s. HIV disease is characterized by a continuing deterioration of immune function. The immune system weakens when CD4+T cells, commonly referred to as “T-helper cells” are damaged or destroyed by HIV. T-helper cells are vital to proper immune response because they notify other cells in the immune system when to perform their special roles (Ibid).

While a healthy person, uninfected with HIV, typically has 800 to 1200 T-helper cells per cubic millimeter of blood, the number is reduced significantly when infected with HIV (Centers for Disease Control; UNAIDS; NIAID, 2001). When an individual’s CD4+ T cell count drops below 200 cells per cubic millimeter of blood, a diagnosis of Acquired Immune Deficiency Syndrome (AIDS) is conferred. At this stage infected individuals become more
susceptible to the opportunistic infections and cancers that typify AIDS—the final stage of HIV disease (NIAID, 2001).

People living with AIDS often experience infections of the brain, eyes, lungs and intestinal tract. They may also experience incapacitating weight loss, neurological conditions, diarrhea, and cancers such as Kaposi’s sarcoma. Many scientists state that HIV causes AIDS by causing the death or debilitation of CD4+T cells, and by acting as a catalyst in the weakening of immune functions within the body (NIAID, 2001).

**Transmission of HIV**

According to the Centers for Disease Control (2001) there are several different modes for transmitting HIV. The most common mode of infection in adults is through sexual intercourse with an infected partner. HIV enters the body through the mucus membranes of the vagina, vulva, penis, or rectum after intercourse. In extremely rare instances HIV has been transmitted via the mouth or gastrointestinal tract after oral sex (Centers for Disease Control, 2000). The probability of transmission is increased by certain factors including the damage of mucus membranes by other sexually transmitted diseases which often cause inflammation or ulcers (NIAID, 2001).
HIV can also be transmitted through contact with infected blood. This most commonly occurs when intravenous drug users share contaminated needles or syringes that contain minute quantities of HIV-infected blood. While there was once a great risk of transmission through blood transfusions, the likelihood has been greatly diminished in the United States since all blood products are screened regularly screened for the virus (NIAID, 2001).

Vertical transmission is the primary cause of HIV infection in children (NIAID, 2001). Vertical transmission occurs when the virus is passed from mother to child during pregnancy or childbirth. After childbirth, infection may occur as a result of breastfeeding. Vertical transmission has been reduced significantly in the United States by treating pregnant, HIV-infected women with a regimen of antiretroviral drugs. However, vertical transmission is still very common in many of the poorer nations across the globe, where antiretroviral drugs are not commonly available, and where mothers may have to choose between starving their children and feeding them with infected breast milk.

HIV can NOT be transmitted through casual contact with others such as shaking hands, hugging or sharing a swimming pool.
HIV/AIDS Pandemic

Over 40 million people are living with HIV/AIDS across the globe, and the epidemic has claimed over 20 million lives (Kaiser Foundation, 2002). The regions most affected by HIV/AIDS are Sub-Saharan Africa, Latin America and the Caribbean, Eastern Europe and Central Asia, and Asia and The Pacific. AIDS is now the leading cause of death in Africa and the fourth leading cause of death in the world (World Health Organization, 2001).

While Sub-Saharan Africa makes up 11% of the global population, it has 71% of the people living with HIV (UNAIDS, 2001; Population Reference Bureau, 2001). Up to 33% of some African nations is HIV infected (UNAIDS, 2001; UNAIDS, 2002). Furthermore, South Africa has the largest number of people living with HIV/AIDS in the world (UNAIDS, 2002).

At the end of 2001, approximately 1.9 million people in Latin American and the Caribbean were HIV infected (UNAIDS, 2001; UNAIDS, 2002). Of that number, 200,000 were infected in the year 2001 (UNAIDS, 2002). Throughout Latin America and the Caribbean, there are a dozen countries with an estimated HIV prevalence rate of 1% or more. Haiti (6%) and the Bahamas
have some of the highest HIV prevalence rates in the region (Ibid.).

The region with the fastest growing HIV incidence is Eastern Europe and Central Asia (UNAIDS, 2002). This is primarily due to injection drug use (Ibid.). There is also increasing concern over the HIV prevalence rates in Asia and the Pacific (UNAIDS, 2002). At the end of 2001, close to 4 million people in India were living with HIV/AIDS (UNAIDS, 2002).

Across the globe, over 5 million new HIV infections occurred in 2001 (UNAIDS, 2002). The majority of HIV-infected individuals worldwide do not know that they are infected (UNAIDS, 2001). HIV/AIDS continues to devastate the structure of many nations, and is significantly affecting population sizes and age distributions (Kaiser Family Foundation, 2002; US Census Bureau, UNAIDS, 2002). The World Bank (2000) has declared HIV/AIDS a development crisis. Evidence lies in the fact that as much as 2.6% of gross domestic product is reduced each year, in countries with prevalence rates of 20% or more (UNAIDS, 2002). Of additional concern is the fact that over 25% of the work force in some sub-Saharan countries may be lost to AIDS by 2020 (Committee of World Food Security, United Nations, 2001). UNAIDS (2002) estimated that between seven and ten million dollars is needed each year to launch an effective response to the global
HIV/AIDS epidemic. Overall, the United States has had the greatest success in fighting HIV. However, there is still much to accomplish.

**Rationale for the Study**

While some factors influencing the spread of HIV/AIDS have been well researched, other areas need to be more closely examined. Some studies have discussed the concerns about the nature of the relationship between Intimate Partner Violence, specifically coercive sex, and the risk for contracting HIV. Wingwood and DiClemente (1997) revealed that African-American women who were involved in physically abusive relationships, were less likely to use condoms and more likely to be victimized by their intimate partners as a result of requesting condom use.

Simoni and Cooperman (2000) who conducted face to face interviews with women living with AIDS in New York City, determined that 59% of their sample of 373 women, had been sexually abused and 69% had been physically abused.

Similarly, other research asserts that women who have no voice or power in their intimate relationships are at risk for numerous forms of abuse including being forced into certain sexual activities. (Kalichman et. al, 1998). This in itself
may place these women at greater risk for HIV infection. In addition, over the past few years, professional medical organizations including the World Health Organization, the American Medical Association and the International Federation of Obstetricians and Gynecologists have reported on the tremendous public health impact of violence against women (WHO, 1998).

Violence against women has been shown to be a risk factor for numerous unfavorable health outcomes (Sorenson & Saftlas, 1994) including the transmission of HIV (Campbell & Soeken, 1999). However, the concern seems largely directed to countries where women’s rights are extremely limited. For example the Human Rights Watch (2003) reported that the mores guiding sexual and reproductive duties of women in many countries tend to victimize them by stripping them of the right to make choices regarding their bodies. As such, many women remain in abusive relationships and at risk for HIV. In the United States however, further exploration is necessary to determine the relationship between Intimate Partner Violence and HIV (Stevens & Richards, 1998).

While there have been pilot programs such as one conducted by Gielen (2001) at Johns Hopkins University, and initiatives in New York State to coordinate the provision of services to HIV-infected individuals as well as victims of domestic violence,
service there are still many questions left unanswered (New York State Office for the Prevention of Domestic Violence, 2001). Research such as this one will add to the body of knowledge that exists specifically about IPV and HIV-risk propensity of African American women in the United States.

**Purpose of the Study**

The purpose of this study was to explore the relationship between Intimate Partner Violence and HIV Risk Propensity. Participants in this research were adult African American females with varied history of intimate partner violence. Each woman’s relationship status (experiencing IPV not experiencing IPV) was determined with the Woman Abuse Screening Tool. In addition to the Woman Abuse Screening Tool, the participants also completed a revised version of the HIV-Risk Screening Instrument, a few questions from the Sexual Experiences Survey (SES) and two questions from Kalichman (1998) and a brief demographic questionnaire. These surveys were self-administered.
**Survey Respondents**

The units of observation for this study were adult African American females recruited from local neighborhood centers for families. Each participant was asked to complete a survey comprised of the Woman Abuse Screening Tool, the HIV Risk Screening Instrument-Revised and a demographic questionnaire.

**Definition of terms**

**Acquired Immune Deficiency Syndrome (AIDS)** - The final stage of HIV disease. A diagnosis of AIDS is conferred when an individual’s CD4+ T cell count drops below 200 cells per cubic millimeter of blood. At this stage infected individuals become more susceptible to opportunistic infections and cancers (National Institute of Allergy and Infectious Diseases (NIAID), 2001).


**Emotional Abuse** - The recurring use of harmful and controlling behaviors by an intimate partner, for the purpose of controlling a woman. Emotional abuse typically causes a woman to live her life in fear, and often leads her to change her behaviors, as
well as deny her thoughts, needs and feelings in an attempt to avoid further abuse (Rennison, C.M. & Welchans, S. (2000).

**Human Immunodeficiency Virus (HIV)** - The virus that causes AIDS. HIV may be transmitted from one person to the next when infected blood, semen, or vaginal secretions come in contact with an uninfected person’s broken skin or mucous membranes. Mucus membranes include the mouth, the opening of the penis, eyes, nose, vagina, and rectum. HIV can also be transmitted from infected pregnant women to their babies during delivery or pregnancy, as well as through breast feeding. This is called vertical transmission. People with HIV have what is called HIV infection. Some of these people will develop AIDS as a result of their HIV infection (National Center for HIV, STD, and TB Prevention, 2003).

**HIV Risk Propensity** - The likelihood of becoming infected with HIV. This is demonstrated by the presence of a variety of risk factors.

**Intimate Partner Violence (IPV)** - Any act that is used to control, terrorize, or dominate another, within the context of an intimate relationship. Such acts include stalking, rape,
Physical Abuse - Includes pushing, punching, hitting, slapping, withholding vital medicine, or refusing to help someone with a medical need (Koss, Goodman, Browne, Fitzgerald, Keita & Russo, 1994).

Sexual Coercion - Sexual coercion exists on a continuum and ranges from nonphysical forms of pressure that induce women to engage in sexual acts unwillingly to rape. Sexually coerced women may yield to the demands of the coercer because they may fear the consequences (Campbell & Soeken, 1999).
CHAPTER TWO: LITERATURE REVIEW

While race or ethnicity are not risk factors for the transmission of HIV, certain factors which are overly present in minority communities place African-Americans at higher risk (Centers for Disease Control, 2000). Minority women living in poverty are among the groups of people at greatest risk for HIV infection (Kalichman, Williams, Cherry, Belcher, and Wachimson; 1998). As such, the concentration of HIV/AIDS cases is higher in low-income communities, in which African-Americans are often disproportionately represented (Centers for Disease Control, 2000).

African-American women are the fastest growing group of HIV infected individuals (Centers for Disease Control, 2000). They are more likely to be infected through heterosexual intercourse than any other method (Centers for Disease Control, 2001).
Figure 3: HIV Transmission categories of African American women diagnosed in 2003

It has been speculated that there is an association between intimate partner violence and the transmission of HIV (Campbell & Soeken, 1999). However, the degree and nature of the intimate partner violence and link to HIV has not been sufficiently or systematically explored (Stevens & Richards, 1998). Further studies are needed to help inform and improve methods of assessment, treatment, and referral protocols of both HIV and intimate partner violence.
HIV/AIDS and African-American Women

Initially, HIV prevention efforts were directed towards the homosexual population (Centers for Disease Control, 2001). As the spread of the disease shifted to more diverse populations, the National AIDS Commission (1992) recommended that federal health educators become aware of the cultural differences of minority populations, in order to be more effective in targeting prevention messages. As it currently stands, the HIV epidemic is increasingly affecting women (CDC, 2004).

African-American women bear the brunt of HIV’s assault on the United States. While African-American women make up 13% of the female population of the United States, they make up 67% of the newly reported AIDS cases (Centers for Disease Control, 2004). With an AIDS case rate of 48.2 per 100,000 population, African-American women are 23 times more likely to be infected with HIV than Caucasian women (CDC, 2005). In addition, the HIV/AIDS mortality rates are highest among African-American women than any other group (National Center for Health Statistics, 2004) and HIV/AIDS is the leading cause of death in African-Americans women between the ages of 25 and 34 (CDC, 2004). Many women currently living with HIV are poverty-
stricken and struggle with complex economic issues as a result of drug addiction, immigration status, mental health disorders, and violent relationships (Aranda-Naranjo, 2000).

**Why the disparity in infection exists**

The HIV Strategic Prevention Plan through 2005 which was developed by the Centers for Disease Control, states that HIV stalks “people who are marginalized because of race or ethnicity, sexual orientation, age or gender” (p.23). As such, HIV/AIDS prevention will not be successful if the special needs of the groups which are marginalized in American society are not addressed in a sensitive fashion by employees who are aware of cultural differences in these communities.

HIV/AIDS spread rapidly in African-American women as a result of the delayed response to these women in the early years. During the years immediately following the introduction of new treatment for HIV, women and racial minorities were less likely to receive such treatment than their Caucasian male counterparts (Strathdee, Palepu, & Cornelisse, 1998; Shapiro, Morton, McCaffrey, Senterfitt, Fleishman, Perlman, Athey, Keesey, Goldman, Berry & Bozzette, 1999).
According to Henderson (1997) the disproportionate impact of HIV on minorities is not unique. Instead it is a microcosm of systemic ills that affect underserved populations. In the United States, minorities and women are more likely to have pre-existing conditions, such as limited financial resources. Epidemiologists also indicate that the spread of HIV in African American women is connected to the demographic and socioeconomic conditions that plague many African American neighborhoods. These neighborhoods are more likely to have high incidences of poverty, drug use, unemployment, and individuals who cycle in and out of jail systems where HIV infection rates are as much as 10 times greater than that of the general population. In addition to lack of resources, gender and race/ethnicity strongly impacts access to healthcare and other services that affect the progression of disease.

Overall, HIV, like other health disparities that plague the African American population occurs as a result of several factors. Figure 4 highlights some of the areas that have consistently been shown in the literature to contribute to health disparities. For African Americans, all the factors contribute to the disproportionate HIV incidence and prevalence in the African American community. While distrust of the system, discrimination by providers, lack or regular source of
care, lack of insurance and the contributors to disparity listed in Figure 4 are often discussed as reasons for health disparities, Limited English Proficiency (LEP) is less often described as an issue for the African American/Black community. Individuals with Limited English Proficiency are those who have a limited ability to speak, read and/or write English. As such, they may have increased difficulty navigating the health system. However, LEP may be an issue for many black individuals, such as Haitians, Black Hispanics from various countries, and other non-English speaking individuals of the African Diaspora, who once they enter the United States, “become” African-Americans.

![Figure 4: Causes of Health Disparities](image)

Figure 4: Causes of Health Disparities
The role of history

The history of the subjugation and mistreatment of African black people living in the United States impacts prevention and treatment efforts. The idea of AIDS conspiracy is a recurring theme described both in scholarly and popular journal articles (Gamble, 2002). A considerable proportion of African Americans, who participated in a telephone survey that was conducted by Oregan State University and RAND Corporation, stated that they believe that U.S. government scientists created HIV to eliminate or control African-American populations (Bogart & Thorburn, 2005). Bogart and Thorburn (2005) found that African-American males who accepted the conspiracy theory had more negative attitudes towards condoms, and used condoms more inconsistently. Similarly, a 1990 survey which was conducted by the Southern Christian Leadership Conference revealed that 35% of over 1000 African American church members who responded to a survey believed that AIDS was a form of genocide (Thomas & Quinn, 1991).

