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Research Article

Evolution of the Sexual Script: Insight into Sexual Decision Making among Young African American Women

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Abstract

Objectives: In a prior paper, a logical model of sexual risk-taking in young, sexually-active, substance-using African American women (YSSAAW) was posited, whereby traumatic emotional experiences, perceived social norms, and idiosyncratic relational factors (such as relationship length and perceived commitment) contribute to sexual script development in YSSAAW. The current paper expounds on the prior work by giving additional insights into factors that influenced YSSAAW's choices to either engage in sexual risk or preventative behavior.

Methods: Face-to-face, tablet-assisted, semi-structured interviews done among 30 YSSAAW in a private or public emergency department in Houston, TX, USA were audio recorded, transcribed verbatim, and analysed for thematic content. Interviews began with the question, 'What does sex mean to you?'. Interviewee responses were the primary influence to the direction of questions asked in each interview pertaining to sexual histories, social norms, gender-based beliefs, etc. Interviews were fluid and were tailored to the subject's comfort level on varied sensitive topics.

Results: Inter-coder reliability was assessed using Kappa statistic. Six primary themes were identified: emotional wounds, norms, decision making, sexual scripts, behavioural risk, and prevention. These themes imply that life experiences and thoughts lead to sexual decisions by YSSAAW to either engage in: a) high risk sex or b) routine use of prevention strategies purposed to avert negative sexual outcomes (i.e. new cases of HIV or sexually transmitted infections).

Conclusions: As emphasized in HIV-prevention literature, a keen understanding of the perspectives of the target population is imperative to tailor effective interventions that reduce HIV risk. Emergency department and primary care physicians, sexual health providers, health intervention researchers, and those generally interested in protecting this vulnerable population will find this information invaluable in having informed discussions about sexual health and preventive behaviors with YSSAAW.

Keywords: Substance use, Sexual decision making, HIV prevention, Young adults, African American women, Emergency department

Introduction