Tuskegee’s Legacy

One study is frequently cited as the primary reason for the distrust that African Americans have of medical and public
health institutions: the Tuskegee Syphilis Study (Gamble, 2002). The Tuskegee study was conducted in Macon County, Alabama, from 1932 to 1972. In an attempt to learn more about syphilis, and to validate the need for treatment programs for African Americans, the United States Public Health Service withheld appropriate treatment from a group of poor black men who were infected with syphilis (Centers for Disease Control). This study has contributed to the eroding trust of African Americans towards Public Health officials, and has come to represent racism in health care, human subjects’ research violations, and the government’s exploitation of African Americans (Gamble, 2002).

Although the Tuskegee Syphilis Study is sometimes mentioned as the primary reason for African American’s distrust of government and medicine, these fears date to the antebellum period when slaves and freed black people were used in a variety of experiments (Savitt, 1982). However, the Tuskegee syphilis study has cast a dark shadow on present-day efforts to improve the health status of African Americans. It pinpoints the larger race relations issues that deeply impact the frames of reference of African Americans (Gamble, 2002).

In light of past injustices, African Americans’ continued distrust of the government and large organizations is not surprising. The legacy of legalized segregation and
discrimination against African Americans contributes to the health disparities in the United States (Institute of Medicine, 2003).

**Intimate Partner Violence**

Hutchins (1988) described the American family as one of the most violent institutions. Women are more likely to be assaulted by an intimate partner than by a stranger, and are five to eight times more likely than men to be victimized by an intimate partner (US Department of Justice, 1998). Furthermore, 76% of women who reported being raped and/or physically assaulted since the age of 18, were victimized by a current or prior intimate partner (Kellerman, 1992). According to former US Surgeon General Antonia Novello, “the home is actually a more dangerous place for the American woman than the city streets. Thirty-three percent of the women slain in the US, die at the hands of husbands, and boyfriends” (New York Times, 1991).

**Definition**

Intimate partner violence (IPV) is defined as any act that is used to control, terrorize, or dominate another, within
the context of an intimate relationship. Intimate Partner Violence includes:

1. Physical violence such as, kicks, punches, pushes and aggravated assaults with weapons
2. Sexual violence such sexual coercion using force, threats, and harassment, and
3. Psychological violence such as stalking, denial of access to financial resources, verbal abuse, imprisonment or humiliation (National Institute of Justice, and the Centers for Disease Control, 2000; Saltzman, Fanslow, McMahon & Shelley, 1999; ).

Such violence is not exclusive to heterosexual populations, and is often a repeated offense.

While men are sometimes victims of IPV, the literature reveals that women are more likely to be victimized, and thus have a greater likelihood of suffering from physical and psychological injuries from IPV (Brush 1990; Gelles 1997; Rand and Strom 1997; Rennison and Welchans 2000). The results of being victimized by IPV include physical injury, psychological trauma, and sometimes death (Gelles 1997; Kernic, Wolf and Holt 2000; Rennison and Welchans 2000; Sorenson and Saftlas 1994).
Costs of IPV

Intimate partner violence is a pervasive social problem in the United States (Tjaden & Thoennes, 2000). Approximately 1.5 million U.S. women are raped and/or physically assaulted each year, by an intimate partner (Tjaden & Thoennes, 2000; Bachman, 1994; Commonwealth Fund, 1993; US Department of Justice, 1983). Many of these women are victimized on more than one occasion; therefore the actual number of rapes and physical assaults committed by an intimate partner far exceeds the number of victims (Ibid.). Tjaden and Thoennes (2000) estimated that women experience 322,230 rapes and 4.5 million physical assaults from their intimate partners. In addition 30% of women, who are murdered, are killed by a husband, ex-husband, boyfriend, or ex-boyfriend (US Department of Justice, 1997). As such intimate partner violence is a great public health concern.

Violence by intimate partners is commonly used to show as well as enforce the man’s position as head of the relationship (Watts & Zimmerman, 2002). Several physical health problems can also be attributed to intimate partner violence. The most common of these, is gynecological problems. A population-based study conducted in the United States revealed that gynecological problems are three times more prevalent in
victims of intimate partner violence than in women who were not being abused (Koss, Koss & Woodruff, 1991). Many of the gynecological problems can be attributed to forced sex (Campbell, 2002). In addition to forced sex, refusal to use condoms or other contraceptives were cited by victims of intimate partner violence as examples of controlling acts demonstrated by their partners (Campbell & Soeken, 1999).

The consequences of IPV can last a lifetime (Centers for Disease Control). Abused women often experience a higher rate of depression, alcohol and drug abuse, suicide attempts and overall health problems than women who are not being victimized by their intimate partners (Golding 1996; Campbell, Sullivan and Davidson 1995; Kessler et al. 1994; Kaslow et al. 1998; Moscicki 1989). As a result they more frequently utilize health care services (Miller, Cohen, & Rossman, 1993). The National Center for Injury Prevention and Control of the Centers for Disease Control and the (2003) estimated the costs of IPV to exceed $5.8 billion dollars. These figures may vary between $3.9 and $7.6 billion. This includes both direct and indirect costs. The direct costs ($4.1 billion) are those incurred when abused individuals access medical and mental health care. Indirect costs ($1.8 billion) include loss of productivity as well as present value of lifetime earnings (Ibid).
HIV and Intimate Partner Violence

Intimate Partner Violence has been shown to be associated with numerous negative health behaviors (Plichta, 2004; Roberts, Auinger, & Klein 2005; Silverman Raj, Mucci & Hathaway, 2001). These include unprotected sex, early sexual initiation, multiple sexual partners, choosing unhealthy sexual partners and alcohol and drug use. Negative health behaviors of victims increase as the levels of violence they experience increases (National Center for Injury Prevention and Control, 2006).

In 1997 Wingwood and DiClemente revealed that African-American women who were involved in physically abusive relationships, were less likely to use condoms and more likely to be victimized by their intimate partners as a result of requesting condom use. As a result, these women are at increased risk for HIV infection. Additionally, Simoni and Cooperman (2000) who conducted face to face interviews with women living with AIDS in New York City, determined that 59% of the sample of 373 women had been sexually abused and 69% had been physically abused.

Other research asserts that women who have no voice or power in their intimate relationships are at risk for numerous forms of abuse including being forced into certain sexual
activities. As a result, they may be at greater risk for HIV infection (Kalichman et. al, 1998). Since race itself is not a risk factor for the spread of HIV (being African American does not by itself make an individual more susceptible to contracting HIV), some argue that the root-cause of the increase in HIV/AIDS incidents in African-American women is gender inequity. Gupta (2002) believes gender inequity must be addressed for the HIV epidemic to be controlled. Gupta (2002) and Gasch, Poulson, Fullilove, & Fullilove (1991) assert that women should be empowered because the unequal balance of power between men and women leads to controlling behavior by men. If men have control of women’s bodies, the women themselves have no control of the spread of the disease.

Wingwood and DiClemente (1997), as well as Klein and Birkhead (2000) add that assessment for Intimate partner violence should be routinely incorporated into HIV prevention programs. From the literature, it could be speculated that abuse of women by their intimate partners has been a factor in the spread of HIV. Since HIV has begun to spread in the general, heterosexual population, all such relationships have become more risky. Those who remain most vulnerable to infection will likely be those who suffer most from injustice, anger, and abuse (Human Rights Watch, 2003).
Sexual Abuse in Intimate Relationships

The scope of marital rape (or sexual abuse of an intimate partner) is largely unknown because it is the least studied type of intimate partner violence (Hines & Malley-Morrison, 2005). The Department of Justice (2001) reported that 41,740 women are sexually assaulted each year or raped by an intimate partner. However, Hines and Malley-Morrison (2005) state that figure may be an underestimate. A variety of factors influence rape in intimate relationships. These include poverty, religion, race/ethnicity and attitudes towards wife rape (Hines & Malley-Morrison, 2005). Other factors include age of the victim (Finkelhor & Yllö, 1985) and excessive consumption of alcohol by the abuser (Frieze, 1983).

Even though marital rape has been a widespread problem for centuries (Russell, 1990) the subject has not been adequately examined (Bennice & Resick, 2003). This is partly because husbands were historically thought to have state sanctioned rights to sexually abuse their wives (United Nations, 1989).

Like female victims of physical violence, victims of marital rape experience severe outcomes including, physical injury and acute post traumatic symptoms (Frieze, 1983). Frieze (1983) also found that women who were both physically and
sexually abused by their husbands were more likely to have lower levels of education, several children, and no employment prior to marriage. As a result, these women were more likely to remain in the relationship because of limited resources (Ibid).

**HIV Risk Factors and Barriers to Prevention in African-American Women**

There are several well established HIV risk factors and barriers to prevention in African American women. These include age, biologic vulnerability and sexually transmitted diseases, sexual inequality in relationships with men and lack of recognition of a partner’s risk factors. Each of these is discussed in more detail below.

**Young Age**

A CDC study conducted in 1998 of Job Corps entrants between the ages of 16-21 years, revealed that HIV prevalence among young women (2.8 per 1,000) was higher than among young men (2.0 per 1,000). African American females in the study were 7 times more likely to be HIV-positive than white women (Valleroy, MacKellar & Karon, 1998). Furthermore, even though overall HIV diagnoses among women decreased slightly from 1984 through 1998,
the number of HIV cases caused by injection drug use in women between the ages of 15-19 increased. Furthermore, the number of HIV cases contracted through heterosexual intercourse more than doubled (Lee & Fleming, 2001).

**Biological Vulnerability and Sexually Transmitted Diseases**

Women are almost twice as likely as a man to contract HIV infection during vaginal intercourse (European Study Group, 1992). Furthermore, women already infected with another sexually transmitted disease have a greater likelihood of contracting HIV (Fleming & Wasserheit, 1999). Since the rates of syphilis and gonorrhea are higher in African-American women, than among white women, this is particularly problematic. The higher rate of sexually transmitted diseases is especially manifest in women of color between the ages of 15-24 (CDC, 2003).

**Sexual Inequality in Relationships with Men**

Sexual inequality is an issue of utmost importance for teenaged girls involved in relationships with older men. A CDC study of urban high schools revealed that more than 33% of African American and Hispanic female teenagers first became
sexually involved with older men (Miller, Clark & Moore, 1997). These teenagers were more likely than teenagers whose partners were also teenagers, to have used condoms inconsistently, were less likely to have used condoms in their first sexual encounter, were less likely to have used a condom during their most recent sexual encounter, and were younger during their first experience with sexual intercourse (Ibid).

**Lack of Recognition of Partners’ Risk**

In a 2003 study of over 8000 HIV-infected people, 34% of African-American men who have sex with men (MSM), 26% of Hispanic MSM, as well as 13% of Caucasian MSM reported that they have had sex with men as well as women. However, in the same study far fewer women, 14% of Caucasian women, and 6% of African-American and Hispanic women stated that they had a bisexual partner (Montgomery, Mokotoff, Gentry, & Blair, 2003). Additionally, a recent CDC study revealed that 65% of men who have had a male sexual partner have also had sex with women. As such, numerous women may be unaware of their male partners’ true HIV-risk (Hader, Smith, Moore & Holmberg, 2001).

Within the African American community, men who portray themselves to their female partners as solely heterosexual, yet
also have sex with men, are said to be “on the down-low” or “on the DL.” Although “DL” has found its way into the vernacular of many young people who use it to define any secretive activity, homosexuality and bisexuality are still viewed as taboo in the African-American community. This often impedes open communication; as a result the HIV-positive rates of American women, whose men are on the down low, are increasing.

Substance Abuse

It is estimated that 20% of new HIV diagnoses in women is related to intravenous drug use (CDC, 2003). Additionally drug users are more likely to be involved in other high-risk behaviors such as unprotected sex when they are under the influence of drugs (Leigh & Stall, 1993).

Socioeconomic and Other Societal Factors

Almost 25% of African Americans live in poverty (US Census Bureau, 1999). Many problems have been associated with poverty. These include higher levels of substance abuse as well as reduced access to quality health care (Diaz, Chu, Buehler et al, 1994). Further research shows that African-American women are less likely than men to receive highly active antiretroviral
therapy and preventive therapy for opportunistic infections than non-minorities with HIV (Shapiro, Morton, McCaffrey, et al., 1999).
CHAPTER THREE: THEORETICAL FRAMEWORK

The theories that dominate HIV-Risk are largely psychological in nature (Gentry, Elifson, & Sterk, 2005). The same is true for Intimate Partner Violence (Campbell, 1999; Plichta, 1996; McCauley, 1995). These include the Health Belief Model (Rosentock, Strecher, & Becker, 1994), stages of change theory (Prochaska, DiClemente & Norcross, 1992) social cognitive theory (Bandura, 1994) and AIDS risk reduction model (Catania, Kegeles, & Coates, 1990). For the purposes of this study however, the feminist theoretical framework will be used. The feminist perspective provides a framework within which the impact of Intimate Partner Violence on HIV-Risk can be examined.

Feminist Perspective

While there is no one single feminist theory, there is a feminist theoretical framework. Over the past thirty years, researchers have demonstrated some support for this perspective (Yodanis, 2004). According to Hierro (1994) the feminist perspective is based on very simple beliefs:

• Women are human beings
• Gender equality must be recognized publicly
• The personal is political.

The feminist theoretical framework asserts that all facets of people’s lives are political, and all political issues are personal and are designed to systemically assign male power over women (Miles, 1996; p. 3). Additionally, there are four factors that are common to feminist explanations of intimate partner violence (Bograd, 1988). These include:

1. The relationship between gender and power
2. An examination of family within a socio-historical context
3. Viewing women’s experiences from their own frames of reference
4. Advocacy for women.

The Relationship between Gender and Power

Violence against women is a fundamental concern of the feminist movement (Crenshaw, 1997). According to the feminist explanation, intimate partner violence is only truly understood by examining the social context in which it occurs (Connell, 1987). The power differential in abusive relationships is reinforced by the sense of entitlement that men develop in a
patriarchal system (Dobash & Dobash, 1979; Schecter, 1982; Yick, 2001). Patriarchy is defined as “the system of male power in society” (Kurz, 1993; p. 49) and encompasses two elements: structure and ideology (Dobash & Dobash, 1979).

The feminist perspective stresses that male dominance often prevents women from taking control of their own bodies. Furthermore, some cultural norms reinforce inequality between the sexes, and put women in subservient positions. The feminist theory also asserts that men use fear to control women’s behavior (Yodanis, 2004). Women’s position in society, as well as their access, is interrelated to the levels of sexual violence against them (Yodanis, 2004).

**An Examination of Family within a Socio-historical Context**

To gain a better understanding of intimate partner violence, violent behavior must be placed in the proper setting, both historical and contemporary. A concerted effort should be made to look beyond the couple involved in such violence. Only when the historical context of violence is explored, can the impact of violence against women in the home be truly discovered and understood (Dobash & Dobash, 1979 p. 27).
Viewing Women’s Experiences from Their Own Frames of Reference

The feminist perspective asserts that male power affects all experiences. To counteract the tendency to accept the lives, values and attitudes of men as the norm, women’s experiences should be viewed from their own frames of reference and should be validated. Feminists are concerned with examining the variety of ways in which victims of intimate partner violence are blamed for the violence.

Advocacy for Women

Intimate partner violence is primarily a hidden problem which causes shame on the part of the victim (United Nations, 1989). As a result victims of Intimate Partner Violence may perceive little or no alternatives to remaining in a violent situation (Short & Rosenberg, 2001; p.64). Historically, members of the medical professions, researchers, and social and community workers viewed violence among intimate partners as a family matter, and therefore failed to respond with sensitivity (United Nations, 1989). This was further compounded if the victim happened to be African-American. As a result, the goal of research guided by the feminist theoretical framework is to
develop models that more accurately portray the experiences of all women.

The Ideal of Androgyny

Contemporary feminists strive for the elimination of male domination and seek to secure the liberation of women (Sterba, 1995). As a result, many who support the principles of the feminist perspective view a gender-free or androgynous society as being the ideal (Ibid). For this ideal to become a reality, a deep-seated reformation in a variety of areas is necessary. These include:

I. The family
   a. Equal socialization of boys and girls
   b. Equal opportunities for mothers and fathers

II. Distribution of economic power
   a. Equal pay for equal work
   b. Affirmative Action and comparable worth programs

III. Violence against women
   a. Ending rape, battery, sexual abuse
   b. Teach conflict resolution
   c. Eliminating sexual harassment.
Conceptual Framework

Although no single theory can fully explain the relationship between Intimate Partner Violence and HIV risk propensity in African-American women, several factors make the Feminist perspective an excellent framework within which to examine these phenomena. The epidemics of HIV and Intimate Partner Violence disproportionately affect individuals who have historically been marginalized because of race/ethnicity and gender. Specifically, African-American women are at greater risk of both becoming infected with HIV as well as being the victim of Intimate Partner Violence (Centers for Disease Control, 2000; Sorenson, Upchurch, & Shen, 1996).

Across the globe, many women feel ill-equipped or unable to negotiate condom use. They continue to become infected with HIV, because of lack of information and personal autonomy, which are stripped from them by abusive partners (Global Coalition on Women and AIDS, 2005).
**Hypotheses**

The principal research question examined during this research process is whether being in a violent relationship impacts HIV risk in African American women. Several hypotheses were tested.

**Hypothesis 1:**

\( H_0^1 \) There is no relationship between Intimate Partner Violence and Sexual Coercion.

\( H_a^1 \) There is significant positive relationship between Intimate Partner Violence and Sexual Coercion.

**Hypothesis 2:**

\( H_0^2 \) There is no relationship between Sexual Coercion and HIV Risk.

\( H_a^2 \) There is a significant positive relationship between the Sexual Coercion and HIV Risk.

**Hypothesis 3:**

\( H_0^3 \) There is a no relationship between the frequency of abuse and HIV Risk.

\( H_a^3 \) There is a significant positive relationship between the frequency of abuse and HIV Risk.

**Hypothesis 4:**

\( H_0^4 \) There is no relationship between Intimate Partner Violence and ability to negotiate condom use.
There is a significant inverse relationship between Intimate Partner Violence and the ability to negotiate condom use.

**Hypothesis 5:**

$H_{a4}$ There is no relationship between Intimate Partner Violence and HIV Risk.

$H_{a5}$ There is a significant positive relationship between Intimate Partner Violence and HIV Risk.
Based on the tenets of the Feminist perspective, the following findings were expected: (a) women in violent relationships would have increased risk factors for HIV (b) the higher the rates of physical and sexual violence, the greater the HIV risk in African-American women and (c) the higher the rate of physical or sexual violence the lower the ability to negotiate condom use (d) women in violent relationships will have more risk factors for HIV than women not in violent relationships.
CHAPTER FOUR: METHODOLOGY

This study used structural equation modeling to examine the relationship between Intimate Partner Violence and HIV Risk Propensity. Structural Equation Models, also referred to as the analysis of Linear Structural Relations (LISREL), are extensions of regression methods (Wan, 2002). Structural equation modeling is used to confirm relationships and test hypotheses. These models verify how and how strongly variables affect each other. Structural Equation Models have been demonstrated to be extremely useful in understanding and profiling HIV-related risk factors (e.g., Huba et. al, 2003; Brunswick & Banaszak-Hill, 1996; Burkholder & Harlow, 1996).

Study Population

The unit of observation for this study was adult African-American females. Women who were experiencing serious problems in an intimate relationship with a man, as well as women who were not experiencing such difficulties were surveyed. The words battering or abuse were not used in the recruitment materials because women who have been physically assaulted by
their intimate partners often do not consider themselves battered or abused (Campbell, Miller, Cardwell & Becklap, 1994; Campbell, 1999).

Recruitment

Orange County Government’s Citizens’ Commission for Children (CCC) supported this research by allowing access to the Neighborhood Centers for Families across Orange County for the purpose of recruitment of research participants. The CCC serves Orange County residents by partnering with local non-profit agencies, local government, school programs, and faith-based organizations and service providers. The Neighborhood Centers for Families is one of the CCC’s three primary components.

Neighborhood Centers for Families (NCF) are available to residents in 13 communities throughout Orange County. A variety of providers are available to clients of the NCF. No two NCFs are the same, as each NCF is individually developed to meet the needs of the surrounding community. Residents are a vital part of the planning process at each NCF. Services offered at each NCF vary, but may include:

- Case Management
- Counseling
Research Design

This research project was an explanatory study. Explanatory studies look for the answers to problems and hypotheses; and describes the relationships among variables of interest (Singleton & Straits, 1999). The study tested relationships between variables representing Intimate Partner Violence and HIV risk.

Questionnaires were administered to the women at four NCFs who met the selection criteria for this study, namely African-American females over the age of 18 who were in an Intimate relationship with a man.

The survey incorporated components of the Woman Abuse Screening Tool (WAST) and the HIV Risk Screening Inventory. Three questions from the Sexual Experiences Survey, a widely used measure of sexual coercion were also included in the
questionnaire. Upon completion of the survey, each person received a $10 gift card to a local superstore. The data were analyzed with SPSS and AMOS software.

**Sample Size**

No specific formula has been developed to calculate sample size for structural equation models. However, the method used to determine a reasonable sample size in other studies utilizing structural equation models, has been to multiply number of parameters to be estimated by 10 participants. As such 200 participants were recruited for the purpose of this study. Hand-written comments on three of the survey revealed that the women were being battered by their adult children and not their intimate partner. As such, these surveys were not included in the analysis.

**Instruments**

Several instruments were combined and utilized for the purpose of this study. Some instruments were revised to more appropriately meet the need of this project. Permission was requested and received from the developers of all the tools used in this study. The instruments are described in more detail.
below. Letters of permission are included in Appendices I through L.

**Woman Abuse Screening Tool**

The WAST is an eight-question survey which focuses on physical, emotional, and sexual abuse (Brown, Lent, Brett, Sas & Pederson, 1996). This instrument has been validated against the longstanding Abuse Risk Inventory (IRI). The WAST short-form which comprises the first two questions of the tool have been shown in a small population (n = 24) to have a sensitivity and specificity of 91.7% and 100%, respectively (Ibid). The WAST has been tested in various populations both small and large, as well as English and Spanish speaking and has maintained its validity. However, the sensitivity in Spanish-speaking populations was lower in primary care patients than in patients in a shelter (Fogarty & Brown, 2002).

**HIV Risk Screening Instrument Revised**

The HIV Risk Screening Instrument (HSI) is a valid and reliable tool (Gerbert, Brownstone, McPhee, Pantilat & Allerton, 1998) with a Kuder-Richardson-20 co-efficient for dichotomous variables (KR-20), of .73 (Ibid). The validity and reliability
for this instrument was determined with a study sample of 459 participants representing high and low risk groups. The original questions was revised to seek information about risk behaviors over the last six months rather than the last 10 years, as this is a more accurate representation of current risk (Kalichman, 1998).

**Sexual Experiences Survey**

The Sexual Experiences Survey (SES) is a commonly used 14-item instrument. The instrument measures degrees of sexual victimization and assesses whether victimization occurred due to threats, coercion, and use of force, authority or drugs (Koss, & Gidycz, 1985; Koss, g). Three questions were taken from the SES for use in this research. Two questions from Kalichman et. al (1998) study on sexual coercion and negotiating condom use were also utilized.

**Demographic Information**

A demographic profile of each participant was taken by asking questions regarding the age, number of completed years of education, income, number of children, and HIV test results if a test has been taken.
Procedure

Prior to conducting this application the research protocol was submitted to the Institutional Review Board (IRB) at the University of Central Florida. Approval to begin the study was received in March 2006. A Waiver of documentation of consent was granted due to the sensitive nature of the questions on the survey. A copy of the IRB approval is included in Appendix A. The surveys were implemented in four NCFs across Orange County. African American women who entered the NCFs for services were asked if they were interested in completing a survey. Interested women were further screened to determine their relationship status. Women who reported that they were in an intimate relationship with a man were eligible for inclusion in the study. Women who met the criteria were provided with the informed consent, which detailed the purpose of the study. If after reading the informed consent the women still agreed to complete the survey, they were provided with an envelope which included the survey as well as a list of community resources which listed HIV and Intimate Partner Violence services in the community. They were instructed to keep the resource sheet and, upon completion of the survey, seal it in the envelope and return it to the researcher. Upon completion and return of the
survey to the researcher, participants were provided with a $10 gift-card to a local superstore.

**Research Questions**

This research sought the answers to the following questions:

1. Does a relationship exist between Intimate Partner Violence and Sexual Coercion in African American women?
2. Does a relationship exist between Sexual Coercion and HIV Risk in African American women?
3. Does the frequency of intimate partner violence (women who report getting abused “often” vs. “sometimes” on the Woman Abuse Screening Tool) impact the HIV Risk of African-American Women?
4. Is the ability of African-American women to negotiate condom use affected by being in a violent relationship?
5. Is there a relationship between Intimate Partner Violence and HIV risk?
Table 1: Operational Definitions of Exogenous Study Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intimate Partner Violence</td>
<td>A latent exogenous variable measured by the following indicators:</td>
</tr>
<tr>
<td></td>
<td>Sexual Coercion Acts ranging from nonphysical forms of pressure that induce</td>
</tr>
<tr>
<td></td>
<td>women to engage in sexual acts unwillingly, to rape.</td>
</tr>
<tr>
<td></td>
<td>Physical Abuse History of pushing, punching, hitting, slapping, or withholding</td>
</tr>
<tr>
<td></td>
<td>vital medicine.</td>
</tr>
<tr>
<td>Emotional Abuse</td>
<td>The recurring use of harmful and controlling behaviors by an intimate partner for the purpose of controlling a woman.</td>
</tr>
</tbody>
</table>
Table 2: Operational Definitions of Endogenous Study Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Risk Propensity</td>
<td>A Latent endogenous variable measured by the following indicators:</td>
</tr>
<tr>
<td>Substance Abuse Frequency</td>
<td>The frequency of illegal drug-use</td>
</tr>
<tr>
<td>Risky Sexual Behavior</td>
<td>Overall involvement in risky sexual behavior</td>
</tr>
<tr>
<td>Sexually Transmitted Diseases</td>
<td>History of Sexually Transmitted Diseases</td>
</tr>
<tr>
<td>Partner’s Risk</td>
<td>Lack of recognition of intimate partner’s HIV risk</td>
</tr>
</tbody>
</table>

Data Analysis

Upon receipt of the completed surveys, numerical codes were assigned to the responses and the information was input into a database using SPSS 14.0. The data was checked for errors by proofreading each case entered into SPSS.
Specification of the Analytical Model

AMOS (Analysis of Moment Structure) 6.0 a multivariate statistical package was used to validate the measurement models of the exogenous latent variable (Intimate Partner Violence) and the endogenous latent variable (HIV Risk Propensity). The models were validated independently via confirmatory factor analysis. Additionally, covariance structure modeling was used to test the structural relationship between Intimate Partner Violence and HIV Risk Propensity. Figure 5 offers a visual demonstration of the study design in the form of a path diagram.
Figure 5: Covariance structure model of the relationship between Intimate Partner Violence and HIV Risk
Research Scope and Generalizability

The focus of this research was limited to adult African-American women in the Central Florida area. The term African American for the purposes of this study means black people regardless of country of origin, who currently reside in the United States. The participants for this study were not randomly selected and thus the external validity or generalizability will be limited. Even so, this research adds to the limited body of knowledge that currently exists about the relationship between IPV and HIV risk.

Ethical Considerations

Because of the sensitive nature of the study, a waiver of written consent was granted by the IRB. No personal identifiers were attached to the survey instrument, and anonymity was promised to the participants. A list of resources and information on how to access services related to HIV, sexual assault, drug-use and Intimate Partner Violence were provided to every participant.

To ensure that the potential participants were adequately informed, the process of obtaining informed consent included a
thorough description of the planned procedures in the form of a letter. Participants were informed that being involved in the project was totally voluntary, and that they could withdraw at any time, without penalty.

**Potential Benefits and Anticipated Risks**

Although there are no anticipated risks for completing this study, some questions in the survey were very sensitive in nature. Participants were advised that they could opt not to answer questions that caused any emotional discomfort or any questions they did not want to answer. Furthermore, participants were informed that they could choose to stop the process at anytime, without penalty, even after agreeing to complete the survey.

Potential benefits of participating in this study included increased knowledge of community resources from which to receive information, counseling or treatment for issues related to HIV, STDs, and Intimate Partner Violence.

**Practical Implications**

HIV and IPV are public affairs issues which affect a variety of fields including healthcare, social work, public
administration and criminal justice. HIV continues to plague the African-American community and has been named the number one killer of women in this group between the ages of 25 and 44 (CDC, 2002). Additionally, violence against women has been shown to be a risk factor for a plethora of unfavorable health outcomes (Sorenson & Saftlas, 1994).

It has been speculated that there is an association between intimate partner violence and the transmission of HIV (Campbell & Soeken, 1999). However, the concern seems largely directed to countries where women’s rights are extremely limited. In the United States, African-American women continue to bear a disproportionate burden of HIV infections. Though prevention efforts have shown great success in some groups, this has not been true for African-American females. For change to occur, factors which have been suspected to impact the levels of transmission of HIV need further exploration. Such is the case with Intimate Partner Violence. Many questions about the relationship between the Intimate Partner Violence and HIV risk remain unanswered (New York State Office for the Prevention of Domestic Violence, 2001). Research such as this one adds to the body of knowledge that exists specifically about IPV and HIV-risks of African-American women.
CHAPTER FIVE: RESULTS

This chapter describes the results of the statistical analyses related to the study hypotheses. Data were collected from various community based settings in Orange County, Florida. With the support of the Orange County Citizen’s Commission for Children, Neighborhood Centers for Families in the Oak Ridge, Pine Hills, Ivey Lane, and Tangelo Park areas of Orlando were used as primary recruitment facilities. Surveys were completed by African-American women who utilized those facilities. The survey questions sought information about levels of intimate partner violence and sexual coercion in relationships.

In all, 200 surveys were completed. Three surveys were excluded because comments handwritten on the form by respondents indicated that they did not meet the criteria for inclusion in the study, namely, currently being in a relationship. As such 197 survey results were included in the analysis.

As described in Chapter 1, the purpose of this study was to explore the relationship between Intimate Partner Violence and HIV Risk Propensity in African American women.
Instruments

All women who agreed to participate in this research were asked to complete a 31 item questionnaire which combined elements of the Woman Abuse Screening Tool, the HIV Risk Screening Instrument Revised, the Sexual Experiences Survey (adapted), two questions adapted from Kalichman et. al (1998) study on sexual coercion and negotiating condom use, and some general demographic questions.

As described in Chapter IV, the WAST is an eight-question survey which focuses on physical, emotional, and sexual abuse (Brown, Lent, Brett, Sas & Pederson, 1996) which has been tested in various populations, and has been validated against the longstanding Abuse Risk Inventory (IRI).

The HIV Risk Screening Instrument was also used. To more appropriately evaluate current risk, the original questions of the HSI were revised to seek information about risk behaviors over the last six months rather than the last 10 years (Kalichman, 1998). The survey also included three questions which were adapted from the Sexual Experiences Survey and two questions adapted from Kalichman et. al (1998) study on sexual coercion and negotiating condom use. Demographic information was also collected.
Age of Respondents

Of the 197 individuals included in the analyses, the largest percentage (35%) fell into the 25-34 age group, 23.4% in the 35-44 age group, 15.2% in the 18-24 age group, 13.2% in the 45-54 age group, 2.5% in the 55-64 age group and 1% in the 65 and older age group. Almost 10% of the survey respondents did not provide an age.

Table 3: Age of Respondents

<table>
<thead>
<tr>
<th>Age</th>
<th>Freq.</th>
<th>Valid Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>30</td>
<td>16.9</td>
<td>16.9</td>
</tr>
<tr>
<td>25-34</td>
<td>69</td>
<td>38.8</td>
<td>55.6</td>
</tr>
<tr>
<td>35-44</td>
<td>46</td>
<td>25.8</td>
<td>81.5</td>
</tr>
<tr>
<td>45-54</td>
<td>26</td>
<td>14.6</td>
<td>96.1</td>
</tr>
<tr>
<td>55-64</td>
<td>5</td>
<td>2.8</td>
<td>98.9</td>
</tr>
<tr>
<td>65 and older</td>
<td>2</td>
<td>1.1</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>178</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
**Employment Status**

Of the survey respondents, 19.9% were unemployed. This includes the stay-at-home mothers; individual's not currently seeking employment, and those actively searching for employment. The remaining respondents reported being employed part-time (14.3%) or full-time (65.8%).

Table 4: Employment Status

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Frequency</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployed/seeking employment</td>
<td>19</td>
<td>9.7</td>
<td>9.7</td>
</tr>
<tr>
<td>Unemployed/not seeking employment</td>
<td>11</td>
<td>5.6</td>
<td>15.3</td>
</tr>
<tr>
<td>Stay at home mom</td>
<td>9</td>
<td>4.6</td>
<td>19.9</td>
</tr>
<tr>
<td>Employed part time</td>
<td>28</td>
<td>14.3</td>
<td>34.2</td>
</tr>
<tr>
<td>Employed full time</td>
<td>129</td>
<td>65.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>196</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Income

Thirty percent of survey respondents reported that they currently earn less than $15,000 annually; 25.4% earn between $15,001 and 25,000; 24.4% earn between $25001 and $35,000; 12.4% earn between $35,001 and $45,000; 7.8% earn over $45,000.

Table 5: Income

<table>
<thead>
<tr>
<th>Income</th>
<th>Freq.</th>
<th>Valid Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;15,000</td>
<td>58</td>
<td>30.1</td>
<td>30.1</td>
</tr>
<tr>
<td>15,001-25,000</td>
<td>49</td>
<td>25.4</td>
<td>55.4</td>
</tr>
<tr>
<td>25,001-35,000</td>
<td>47</td>
<td>24.4</td>
<td>79.8</td>
</tr>
<tr>
<td>35,001-45,000</td>
<td>24</td>
<td>12.4</td>
<td>92.2</td>
</tr>
<tr>
<td>&gt;45,000</td>
<td>15</td>
<td>7.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>193</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Cultural or Ethnic Group

Although all participants in this research are Black, additional information was requested about cultural or ethnic group. The African-American population is often described as a homogenous population; however there are many groups, from many countries included in this population. While the majority of the respondents (79.2%) reported that they are African-American
(American born Black individuals), 9.6% were Jamaican, 5.6% were Haitian, and 5.1% reported themselves as other. Write-ins in the other category included Panamanian, Dominican, French, Islander, Puerto Rican, Curacao, and Black Hispanic

Table 6: Ethnicity of Respondents

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Freq.</th>
<th>Valid Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>African-American</td>
<td>156</td>
<td>79.2</td>
<td>79.2</td>
</tr>
<tr>
<td>Haitian</td>
<td>11</td>
<td>5.6</td>
<td>84.8</td>
</tr>
<tr>
<td>Jamaican</td>
<td>19</td>
<td>9.6</td>
<td>94.4</td>
</tr>
<tr>
<td>Trinidadian</td>
<td>1</td>
<td>.5</td>
<td>94.9</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>5.1</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>197</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Level of Education Completed

The largest percent of respondents (39.5%) reported that their highest level of education completed was high school. Additionally, (14.9%) reported that they had completed some college, or had received an Associate’s degree; 10.7% had completed the requirements for Bachelor’s degrees and 14.9% had completed Master’s Degrees.
Table 7: Level of Education

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Freq.</th>
<th>Valid Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than High Sch.</td>
<td>10</td>
<td>5.1</td>
<td>5.1</td>
</tr>
<tr>
<td>High school</td>
<td>77</td>
<td>39.5</td>
<td>44.6</td>
</tr>
<tr>
<td>Some college</td>
<td>29</td>
<td>14.9</td>
<td>59.5</td>
</tr>
<tr>
<td>Associates Degree</td>
<td>29</td>
<td>14.9</td>
<td>74.4</td>
</tr>
<tr>
<td>Bachelors degree</td>
<td>21</td>
<td>10.7</td>
<td>85.1</td>
</tr>
<tr>
<td>Masters degree</td>
<td>29</td>
<td>14.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>195</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Number of Children

Participants in this research project were asked to report the number of children they had. The data showed that 13.2% of the respondents reported zero children, 23.4% reported one child, 31% had two children, 16.2% had three children, and 15.7% of the respondents reported having four or more children.
Table 8: Number of Children

<table>
<thead>
<tr>
<th># of Children</th>
<th>Freq.</th>
<th>Valid Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>26</td>
<td>13.3</td>
<td>13.3</td>
</tr>
<tr>
<td>One</td>
<td>46</td>
<td>23.5</td>
<td>36.7</td>
</tr>
<tr>
<td>Two</td>
<td>61</td>
<td>31.1</td>
<td>67.9</td>
</tr>
<tr>
<td>Three</td>
<td>32</td>
<td>16.3</td>
<td>84.2</td>
</tr>
<tr>
<td>Four</td>
<td>31</td>
<td>15.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>196</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Levels of Intimate Partner Violence

The first seven questions of the survey inquired about the intimate partner relationships in which the women were involved. The questions sought to gain more insight into the levels of physical and emotional abuse being experienced by the women. The questions and results are listed below.

1. In general, how would you describe your relationship with your partner?

Overall, 35.5% of the women reported that they had no tension in their intimate relationships, 41.6% reported some tension, and 22.8% reported a lot of tension.
Table 9: Level of relationship tension

<table>
<thead>
<tr>
<th>Level of Tension</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Tension</td>
<td>70</td>
<td>35.5</td>
<td>35.5</td>
</tr>
<tr>
<td>Some Tension</td>
<td>82</td>
<td>41.6</td>
<td>77.2</td>
</tr>
<tr>
<td>A lot of Tension</td>
<td>45</td>
<td>22.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>197</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

2. How do you and your partner work out arguments?

Thirty-one percent (n=61) of the research participants reported no difficulty in working out arguments with their intimate partners, 51.3% reported some difficulty, and 17.8% reported great difficulty.
Table 10: Level of Difficulty Working out arguments

<table>
<thead>
<tr>
<th>Level of Difficulty</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Difficulty</td>
<td>31</td>
<td>31.0</td>
<td>31.0</td>
</tr>
<tr>
<td>Some Difficulty</td>
<td>101</td>
<td>51.3</td>
<td>82.2</td>
</tr>
<tr>
<td>Great Difficulty</td>
<td>35</td>
<td>17.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>197</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

3. Do arguments with your partner ever result in you feeling down or bad about yourself?

Thirty-nine percent of the respondents (n=77) reported that arguments with their partner never results in their feeling down or bad about themselves. Almost 44% (n=86) sometimes felt down or bad about themselves following arguments, and 17.3% (n=34) often felt down or bad about themselves following an argument.
Table 11: Arguments leading to feeling down/bad about self

<table>
<thead>
<tr>
<th>Feeling Down</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>77</td>
<td>39.1</td>
<td>39.1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>86</td>
<td>43.7</td>
<td>82.7</td>
</tr>
<tr>
<td>Often</td>
<td>34</td>
<td>17.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>197</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

4. Do arguments with your partner ever result in hitting, kicking or pushing?

Sixty-nine percent (n=136) of the females in this study reported that their arguments never resulted in hitting, kicking or pushing. Twenty-three percent (n=46) had arguments that sometimes resulted in hitting, kicking, or pushing, and almost eight percent (n=15) had arguments that often resulted in hitting, kicking or pushing.
Table 12: Arguments resulting in hitting, kicking, or pushing

<table>
<thead>
<tr>
<th>Arguments result in violence</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>136</td>
<td>69</td>
<td>69</td>
</tr>
<tr>
<td>Sometimes</td>
<td>46</td>
<td>23.4</td>
<td>92.4</td>
</tr>
<tr>
<td>Often</td>
<td>15</td>
<td>7.6</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>197</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

5. Do you ever feel frightened by what your partner says or does? Almost 71% of the survey respondents (n=139) reported that they never felt frightened by what their partner says; almost 20% (n=39) sometimes feel frightened, and 10% (n=19) often feel frightened.
Table 13: Feel frightened by what partner says/does

<table>
<thead>
<tr>
<th>Feel Frightened</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>139</td>
<td>70.6</td>
<td>70.6</td>
</tr>
<tr>
<td>Sometimes</td>
<td>39</td>
<td>19.8</td>
<td>90.4</td>
</tr>
<tr>
<td>Often</td>
<td>19</td>
<td>9.6</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>197</strong></td>
<td><strong>100.0</strong></td>
<td></td>
</tr>
</tbody>
</table>

6. Has your partner ever abused you physically?

When asked about physical abuse, 74.6% (n=147) reported that they have never been physically abused by their partners; 20.3% (n=40) reported sometimes being abused by their partners, and five percent (n=10) report often being abused by their partners.

Table 14: Frequency of Physical Abuse

<table>
<thead>
<tr>
<th>Abuse frequency</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>147</td>
<td>74.6</td>
<td>74.6</td>
</tr>
<tr>
<td>Sometimes</td>
<td>40</td>
<td>20.3</td>
<td>94.9</td>
</tr>
<tr>
<td>Often</td>
<td>10</td>
<td>5.1</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>197</strong></td>
<td><strong>100.0</strong></td>
<td></td>
</tr>
</tbody>
</table>
7. Has your partner ever abused you emotionally?

In terms of emotional abuse, 41.6% (n=82) reported never being abused by their partners; 44.2% (n=87) reported sometimes being emotionally abused, and 13.7% (n=27) reported that they are often emotionally abused by their intimate partners.

Table 15: Frequency of emotional abuse

<table>
<thead>
<tr>
<th>Emotional Abuse</th>
<th>Frequency</th>
<th>Valid</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Percent</td>
<td>Cum. Percent</td>
</tr>
<tr>
<td>Never</td>
<td>82</td>
<td>41.8</td>
<td>41.8</td>
</tr>
<tr>
<td>Sometimes</td>
<td>87</td>
<td>44.4</td>
<td>86.2</td>
</tr>
<tr>
<td>Often</td>
<td>27</td>
<td>13.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>196</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Of particular interest is the fact that the participants had different responses when asked about the frequency with which arguments result in hitting, kicking or pushing, and when asked about the frequency of physical abuse. Thirty-one percent (31%) of the women surveyed indicated that their arguments sometimes or often result in hitting, kicking, or pushing, as compared to 25.4% who reported that they are being physically
abused sometimes or often. This may have implications in the way questionnaires are developed, or questions are posed to women. It could be that women may be less likely to report being physically abused, because of social desirability issues, because physical abuse sounds more serious than hitting, kicking or pushing, or because they don’t understand the definition of physical abuse. Since the question doesn’t ask who hits, kicks or pushes, another explanation could be that arguments result in the women hitting, kicking or pushing their partners.

**HIV Risk Factors**

The HIV Risk Screening Instrument (HSI) was used to examine the HIV risk factors of the respondents. The original questions were revised to seek information about risk behaviors over the last six months rather than the last 10 years. As Table 16, 17 and 18 reveal, almost 15% of the respondents reported that they had two or more sex partners in the six months prior to completing the survey and 17% reported having anal sex. Additionally, approximately 10% reported that they used condoms “sometimes” or “never”, and 9% reported that they “always” use condoms during anal sex. Although just over 17% initially
indicated that they engage in anal sex, almost 28.9% reported on their use of condoms during anal sex.

Table 16: Two or more sex partners

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>167</td>
<td>85.2</td>
</tr>
<tr>
<td>Yes</td>
<td>29</td>
<td>14.8</td>
</tr>
</tbody>
</table>

Total 196 100.0

Table 17: Anal sex in the last 6 months

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>163</td>
<td>82.7</td>
</tr>
<tr>
<td>Yes</td>
<td>34</td>
<td>17.3</td>
</tr>
</tbody>
</table>

Total 197 100.0
The prevalence of sexually transmitted diseases within the survey respondents was examined by asking “In the last 6 months, have you had a sexually transmitted disease such as gonorrhea, syphilis, chlamydia, genital warts, or genital herpes?” Over 20% (see Table 19) of the respondents revealed that they had had a sexually transmitted disease.

### Table 18: Condom use during anal sex

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>20</td>
<td>10.2</td>
<td>10.2</td>
</tr>
<tr>
<td>Sometimes</td>
<td>19</td>
<td>9.6</td>
<td>19.8</td>
</tr>
<tr>
<td>Often</td>
<td>18</td>
<td>9.1</td>
<td>28.9</td>
</tr>
<tr>
<td>Not had anal</td>
<td>140</td>
<td>71.1</td>
<td>100.0</td>
</tr>
<tr>
<td>sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>197</strong></td>
<td><strong>100.0</strong></td>
<td></td>
</tr>
</tbody>
</table>
Table 19: Prevalence of STDS in respondents

<table>
<thead>
<tr>
<th>STDs</th>
<th>Frequency</th>
<th>Valid Percent</th>
<th>Cum. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>156</td>
<td>79.6</td>
<td>79.6</td>
</tr>
<tr>
<td>Yes</td>
<td>40</td>
<td>20.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>196</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Questions were also asked about receiving money or drugs for sex, paying money or drugs for sex and injection drug use of the survey respondent and partner, having a partner with sexually transmitted diseases and having a partner who is a man who also has sex with men.

None of the survey respondents reported having paid money or drugs for sex, and only 1 of 197 respondents indicated that she injects drugs intravenously. Almost nine percent (n=17) of the women indicated that they have received money or drugs for sex.

Additional HIV risk factors about which respondents were queried included partners who inject street drugs with a needle, partners who have sexually transmitted diseases or infections, and partners who are men who have sex with men. One percent (n=2) reported having partners who inject street drugs with a
needle, 7.6% (n=15) reported having a partner with STDs and 1.5% reported having a partner who was a man who had sex with other men.

Table 20: Partners who inject street drugs with a needle

<table>
<thead>
<tr>
<th>Partner IDU</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum.Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>161</td>
<td>81.7</td>
<td>81.7</td>
</tr>
<tr>
<td>Yes</td>
<td>2</td>
<td>1.0</td>
<td>82.7</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>34</td>
<td>17.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>197</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

A much greater percentage reported that they did not know the status of their partner’s drug use, sexually transmitted diseases and sexuality. In fact 17.3% of the respondents reported that they “don’t know” if their partner injects street drugs with a needle, 13.2% reported that they “don’t know” if their partners have STDs and almost 20% “don’t know” if their partner is a man who has sex with other men. The descriptive statistics of partners HIV risk factors are included below in Tables 22 and 23.
Table 21: Partners with sexually transmitted diseases

<table>
<thead>
<tr>
<th>Partner STD</th>
<th>Frequency</th>
<th>Valid Percent</th>
<th>Cum.Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>155</td>
<td>79.1</td>
<td>79.1</td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td>7.6</td>
<td>86.7</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>26</td>
<td>13.3</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Total 196 | 100.0

Table 22: Partners who are men who have sex with men

<table>
<thead>
<tr>
<th>Partner MSM</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cum.Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>155</td>
<td>78.7</td>
<td>78.7</td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>1.5</td>
<td>80.2</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>39</td>
<td>19.8</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Total 197 | 100.0
Research Questions

This research sought the answer to the following questions:

1. Does a relationship exist between Intimate Partner Violence and Sexual Coercion in African American women?
2. Does a relationship exist between Sexual Coercion and HIV Risk in African American women?
3. Does the frequency of intimate partner violence (women who report getting abused “often” vs. “sometimes” on the Woman Abuse Screening Tool) impact the HIV Risk of African-American Women?
4. Is the ability of African-American women to negotiate condom use affected by being in a violent relationship?
5. Is there a relationship between Intimate Partner Violence and HIV risk?
<table>
<thead>
<tr>
<th>Definitions of the variables measuring Intimate Partner Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coerce 1</strong> Had sex with partner when she didn’t want to</td>
</tr>
<tr>
<td>because he threatened to end relationship</td>
</tr>
<tr>
<td><strong>Coerce 2</strong> Had sex with partner when she didn’t want to</td>
</tr>
<tr>
<td>because he threatened to use force</td>
</tr>
<tr>
<td><strong>Coerce 3</strong> Had sex with partner when she didn’t want to</td>
</tr>
<tr>
<td>because he used force</td>
</tr>
<tr>
<td><strong>Pabuse</strong> Frequency of physical abuse</td>
</tr>
<tr>
<td><strong>Eabuse</strong> Frequency of emotional abuse</td>
</tr>
<tr>
<td><strong>Hit</strong> Arguments result in hitting, kicking or pushing</td>
</tr>
<tr>
<td><strong>Fright</strong> Feel frightened by what partner says</td>
</tr>
<tr>
<td><strong>Down</strong> Arguments result in feeling down or bad about self</td>
</tr>
</tbody>
</table>
Through the use of the AMOS computer program, confirmatory factor analysis was applied to determine how well eight indices obtained from the survey completed by 197 African American women represent a single latent variable called Intimate Partner Violence. The original model is presented in Figure 6.

**Model of Intimate Partner Violence**

The original model (Figure 6) proposes that the latent variable Intimate Partner Violence (IPV) determined by eight observed variables:

1) frequency of physical abuse (PABUSE);
2) frequency of emotional abuse (EABUSE);
3) how often arguments cause respondent to feel down or bad about herself (DOWN);
4) how often arguments result in hitting, kicking or pushing (HIT);
5) how often the respondent feels frightened by what partner says or does (FRIGHT);
6) engaging in coerced sexual intercourse because the partner threatens to end the relationship otherwise (COERCE1);
7) engaging in coerced sexual intercourse because the partner threatens to use physical force otherwise (COERCE2);

8) engaging in coerced sexual acts (oral or anal sex etc.) because the partner threatens to use physical force otherwise (COERCE3);

Goodness of fit Statistics revealed that the model poorly fitted the data. Modification indices were used in conjunction with theory to improve the model. Namely, since the items on the survey tool were completed by individual women at a single point in time, it would make sense that variables inquiring about similar constructs, such as three questions about types of sexual coercion, would be related. As such, the model was adjusted to account for the correlations between Coerce1, Coerce2, and Coerce 3 as well as Eabuse, Down and Fright. The revised model is shown in Figure 7.

The modification to the model resulted in a chi-square reduction from the original value of 600.1 with 20 degrees of freedom to 11.5 with 15 degrees of freedom. Chi-square in the revised model was shown to be non-significant at the .05 level. The p-value of the revised model is .715. In structural equation modeling, chi-square should NOT be significant if the model has a good fit. In other words, if the probability level is below
\[0.05,\] the model would be rejected. This is because the null hypothesis, or the hypothesis that the model does not fit the data, is what is being tested.
Figure 6: Original measurement model of Intimate Partner Violence
The p-value of .715 implies that model fits the data acceptably in the population from which the sample was drawn. Additional evidence corroborating the improved goodness of fit of the revised model is provided by the root mean square approximated (RMSEA) fit statistic. The revised model has a RMSEA of .000. This is considerably below the .06 cutoff recommended by Hu and Bentler (1999). Additionally, the Tucker-Lewis Index result of 1.006 is considerably above the .95 threshold indicating satisfactory model fit. Table 18 shows the goodness of fit statistics. Hu and Bentler (1999) recommend Tucker-Lewis scores of at least .95. The goodness-of-fit index (GFI) and the AFGI should both be at least .90 (Bollen, 1990).
<table>
<thead>
<tr>
<th></th>
<th>Original</th>
<th>Revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-squared (degrees of freedom)</td>
<td>600.1 (20)</td>
<td>11.5 (15)</td>
</tr>
<tr>
<td>Probability</td>
<td>.000</td>
<td>.715</td>
</tr>
<tr>
<td>Goodness of fit index</td>
<td>.678</td>
<td>.986</td>
</tr>
<tr>
<td>Adjusted goodness of fit index</td>
<td>.420</td>
<td>.966</td>
</tr>
<tr>
<td>Root mean square approximated</td>
<td>.385</td>
<td>.000</td>
</tr>
<tr>
<td>Tucker-Lewis Index</td>
<td>.286</td>
<td>1.006</td>
</tr>
</tbody>
</table>
Figure 7: Revised measurement model of Intimate Partner Violence
Regression Weights for Intimate Partner Violence

The regression weights, and standardized regression weights for the revised model of Intimate Partner Violence are shown below in Tables 25 and 26. The unstandardized regression weights reflect the relationship between the latent predictor variable Intimate Partner Violence and the eight observed variables. All coefficients were statistically significant at 0.001 or lower level and are positively associated with Intimate Partner Violence. However, standardized path coefficients revealed that Pabuse, Hit, Down and Fright, are the strongest predictors of Intimate Partner Violence.
Table 25: Regression weights of the revised structural equation model of Intimate Partner Violence

<table>
<thead>
<tr>
<th>Regression Weights of the revised model of IPV</th>
<th>Estimate</th>
<th>S.E.</th>
<th>C.R.</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pabuse&lt;--- Intimate Partner Violence</td>
<td>1.000</td>
<td>16.157</td>
<td>***</td>
<td></td>
</tr>
<tr>
<td>Hit&lt;--- Intimate Partner Violence</td>
<td>1.037</td>
<td>.064</td>
<td>9.585</td>
<td>***</td>
</tr>
<tr>
<td>Down&lt;--- Intimate Partner Violence</td>
<td>.853</td>
<td>.089</td>
<td>6.025</td>
<td>***</td>
</tr>
<tr>
<td>Coerce1&lt;--- Intimate Partner Violence</td>
<td>.610</td>
<td>.101</td>
<td>3.796</td>
<td>***</td>
</tr>
<tr>
<td>Coerce2&lt;--- Intimate Partner Violence</td>
<td>.507</td>
<td>.134</td>
<td>3.256</td>
<td>.001</td>
</tr>
<tr>
<td>Coerce3&lt;--- Intimate Partner Violence</td>
<td>.439</td>
<td>.135</td>
<td>13.931</td>
<td>***</td>
</tr>
<tr>
<td>Fright&lt;--- Intimate Partner Violence</td>
<td>.996</td>
<td>.071</td>
<td>7.277</td>
<td>***</td>
</tr>
<tr>
<td>Eabuse&lt;--- Intimate Partner Violence</td>
<td>.864</td>
<td>.119</td>
<td>7.031</td>
<td>***</td>
</tr>
</tbody>
</table>

***p<.001
Table 26: Standardized regression weights for the revised structural equation model of Intimate Partner Violence

<table>
<thead>
<tr>
<th>Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pabuse</td>
</tr>
<tr>
<td>Hit</td>
</tr>
<tr>
<td>Down</td>
</tr>
<tr>
<td>Coerce1</td>
</tr>
<tr>
<td>Coerce2</td>
</tr>
<tr>
<td>Coerce3</td>
</tr>
<tr>
<td>Fright</td>
</tr>
<tr>
<td>Eabuse</td>
</tr>
</tbody>
</table>

All values are significant at the p<.001 level

As with the measurement model for Intimate Partner Violence, confirmatory factor analysis was applied to determine how well eight indices obtained from the survey completed by 197 African American women represent a single latent variable called HIV Risk. The original model is presented in Figure 8.
Model of HIV Risk

The original model (Figure 8) proposes that the latent variable HIV Risk (HIV_Risk) is determined by eight observed variables:

1) sexually transmitted diseases (STD);
2) receiving money or drugs for sex (Get);
3) intravenous drug use by partner (PIDU);
4) having a partner who is a man who has sex with other men (MSM);
5) having a partner who has sexually transmitted diseases (PSTD);
6) engaging in unprotected anal sex (ANAL sex);
7) level of income (income); and
8) level of education (educ).

The probability level for the original model of HIV risk was $p=.000$. This indicates that the model poorly fitted the data. The model was re-specified to show the correlation of the error terms of education (Educ) and income (Income). The resulting modifications reduced the Chi-Square from 92 with 20 degrees of freedom to 21 with 15 degrees of freedom. Furthermore, the model chi-square, which is also referred to as
discrepancy or discrepancy function, changed from p=.000 to p=.306.
Overall, the revised model had improved goodness-of-fit. The revised model is shown below in Figure 9. The goodness-of-fit statistics for the original and revised models of HIV Risk can been seen below in Table 27.
Figure 8: Original measurement model of HIV Risk
Figure 9: Revised measurement model of HIV Risk
Table 27: Goodness of fit statistics for the original and revised models of HIV Risk

<table>
<thead>
<tr>
<th></th>
<th>Original</th>
<th>Revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-square (degrees of freedom)</td>
<td>92.161 (20)</td>
<td>21.571 (19)</td>
</tr>
<tr>
<td>Probability</td>
<td>.000</td>
<td>.306</td>
</tr>
<tr>
<td>Goodness of fit</td>
<td>.905</td>
<td>.974</td>
</tr>
<tr>
<td>Adjusted goodness of fit</td>
<td>.828</td>
<td>.951</td>
</tr>
<tr>
<td>Root mean square</td>
<td>.136</td>
<td>.026</td>
</tr>
<tr>
<td>Tucker-Lewis Index</td>
<td>.598</td>
<td>.985</td>
</tr>
</tbody>
</table>

Regression Weights for HIV Risk

The regression weights, and standardized regression weights for the revised model of HIV Risk are shown below in Tables 28 and 29. The unstandardized regression weights reflect the relationship between the latent predictor variable HIV Risk and the eight observed variables. Five coefficients, (GET, PIDU, INCOME, EDUC and PSTD) were statistically significant at 0.05 or
lower level and are positively associated with HIV Risk. The standardized path coefficients revealed that PIDU, MSM, and PSTD are the strongest predictors of HIV Risk in the population studied. Education and income were shown to be negatively associated with HIV Risk.
Table 28: Regression Weights for Revised measurement model of HIV Risk

<table>
<thead>
<tr>
<th>Path</th>
<th>Estimate</th>
<th>S.E.</th>
<th>C.R.</th>
</tr>
</thead>
<tbody>
<tr>
<td>STD &lt;--- HIV_Risk</td>
<td>0.089</td>
<td>0.054</td>
<td>1.634</td>
</tr>
<tr>
<td>Get &lt;--- HIV_Risk</td>
<td>0.071</td>
<td>0.034</td>
<td>2.092</td>
</tr>
<tr>
<td>Pidu &lt;--- HIV_Risk</td>
<td>0.922***</td>
<td>0.113</td>
<td>8.173</td>
</tr>
<tr>
<td>MSM &lt;--- HIV_Risk</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educ &lt;--- HIV_Risk</td>
<td>-0.581**</td>
<td>0.205</td>
<td>-2.833</td>
</tr>
<tr>
<td>Income &lt;--- HIV_Risk</td>
<td>-0.410*</td>
<td>0.199</td>
<td>-2.066</td>
</tr>
<tr>
<td>Anal &lt;--- HIV_Risk</td>
<td>0.046</td>
<td>0.046</td>
<td>0.996</td>
</tr>
<tr>
<td>Pstd &lt;--- HIV_Risk</td>
<td>0.808***</td>
<td>0.115</td>
<td>7.031</td>
</tr>
</tbody>
</table>

***p<.001, **p<.01, *p<.05 (two tailed)
<table>
<thead>
<tr>
<th>Variable</th>
<th>Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>STD &lt;--- HIV_Risk</td>
<td>.130</td>
</tr>
<tr>
<td>Get &lt;--- HIV_Risk</td>
<td>.166</td>
</tr>
<tr>
<td>Pidu &lt;--- HIV_Risk</td>
<td>.795</td>
</tr>
<tr>
<td>MSM &lt;--- HIV_Risk</td>
<td>.818</td>
</tr>
<tr>
<td>Education &lt;--- HIV_Risk</td>
<td>-.225</td>
</tr>
<tr>
<td>Income &lt;--- HIV_Risk</td>
<td>-.164</td>
</tr>
<tr>
<td>Anal &lt;--- HIV_Risk</td>
<td>.079</td>
</tr>
<tr>
<td>Pstd &lt;--- HIV_Risk</td>
<td>.567</td>
</tr>
</tbody>
</table>

Once measurement models were correctly specified, the full covariance structure model exploring the relationship between Intimate Partner Violence and HIV Risk was developed. The observed variable Coerce1 was used as a mediating variable between Intimate Partner Violence and HIV Risk. This was done, because, consistent with the Feminist theoretical framework used to guide this study, being in an abusive relationship affects the woman’s choice. This was captured in the variable COERC1 which measures Acts ranging from nonphysical forms of pressure that induce women to engage in sexual acts unwillingly, to
forced sex by partners. If women cannot control when sex occurs, it may place them at higher risk for HIV. The model also examined the relationship between HIV Risk and Intimate Partner Violence.

While some of the goodness-of-fit measurements indicated a good fit, the overall model was rejected as indicated by a significant chi-square result. As such, the model was trimmed. This was done by removing a non-significant indicator, receiving money or drugs for sex (GET). The revised model better fit the data as indicated by the non-significant chi-squared result. Other goodness-of-fit indices such as Tucker-Lewis Index (.995), GFI (.969), AGFI (.941) and RMSEA (.019) indicated a good fit. The original and revised models as well as the goodness-of-fit statistics for the original and revised models are shown below in Figures 10 and 11 and Table 23.
Figure 10: Original covariance structure model of HIV Risk and Intimate Partner Violence
Figure 11: Revised covariance structure model of HIV Risk, Sexual Coercion and Intimate Partner Violence
Table 30: Goodness of fit statistics for the original and revised covariance structure models of HIV, Sexual Coercion and Intimate Partner Violence

<table>
<thead>
<tr>
<th></th>
<th>Original</th>
<th>Revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-squared (degrees of freedom)</td>
<td>58.154 (38)</td>
<td>30.959 (29)</td>
</tr>
<tr>
<td>Probability</td>
<td>.019</td>
<td>.367</td>
</tr>
<tr>
<td>Goodness of fit index (GFI)</td>
<td>.948</td>
<td>.969</td>
</tr>
<tr>
<td>Adjusted goodness of fit index (AGFI)</td>
<td>.909</td>
<td>.941</td>
</tr>
<tr>
<td>Root mean square approximated (RMSEA)</td>
<td>.958</td>
<td>.019</td>
</tr>
<tr>
<td>Tucker-Lewis Index (TLI)</td>
<td>.052</td>
<td>.995</td>
</tr>
</tbody>
</table>

Regression Weights for the Covariance Structure Model of Intimate Partner Violence and HIV Risk

The regression weights for the relationship between Intimate Partner Violence and HIV Risk are shown below in Table 31. All coefficients except INCOME were shown to be
significant. Sexual coercion (COERC1) as a predictor of HIV Risk was shown to be significant at the p<.001 level, and HIV Risk as a predictor of Intimate Partner Violence was significant at the p<.05 level.

Table 31: Regression Weights for Revised covariance structure model of Intimate Partner Violence and HIV Risk

<table>
<thead>
<tr>
<th>Estimate</th>
<th>S.E.</th>
<th>C.R.</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hit&lt;--- IPV</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eabuse&lt;--- IPV</td>
<td>.864</td>
<td>.141</td>
<td>6.119 ***</td>
</tr>
<tr>
<td>Down&lt;--- IPV</td>
<td>.846</td>
<td>.123</td>
<td>6.880 ***</td>
</tr>
<tr>
<td>PSTD&lt;--- HIV_Risk</td>
<td>2.415</td>
<td>.423</td>
<td>5.708 ***</td>
</tr>
<tr>
<td>MSM&lt;--- HIV_Risk</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pidu&lt;--- HIV_Risk</td>
<td>.901</td>
<td>.119</td>
<td>7.592 ***</td>
</tr>
<tr>
<td>Educ.&lt;--- HIV_Risk</td>
<td>-1.030</td>
<td>.348</td>
<td>-2.961 **</td>
</tr>
<tr>
<td>Income&lt;--- HIV_Risk</td>
<td>-.590</td>
<td>.325</td>
<td>-1.815 .070</td>
</tr>
<tr>
<td>Fright&lt;--- IPV</td>
<td>.993</td>
<td>.119</td>
<td>8.339 ***</td>
</tr>
<tr>
<td>HIV_Risk&lt;--- Coercel</td>
<td>.329</td>
<td>.063</td>
<td>5.259 ***</td>
</tr>
<tr>
<td>Coercel&lt;--- IPV</td>
<td>.480</td>
<td>.152</td>
<td>3.146 **</td>
</tr>
<tr>
<td>IPV&lt;--- HIV_Risk</td>
<td>.321</td>
<td>.166</td>
<td>1.928 *</td>
</tr>
</tbody>
</table>

*** p<.001, ** p<.01, *p<.05
Table 32: Standardized regression weights of the revised model of Intimate Partner Violence, Sexual Coercion and HIV Risk

<table>
<thead>
<tr>
<th>Path</th>
<th>Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hit --- IPV</td>
<td>.839</td>
</tr>
<tr>
<td>Eabuse --- IPV</td>
<td>.499</td>
</tr>
<tr>
<td>Down --- IPV</td>
<td>.618</td>
</tr>
<tr>
<td>PSTD --- HIV_Risk</td>
<td>.979</td>
</tr>
<tr>
<td>MSM --- HIV_Risk</td>
<td>.472</td>
</tr>
<tr>
<td>Pidu --- HIV_Risk</td>
<td>.449</td>
</tr>
<tr>
<td>Educ --- HIV_Risk</td>
<td>-.230</td>
</tr>
<tr>
<td>Income --- HIV_Risk</td>
<td>-.136</td>
</tr>
<tr>
<td>Fright --- IPV</td>
<td>.792</td>
</tr>
<tr>
<td>HIV_Risk --- Coerce1</td>
<td>.655</td>
</tr>
<tr>
<td>Coerce1 --- IPV</td>
<td>.334</td>
</tr>
<tr>
<td>IPV --- HIV_Risk</td>
<td>.231</td>
</tr>
</tbody>
</table>
Hypothesis Testing Results

Hypothesis 1

The alternate hypothesis indicated that a positive relationship would exist between Intimate Partner Violence and Sexual coercion.

Bivariate correlation analyses of the variables measuring intimate partner violence and sexual coercion were performed to examine their relationship. Bivariate analysis determines both whether a relationship is likely to exist and also the level of influence that one variable has on another (Singleton & Strait, 1999). Levels of correlation are usually interpreted as being large or strong if they are greater than .50, moderate or medium between .30 and .49, and low or weak between .1 and .29 (Cohen, 1988).

The correlation matrix shown in Table 33 below reveals a strong correlation exists between at least one measure of sexual coercion, and frequency of physical abuse, which is labeled, PABUSE (.52) and frequency of feeling frightened by what a partner says, which is labeled FRIGHT (.50). Moderate levels of correlations were revealed between sexual coercion and the frequency of being emotionally abused, EABUSE (.397), the
frequency with which an argument results in being down, DOWN (.398) and the frequency of an argument results in hitting, kicking or pushing, HIT (.454).

Additionally, the statistically significant standardized regression weight of Intimate Partner Violence on sexual coercion is .334 (p<.01) indicates that for each standard deviation that Intimate Partner Violence increases, sexual coercion also increases by .334 standard deviations.

**Hypothesis 2**

The alternate hypothesis indicated that a positive relationship exists between sexual coercion and HIV Risk.

Results of bivariate correlation analyses and structural equation modeling supported this hypothesis. The standardized regression weight of .655 (p<.001) indicates that for each standard deviation that sexual coercion increases, HIV risk also increase by .655 standard deviation. Standardized regression weights are listed above in Table 25.

Bivariate correlation analyses were conducted for sexual coercion and HIV risk. The following results were shown:

The variable COERCE1, individuals who engaged in sex because their partner threatened to leave them otherwise, was
shown to be moderately correlated (.300) at the p<.01 level, to having a partner who uses intravenous drugs (PIDU). Moderate positive correlations were also found between COERCE1 and MSM—men who have sex with men (.325), PSTD—partners with a sexually transmitted disease (.371).

The variable COERCE 2, individuals who have sex with their partners because the partners threatens to use force if they do not, was shown to be moderately correlated to PSTD (.377, p<.01). Weak correlations also exist between COERCE 2 and PIDU (.275, p<.01), MSM (.263, p<.01), and IDU (.169, p<.01).

The variable COERCE 3, individuals who engage in oral or anal sex with a partner, even they do not want to, because partners use or threaten to use force, was to be moderately correlated to the variables PIDU (.415, p<.01) and PSTD (.358, p<.01). Weak correlations also exist between COERCE 3 and the variables IDU (.166, p<.01) and MSM (.293, p<.01).

Sexual coercion was also found to have moderate to high levels of correlation with the ability to negotiate condom use. Women who reported that they engaged in sexual activities with their partner even though they didn’t want to, because he threatened to end the relationship otherwise (COERCE 1) was shown to be moderately correlated to being afraid to ask partner to use a condom for fear he would leave (FEARASKL, .411) and
being afraid to ask partner to use a condom because of being afraid he may hit (FEARASKH, .407). The variable COERC3, women who report engaging in sexual intercourse with partner, even without wanting to, because he threatened to hit them otherwise, was highly correlated to being afraid to ask partner to use a condom for fear that he may leave (FEARASKL, .517), and fear that he might hit (FEARASKHIT, .669). Finally, engaging in oral or anal intercourse, because of the threat or use of force by partner (COERC3) is highly correlated to FEARASKL (.607) and FEARASKH (.694). Correlation coefficients for sexual coercion and inability to negotiate condom use are statistically significant at the p<.01 level.
Table 33: Correlation matrix for the variables measuring IPV, sexual coercion and ability to negotiate condom use

<table>
<thead>
<tr>
<th></th>
<th>Hit</th>
<th>Pabuse</th>
<th>Eabuse</th>
<th>Coerce1</th>
<th>Coerce2</th>
<th>Coerce3</th>
<th>Fearask1</th>
<th>Fearaskh</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hit</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pabuse</td>
<td>.756**</td>
<td>1.000</td>
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<tr>
<td>Coerce1</td>
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<td>.524**</td>
<td>.397**</td>
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<tr>
<td>Coerce2</td>
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<td>.522**</td>
<td>.349**</td>
<td>.550**</td>
<td>1.000</td>
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<tr>
<td>Coerce3</td>
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<td>.411**</td>
<td>.300**</td>
<td>.567**</td>
<td>.707**</td>
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<tr>
<td>Fearask1</td>
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<td>.255**</td>
<td>.183**</td>
<td>.411**</td>
<td>.517(**)</td>
<td>.607**</td>
<td>1.000</td>
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<tr>
<td>Fearaskh</td>
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<td>.410**</td>
<td>.276**</td>
<td>.407**</td>
<td>.669**</td>
<td>.694**</td>
<td>.431**</td>
<td>1.000</td>
</tr>
</tbody>
</table>

**p<.01
Hypothesis 3

The alternate hypothesis indicated that a positive relationship would exist between Intimate Partner Violence and HIV Risk.

Results of bivariate correlation analyses and structural equation modeling reveal that a positive correlation exists between Intimate Partner Violence and HIV risk. The standardized regression weight of .231 (p<.05) indicates that for each standard deviation that sexual coercion increases, HIV risk also increase by .231 standard deviation. Standardized regression weights are listed above in Table 25.

Bivariate correlations reflect that there is a moderate correlation between the variables PABUSE (physical abuse) and PSTD (.389), MSM (.308) and being afraid to ask partner to use a condom because of fear of being hit (FEARASKH, .410). Low positive correlations also exist between PABUSE and the variables PIDU (.286) and being afraid to ask partner to use a condom because of fear that partner will end relationship (FEARASKL, .255).

The variable FRIGHT (feeling frightened by what partner says or does) was shown to have a moderate positive correlation to the variables PSTD (.394), and FEARASKH (.395). FRIGHT also
has a low correlation to MSM (.278), FEARASKL (.293) and PIDU (.298). All correlations are significant at the p<.01 level.

The variable HIT (arguments resulting in hitting, kicking or pushing) was shown have a moderate positive correlation to PTSD (.346) and a low correlation PIDU (.286), MSM (.271) and IDU (.137). Correlations are significant at the p<.01, level.

The variable EABUSE (emotional abuse) was shown to have small positive correlations with FEARASKL (.183), PIDU (.207), PTSD (.236), MSM (.251), and FEARASKH (.276). Correlations are significant at the p<.01, level.

**Hypothesis 4**

The alternate hypothesis indicated that the frequency of abuse would impact HIV Risk.

Analysis of variance was conducted to explore this hypothesis. A test of homogeneity of variances revealed that the groups were heteroscedastic. Post Hoc multiple comparisons were conducted. Tamhane’s post hoc statistics revealed that women who reported that they SOMETIMES had arguments that resulted in being hit, kicked, or pushed (HIT) were more likely to be sexually coerced (COERCE 1) than women who reported that...
they NEVER had arguments that result in being hit, kicked or pushed. Results were significant at the p<.001 level.

Similarly, women who reported that they SOMETIMES have arguments that result in being hit kicked or pushed (HIT) were more likely to have a partner with an STD (PSTD, p<.01), a partner who uses intravenous drugs (PIDU, p<.05) or a partner who is a man who has sex with other men (MSM, p<.01) than women who report that their arguments NEVER result in being hit, kicked or pushed. Finally, women who reported that arguments OFTEN result in hitting, kicking or pushing, were more likely to have a partner who uses intravenous drugs (PIDU, p<.05) or a partner who is a man who has sex with other men (MSM, p<.01) than women who report that their arguments NEVER result in being hit, kicked or pushed.

**Hypothesis 5**

The alternate hypothesis indicated that there is a correlation between being in abusive relationships and the ability to negotiate condom use.

Bivariate correlations reflect that there is a moderate correlation between the variables FRIGHT (being frightened by what partner says or does) and being afraid to ask partner to
use a condom because of fear that he will hit (FEARASKH, 395, p,.001), physical abuse (PABUSE, .410, p<.001) and arguments that result in hitting, kicking or pushing (HIT, .371, p<.01). FEARASKH was also shown to have a small correlation with the variables with have arguments that lead to feeling down or bad about oneself (DOWN, .241, p<.001) and frequency of emotional abuse (EABUSE, .276, p<.01).

The variable FEARASKL (being afraid to ask partner to use a condom because of fear that he may leave) was shown to have a small correlation with FRIGHT (.293, p<.001), DOWN (.245, p<.001) PABUSE(.255, p<.001), EABUSE (.183, p<.01) and HIT (.201, p<.01). Additionally, as mentioned in hypothesis 2, sexual coercion, is highly correlated to inability to negotiate condom use.
The HIV/AIDS epidemic continues to be a health emergency for African Americans (Anderson & Smith, 2005). Evidence of health disparities can be seen no more evidently than in the incidence and prevalence of HIV/AIDS in African Americans. The Centers for Disease Control reports that African Americans are the most severely impacted of all the racial/ethnic groups from diagnosis until death.

While many risk factors and barriers to prevention of HIV transmission are known, this is not true of the relationship between Intimate Partner and HIV Risk. This chapter summarizes the findings of a research which was designed to explore such a relationship. Limitations of the study are presented. In addition, suggestions for future research are provided and the potential implications in HIV research and prevention are examined.

The purpose of this study was to explore the relationship between Intimate Partner Violence and HIV Risk Propensity. Participants in of this research were adult African American females with varied history of intimate partner violence. The feminist theoretical framework was used to guide the study, and
provided a framework for the examination of the relationship between Intimate Partner Violence on HIV-Risk.

Data were collected from various community based settings in Orange County, Florida. Surveys were completed by 200 African-American women who utilized Neighborhood Centers for Families. One hundred and ninety seven surveys were included in the analysis, after hand-written comments on three of the surveys indicate that they did not meet the survey criteria.

While attempts to reduce the rate of infections in other high risk groups have been somewhat successful, the infection rates continue to rise in African American females. Many factors contribute to the elevated rates. These include stigma associated with HIV in the black community, and the concept of the down-low (double-lives of African-American men who pose as heterosexuals while secretly engaging in sex with other men). Other factors that affect the disparity rates include poverty, lack of access to care, and unwillingness to seek care due to the distrust of the health care system.
Hypotheses

Table 34 describes the results of the hypotheses tested in this study. The primary purpose of this research was to test the alternate hypothesis one (1). Alternate hypotheses two (2) through five (5) provide additional evidence to support alternate hypothesis one (1).

Table 34: Summary of Hypothesis Testing Results

<table>
<thead>
<tr>
<th>Alternate Hypotheses</th>
<th>Significant</th>
</tr>
</thead>
<tbody>
<tr>
<td>$H_{a1}$ A positive relationship exists between Intimate Partner Violence and Sexual Coercion.</td>
<td>Yes</td>
</tr>
<tr>
<td>$H_{a2}$ A positive relationship exists between Sexual Coercion and HIV Risk.</td>
<td>Yes</td>
</tr>
<tr>
<td>$H_{a3}$ A positive relationship between Intimate Partner Violence and HIV Risk</td>
<td>Yes</td>
</tr>
<tr>
<td>$H_{a4}$ A positive relationship exists between the frequency of abuse and HIV Risk.</td>
<td>Yes</td>
</tr>
<tr>
<td>$H_{a5}$ An inverse relationship exists between Intimate Partner Violence and the ability to negotiate condom use.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Hypothesis 1

A strong positive correlation was found between sexual coercion and frequency of physical abuse as well as between sexual coercion and feeling frightened by what a partner says or does. Medium or moderate levels of positive correlations were also found to exist between sexual coercion and the frequency of being emotionally abused, the frequency an argument results in being down, and the frequency of an argument results in hitting, kicking or pushing. Additionally, statistically significant standardized regression weight revealed that as Intimate Partner Violence increases, sexual coercion also increases.

Hypothesis 2

A positive correlation was found to exist between sexual coercion and HIV risk. A statistically significant standardized regression weight indicated that HIV risk increases with increased sexual coercion. Specifically, individuals who engaged in sex, because their partner threatened to leave them if they did not, were shown to be moderately correlated having a partner who uses intravenous drugs, being in a relationship with
men who have sex with men, and having a partner with sexually transmitted disease(s).

Additionally, individuals who have sex with their partners because the partners threaten to use force if they do not, was found to be moderately correlated to having a partner who has sexually transmitted diseases. Weak correlations were also revealed between individuals who have sex with their partners because the partners threatens to use force if they do not and having a partner who is an intravenous drug user or a man who has sex with men.

Individuals who engage in oral or anal sex with a partner, even they do not want to, because the partner uses or threatens to use force, was to shown to be moderately correlated to the having a partner who uses intravenous drug user, and having a partner with sexually transmitted diseases. Weak correlations also exist between individuals who are coerced into oral or anal sex with a partner, and having a partner who is man who has sex with other men.

Finally, sexual coercion was also found to be moderately or highly correlated to the ability to negotiate condom use. More specifically, being coerced into engaging in vaginal or oral/anal intercourse with a because the partner threatened to end the relationship if they didn’t, was shown to be moderately
correlated with being afraid to ask the intimate partner to use a condom for fear that the partner might leave or might hit. Additionally, being coerced into engaging in vaginal or oral/anal intercourse with a because the partner threatened to hit them if they didn’t, was found to be highly correlated to being afraid to ask the intimate partner to use a condom for fear of being hit.

**Hypothesis 3**

A positive correlation was found between Intimate Partner Violence and HIV risk. Bivariate correlations revealed a moderate correlation between the variables physical abuse, having a partner with STDs, having a partner who is a man who has sex with other men, and being afraid to ask partner to use a condom because of fear of being hit. A small positive correlation was also found between physical abuse, having a partner who uses intravenous drugs and being afraid to ask partner to use a condom because of fear that partner will end relationship.

Feeling frightened by what partner says or does was shown to have a moderate positive correlation to being afraid to ask partners to use a condom for fear of being hit.
Hypothesis 4

Women who reported that they sometimes had arguments that result in being hit, kicked, or pushed were statistically more likely to be sexually coerced than women who reported that they never had arguments that result in being hit, kicked or pushed.

Similarly, women who reported that they sometimes have arguments that result in being hit kicked or pushed were statistically more likely to have a partner with an STD, a partner who uses intravenous drugs, or a partner who is a man who has sex with other men than women who report that their arguments never result in being hit, kicked or pushed.

Finally, women who reported that their arguments often result in hitting, kicking or pushing, were statistically more likely to have a partner who uses intravenous drugs or a partner who is a man who has sex with other men than women who report that their arguments never result in being hit, kicked or pushed.
Hypothesis 5

A moderate correlation was found to exist between women who reported being frightened by what partner says or does and (1) being afraid to ask a partner to use a condom because of fear that he will hit, (2) physical abuse, and (3) arguments that result in hitting, kicking or pushing.

Small levels of correlation were also found between women who are afraid to ask their partner to use a condom for fear of being hit and having arguments that lead to feeling down or bad about oneself and frequency of emotional abuse. Likewise, being afraid to ask partner to use a condom because of fear that he may leave was shown to have a small correlation with (1) women who reported that they were frightened by the things their partners say or do, (2) having arguments that lead to feeling down or bad about themselves, (3) physical abuse, (4) emotional abuse, and (5) frequency that arguments result in hitting, kicking or pushing. Additionally, as mentioned in hypothesis 2, sexual coercion, is highly correlated to inability to negotiate condom use.
Results Examined from the Feminist Perspective

The feminist perspective stresses that male dominance often prevents women from taking control of their own bodies, and that men use fear to control women’s behavior (Yodanis, 2004). Women’s position in society, as well as their access, is interrelated to the levels of sexual violence against them (Ibid). As such, the findings of this study are not surprising. The fear, restriction of the potentially life-saving choice of using a condom, and sexual coercion would be explained by the feminist perspective as various ways in which power and control are exerted over women in abusive relationships. Loss of power and control in a relationship may have far reaching public health implications, because battered women often do not have the option to utilize one of the most effective HIV-prevention tools: requesting the use of a condom.

Limitations

The limitations of the study include the non-representative volunteer nature of the sample. The study utilized self-administered surveys which asked several questions of a sensitive nature. As a result, social desirable answers may have been provided. The social desirability effect is the
tendency of some respondents to lean their answers in a direction which is more accepted by society either to make a favorable impression on the researcher or to enhance their feelings about themselves (Singleton & Straits, 1999). This would have lead to under-reports of the actual occurrence of physical abuse, emotional abuse, sexual coercion, substance abuse and other risk behaviors.

Other limitations include the fact that the study sample may not be representative of the African American population at large. As such, external validity may be limited. Nevertheless, this research was able to get a wide array of women, from different ethnic groups, with different levels or income and education.

**Implications for Practice**

Despite the limitations mentioned, the findings of this study have significant implications for fields such as Social Work and Counseling, Criminal Justice, Health Services and Public Administration.
Social Work and Mental Health

Social Workers and Mental Health Professionals provide services on both prevention and treatment sides of HIV and Intimate Partner Violence. As such, the results of this study have important implications for their work.

HIV prevention methods have principally focused on two areas, consistent and correct condom use and mutual monogamy. In cases where Intimate Partner Violence occurs, women usually are stripped of the authority to make safe-sexual decisions. Social Workers, Mental Health Counselors, victim advocates and other social service providers in all practice settings should recognize the correlation between Intimate Partner Violence on HIV-risk. Social service providers should remain cognizant of the numerous barriers (sexual coercion, reduced ability to negotiate condom use etc.) that victims of Intimate Partner Violence experience when trying to protect themselves from HIV and other sexually transmitted infections.

Information on HIV/AIDS should become a standard part of the psycho-educational information provided to women in battered women shelters and women who seek counseling in private settings for relationship-issues. All social service providers, particularly ones who do not specialize in providing services to
battered women, should be aware that women who are in violent relationships do not always admit that they are being battered. These women may speak of the high (1) levels of tension in the relationship, (2) the level of difficulty working out arguments, or (3) feeling frightened by what a partner says. The three variables just mentioned were shown in this study to be highly correlated with experiencing physical abuse. It is imperative that HIV prevention services become entrenched in wider range of social services, and not be quarantined to HIV prevention programs or community clinics.

HIV-risk assessments should become standard part of the intake/screening and comprehensive assessments typically completed prior to social service provision. In addition, facilities focusing on the prevention and treatment of HIV, should conduct assessments of Intimate Partner Violence, and elevate the HIV-risk scores for battered women.

**Criminal Justice**

As with HIV/AIDS, minorities are disproportionately represented in the populations of jails and prisons. Between 1990 and 2005, African-Americans were almost three times more likely than Hispanics and five times more likely than Caucasians
to be in jail and more than 2.5 times more likely than Hispanics and almost 7 times more likely than Caucasians to be imprisoned (Bureau of Justice Statistics, 2006). Women belonging to racial and ethnic minority groups make up 60 percent of the female incarcerated population (Bureau of Justice Statistics, 2005).

The high rates of turnover in jails, and the fact that prevalence of HIV prevalence among the incarcerated population (2.0%) is almost five times greater than for the general U.S. adult population (0.4%) create a hazardous public health situation in jails, prisons and other correctional facilities in the United States (CDC, 2006).

In light of these facts, and the results of this research project, there are some implications for practice for the field of Criminal Justice. Due to the captive nature of the audience, correctional facilities could provide an ideal location for HIV-prevention education and HIV-treatment. Because of the general distrust of the “system”, information provided to incarcerated individuals by employees at the institutions may not be trusted (Kantor, 2006). As such, trustees (incarcerated individuals who are not recognized as a threat and are given some level of responsibility within correctional institutions) can be taught a fairly simple curriculum on the relationship between Intimate Partner Violence and HIV Risk. These individuals can then
impart such information in groups which they co-lead. In addition, correctional institutions which provide individual counseling to the inmate population should also provide information on HIV and Intimate Partner Violence. Finally, discharge planners at correctional facilities should become more aware of services available to inmates once they are released from jail or prison.

Other implications for the field of Criminal Justice include the possibility of having law enforcement agents include information on HIV in a packet of information on family violence. Such a packet could be provided to the victim of Intimate Partner Violence any time an officer responds to a call.

**Health Services**

In September 2006, the Centers for Disease Control and Prevention released the *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings*. For patients in all health-care settings, including correctional health-care facilities, the CDC stated that HIV-screening of all patients is recommended after the patient is notified that testing will be performed unless the patient
refuses. In addition general consent for medical care is sufficient to include consent for HIV testing. These guidelines could create an avenue to conducting additional HIV tests. Information on the relationship between Intimate Partner Violence and HIV could be provided to those who are given an HIV test either at the time of the test or at the time the results are provided.

Hospitals, primary care practitioners and community health centers could systematically conduct screenings for Intimate Partner Violence in their facilities. Individuals with elevated risk factors should be provided with information about HIV prevention.

**Public Administration and Policy**

The response to the HIV/AIDS epidemic to date has been fragmented and ineffective. The United States is in great need of a sensible HIV prevention policy that would mandate all states to provide prevention programs in a balanced way. While past prevention efforts have been effective, and have helped to slow the spread of HIV overall, increased complacency leads to high-risk behaviors. A national coordinated response to HIV is warranted because prevention is by far the most sensible and
economical solution. The Centers for Disease Control estimates that “if only 1,255 infections are prevented each year, CDC’s federally funded prevention efforts in the United States are cost effective. If only, 3,955 infections are prevented, our nation’s investment in HIV prevention has actually saved money” (CDC; 1998).

The results of this research reiterate that importance of recognizing and addressing gender-related issues in HIV prevention education. Policies need to be developed on the national, state and organizational levels to address these correlated issues. Additionally, more prophylactic options should be developed for and marketed to women.

Another implication for public administration and policy is the need to develop culturally competent HIV-prevention strategies. It is very important to recognize that a one-size-fits-all approach to HIV prevention is not ideal. For programs to be effective, they have to be tailored to the needs of the target group. Ignorance, prejudice, fear, stigma, and discrimination continue to claim lives.
Suggestions for Future Research

Understanding the cultural factors that impact the spread of HIV is vital to the developing culturally competent intervention and prevention strategies. Culturally competent services are critical in the quest to reduce health disparities. As such, future research needs to more closely examine the within group differences in the rates of infection in the black community. The African-American community of females is not a homogenous group. It is comprised of women from a variety of backgrounds and cultures, including native born black Americans, Jamaicans, Trinidadians and other West Indians, Africans, Guyanese and Black Hispanics from Cuba, Dominican Republic, and numerous others who have immigrated to the United States. Differences in the modes of infection and the need for different intervention and prevention methods may be realized if cultural factors that impact disease transmission are identified. Demographic information should be broken down further than African-American. This research was a step in that direction.

Future research should also couple quantitative and qualitative techniques to further tease out information to improve treatment and prevention. On the surveys that were completed, some women chose to add unsolicited hand-written
comments. While they may have been more inclined to add comments due to the anonymous nature of the survey, perhaps a highly structured confidential interview could be beneficial. Additionally, women from a wider geographical region, including rural areas should be included in the study to further enrich the quality of the data.

The descriptive statistics from this research project revealed that an alarming amount of the women surveyed did not know the status of their partner’s drug use, sexually transmitted diseases and sexuality. In fact 17.3% of the respondents did not know if their partner injects street drugs with a needle, 13.2% did not know if their partners have STDs and almost 20% did not know if their partner is a man who has sex with other men. Lack of knowledge of a partner’s risk factor can be of tremendous detriment and is a major barrier to the prevention of HIV.

Of particular interest is the fact that the participants had different responses when asked about the frequency with which arguments result in hitting, kicking or pushing, and when asked about the frequency of physical abuse. Thirty-one percent (31%) of the women surveyed indicated that their arguments sometimes or often result in hitting, kicking, or pushing, as compared to 25.4% who reported that they are being physically
abused sometimes or often. This may have implications in the way questionnaires are developed, or questions are posed to women. It could be that women may be less likely to report being physically abused, because of social desirability issues, because physical abuse sounds more serious than hitting, kicking or pushing, or because they don’t understand the definition of physical abuse. Additionally, since the questions do not ask who initiates the hitting, kicking or pushing, it could be that some females are physically abusive to their male partners. Qualitative research could assist in elucidating the reasons for the differences.

**Conclusion**

This study adds to the body of knowledge about HIV and Intimate Partner Violence by highlighting a variety of ways in which IPV intertwines with the HIV epidemic. Fear of abandonment and violence were shown to impact women’s ability to negotiate condom-use. Additionally, violence perpetrated against women by their intimate partners was shown to impact sexual decision-making, free-choice, and ultimately increase HIV-risk factors.
The power and control exerted by men who batter their female partners permeates all aspects of the relationship and has devastating psychological and physical consequences including potentially increasing the risk of transmitting HIV.
APPENDIX A: IRB APPROVAL LETTER
March 15, 2006

Lauren Josephs
Orlando, Fl.

Dear Ms. Josephs:

With reference to your protocol #06-3353 entitled, "Exploring the Relationship between Intimate Partner Violence and HIV-Risk Propensity in African-American Women," I am enclosing for your records the approved, expedited document of the UCFIRB Form you had submitted to our office. This study was approved on 3/15/06. The expiration date will be 3/14/07. Should there be a need to extend this study, a Continuing Review form must be submitted to the IRB Office for review by the Chairman or full IRB at least one month prior to the expiration date. This is the responsibility of the investigator. Please notify the IRB office when you have completed this research study.

Please be advised that this approval is given for one year. Should there be any addendums or administrative changes to the already approved protocol, they must also be submitted to the Board through use of the Addendum Modification Request form. Changes should not be initiated until written IRB approval is received. Adverse events should be reported to the IRB as they occur.

Should you have any questions, please do not hesitate to call me at 407-823-2901.

Please accept our best wishes for the success of your endeavors.

Cordially,

Barbara Ward
Barbara Ward, CIM
UCF IRB Coordinator
FWA00000351 Exp. 5/13/07, IRB00001138

Copies: IRB File
Eileen Abel, Ph.D.
Jana Jasinski, Ph.D.
Aurora Liberman, Ph.D.
Mary Van Hook, Ph.D.

BW:jm

12443 Research Parkway • Suite 302 • Orlando, FL 32826-3252 • 407-823-3778 • Fax 407-823-3295
Equal Opportunity and Affirmative Action Institution
THE UNIVERSITY OF CENTRAL FLORIDA
INSTITUTIONAL REVIEW BOARD (IRB)

IRB Committee Approval Form

PRINCIPAL INVESTIGATOR(S): Eileen Abell, Ph.D., #06-3353
Lauren Josephs, Jana Jasinski, Ph.D.,
Aaron Liberman, Ph.D., and Mary Van Hook, Ph.D.


[X] New project submission
[ ] Continuing review of lapsed project #
[ ] Study expires
[ ] Initial submission was approved by expedited review
[ ] Initial submission was approved by full board review but continuing review can be expedited
[ ] Suspension of enrollment email sent to PI, entered on spreadsheet, administration notified

Chair
[X] Expedited Approval

Dated: 3/15/2006
Signed:
Dr. Sophia Dziegledowski, Vice-Chair

[ ] Exempt

Dated: 3/15/2006
Signed:
Dr. Jacqueline Byers, Chair

Signed:
Dr. Tracy Dietz, Designated Reviewer

IRB Reviewers:

Complete reverse side of expedited or exempt form

[X] Waiver of documentation of consent approved
[ ] Waiver of consent approved
[ ] Waiver of HIPAA Authorization approved

NOTES FROM IRB CHAIR (IF APPLICABLE): Waiver of documentation of consent approved with clarification:
Sensitive population/Issues:
Informed Consent

You are being asked to participate in an anonymous survey. You will receive a $10 gift-card upon completion of the survey.

- This survey is completely voluntary. **You may choose not to participate or not to answer any specific questions.** You may skip any question you are not comfortable answering. There are no anticipated risks.
- **Do not take this survey if you are under the age of 18.**
- The survey is anonymous and many of the questions are personal in nature. **Do NOT include your name on the survey**
- This study examines relationship status and how it affects what you do to protect yourself from HIV. The information will be used to evaluate the effectiveness of current programs prevention activities and to improve prevention programs for African American women.
- **Please answer questions honestly.**
- The survey will take approximately **10 -15 minutes** to complete.
- The results of this study may be published. However, the data obtained from you will be combined with data from others in the publication. The published results will not include your name or any other information that would personally identify you in any way.
- **If you have any questions about this survey, please contact me** at (407) xxx-xxxx or at Loyjay@aol.com or my supervisor Dr. Eileen Abel at (407) 823-3967 or Eabel@mail.ucf.edu.
- Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board (IRB). Questions or concerns about research participants’ rights may be directed to UCF Institutional Review Board Office at the University of Central Florida, Office of Research and Commercialization, 12443 Research Parkway, Suite 302, Orlando, FL 32826-3252. The phone numbers are 407-823-2901 or 407-882-2276.

Thank you for taking the time and thought to complete this survey. We sincerely appreciate your participation. Your time and effort in helping us gather information is greatly appreciated.

Sincerely,
Lauren Josephs, Ed.S, LMHC
Licensed Mental Health Counselor
APPENDIX C: WOMAN ABUSE SCREENING TOOL (WAST)
Woman Abuse Screening Tool (WAST)

1. In general, how would you describe your relationship?
   ____ A lot of tension
   ____ Some tension
   ____ No tension

Coding Scheme [no tension = 0; some tension =1; a lot of tension =2]

2. Do you and your partner work out arguments with:
   ____ Great difficulty?
   ____ Some difficulty?
   ____ No difficulty?

Coding Scheme [no difficulty = 0; some difficulty =1; a lot of difficulty =2]

3. Do arguments ever result in you feeling down or bad about yourself?
   ____ Often
   ____ Sometimes
   ____ Never
Coding Scheme questions 3-7 [Never = 0; Sometimes =1; Often =2]

4. Do arguments ever result in hitting, kicking or pushing?
   __ Often
   __ Sometimes
   __ Never

5. Do you ever feel frightened by what your partner says or does?
   __ Often
   __ Sometimes
   __ Never

6. Has your partner ever abused you physically?
   __ Often
   __ Sometimes
   __ Never

7. Has your partner ever abused you emotionally?
   __ Often
   __ Sometimes
   __ Never
HIV Risk Screening Instrument-Revised

1. Have you had 2 or more sexual in the past 6 months?
   - Yes
   - No

Coding Scheme questions 1, 2, 4-10 [No=0; Yes=1; Don’t know=2]

2. Have you had anal sex (a man puts his penis into the anus of another person) with any of your sexual partners during the past 6 months?
   - Yes
   - No

3. How often have you used a condom when having anal sex in the past 6 months?
   - Never
   - Sometimes
   - Always
   - Have not had anal sex

Coding Scheme [Never=2, Sometime=1, Always/ Not had anal sex=0]

4. In the last 6 months, have you had a sexually transmitted disease such as gonorrhea, syphilis, chlamydia, genital warts, or genital herpes?
   - Yes
   - No
5. In the last six months have you given money or drugs to anyone to have sex with you?
   Yes
   No

6. Have you ever had sex with someone so that they could give you money or drugs?
   Yes
   No

7. Have you ever injected street drugs, steroids, or vitamins with a needle?
   Yes
   No

8. Have any of your sexual partners in the past 6 months ever injected street drugs, steroids or vitamins with a needle?
   Yes
   No
   Don’t Know

9. Have any of your sexual partners in the past 6 months been men who have had sex with other men?
   Yes
   No
   Don’t Know
10. Have any of your sexual partners in the past 6 months ever had a sexually transmitted disease, such as gonorrhea, syphilis, chlamydia, genital warts, or genital herpes?

Yes

No

Don’t Know
Questions to be taken from the Sexual Experiences Survey

Please answer YES or NO to the following questions

Have you ever:

1. Have you ever had sexual intercourse with your partner even though you really didn’t want to because he threatened to end your relationship otherwise?

2. Have you ever had sexual intercourse with your partner when you didn’t want to because he threatened to use physical force (twisting your arm, holding you down etc.) if you didn’t cooperate?

3. Have you ever been in a situation where your partner obtained sexual acts with you such as anal or oral intercourse when you didn’t want to by using threats of physical force (twisting your arm, holding you down etc.)?

Coding Scheme: [No=0; Yes=1]
APPENDIX F: QUESTIONS FROM KALICHMAN ET. AL (1998)
Questions from Kalichman et. al (1998)

1. Would you be afraid to ask your partner to use a condom because you are afraid he might leave you?

2. Would you be afraid to ask your partner to use a condom because you are afraid he might hit you?

Coding Scheme: [No=0; Yes=1]
APPENDIX G: DEMOGRAPHIC QUESTIONS
Demographic Questions

1. How would you describe your racial/ethnic group?
   - Black
   - White
   - Asian/Pacific Islander
   - Native American
   - Other (Please specify___________________)

2. To which cultural group do you belong?
   - Haitian
   - Jamaican
   - African-American
   - Other (Please list__________________)

3. What is your highest level of education
   - Less than high school
   - High School
   - Some college
   - College Graduate
   - Some Graduate School
   - Graduate Degree Earned

4. What is your current employment status
   - Currently unemployed but seeking employment
Currently unemployed not seeking employment

Employed Part-time

Employed Full-time

5. How many children do you have?

6. What is your current income

Under $5000

$5001-$15,000

$15,001-$25,000

$25,001-$35,000

Above $35,000

7. Have you ever taken an HIV test?

Yes

No

8. IF you have taken an HIV test what was the result

I am HIV-Negative (I don’t have the virus)

I am HIV-Positive (I have the virus)
APPENDIX H: LETTER OF SUPPORT (CITIZEN’S COMMISSION FOR CHILDREN)
Lauren,

I am happy to report that you have the support of the Citizens’ Commission for Children to recruit participants for your project. Additionally, however, our Deputy Department Director also suggested that you should contact Syd McCallister, Health and Family Services Administrator with the Ryan White Title 1 Office. Syd is also very interested in your research and may have some additional suggestions in recruiting participants from the agencies with which he works. Syd’s office number is 407-897-6394 and his email address is syd.mccallister@ocfl.net.

Please feel free to contact me when you are ready to begin reaching out to the NCFs. I would like to have a brief meeting with the appropriate Neighborhood Coordinators in order to ensure that we are all on the same page with the recruitment procedures to be utilized. I look forward to working with you.

Jennifer Grant  
Director of NCF Programming  
Citizens’ Commission for Children  
407-836-7686

-----Original Message-----
From: Loyjay@aol.com [mailto:Loyjay@aol.com]  
Sent: Monday, October 10, 2005 12:25 AM  
To: Grant, Jennifer  
Cc: eabel@mail.ucf.edu  
Subject: Request for use of NCF

Dear Ms. Grant:

This email will serve as a follow-up to the conversation we had last week. I am currently a doctoral candidate in the College of Health and Public Affairs at the University of Central Florida. As a part of my degree requirements, I will be conducting a research project to explore the relationship between Intimate Partner Violence and HIV-Risk Propensity in African American women. This research project will be monitored by Eileen Abel, Ph.D. (dissertation chair) Aaron Liberman, Ph.D. (committee member) Jana Jasinski, Ph.D. (committee member) and Mary Van Hook, Ph.D. (committee member), and will be reviewed by the University of Central Florida's Institutional Review Board.

I am hoping to utilize the Neighborhood Centers for families located in areas with a high percentage of Black/African-American individuals to recruit participants for this project. A nominal fee will be paid to each woman who meets the requirements, (African American female over 18 years old), and completes a 20-30 minute survey. The NCF’s which have been identified as possible sites for recruitment of participants include Ivey Lane, Tangelo Park, and Eatonville.

As a Licensed Mental Health Counselor, I am well aware of issues related to confidentiality, and will guarantee confidentiality to all research participants. In accordance with the Institutional
Review Board of the University of Central Florida, informed consent will be obtained from all who agree to participate. To protect the identity of the participants no identifying information will be required.

I would welcome an opportunity to discuss this issue with you in further detail. If you would like a more formal presentation, please let me know. I will gladly answer any questions about the specifics of this project, including significance of the study, rationale, theoretical framework and research methodology if required.

Thank you very much for your consideration of this matter.

Sincerely,

Lauren Josephs
APPENDIX I: APPROVAL TO USE QUESTIONS FROM KALICHMAN ET. AL
yes.. use and adapt whatever you like from our work.
best of luck
sck
Yes you have my permission. I wish you very good luck with your dissertation. It sounds like a very important investigation.

Mary

Mary P. Koss, Ph.D.
Professor and Principal Investigator, RESTORE Program
Mcl and Enid Zuckerman College of Public Health
University of Arizona
1632 E. Lester Street
Tucson, AZ 85719
voice: 520-626-9502 fax: 520-626-9515
http://restoreprogram.publichealth.arizona.edu

From: Loyjay@aol.com [mailto:Loyjay@aol.com]
Sent: Monday, March 13, 2006 3:22 AM
To: mpk@u.arizona.edu
Subject: Requesting permission to use questions from the SES
Dear Dr. Koss,

My name is Lauren Josephs and I am a doctoral candidate at the University of Central Florida. I am writing to request permission to use three questions from The Sexual Experiences Survey (Koss, Gidycz, & Wisniewski, 1987) in my dissertation research. The questions are as follows:

1. Have you ever had sexual intercourse (anal or vaginal sex) with your partner even though you really didn't want to because he threatened to end your relationship otherwise?
2. Have you ever had sexual intercourse with your partner when you didn't want to because he threatened to use physical force (twisting your arm, holding you down etc.) if you didn't cooperate?
3. Have you ever been in a situation where your partner obtained sexual acts with you such as anal or oral intercourse when you didn't want to by using threats of physical force (twisting your arm, holding you down etc.)?

For my dissertation project, I will be exploring the relationship between Intimate Partner Violence and HIV-Risk propensity in African-American women. At this time I am also requesting permission to use questions from the Woman Abuse Screening Tool, as well as some questions from the Dr. Kalichman's 1998 study on sexual coercion and negotiating condom use in African-American women.

I would sincerely appreciate your permission to use the questions from the Sexual Experience Survey. If permission is granted from all, questions will be combined into one survey instrument.

Thank you very much for your consideration of this matter.

Sincerely,

Lauren Josephs
APPENDIX K: APPROVAL TO USE WAST
Hi Lauren - you may use the WAST measure and I would appreciate hearing more about your findings down the road.

best of luck

Judy  
Judith Belle Brown PhD  
Professor  
Chair, Masters in Clinical Science Program  
Center for Studies in Family Medicine  
245-100 Collip Circle  
UWO Research Park  
London, Ontario N6G 4X8  
Phone 519 858 5028  
Fax 519 858 5029
APPENDIX L: PERMISSION TO USE HSI
Hello,

You have Dr. Gerbert’s permission to use her screening tool for HIV risk. Best of luck in your work.

Thanks,

Sophie

Sophie Calderon  
Administrative Assistant  
Division of Behavioral Sciences, Box 1382 
UCSF  
350 Parnassus, Suite 905  
San Francisco, CA 94117  
(415) 502-8364  
www.ucsf.edu/chips
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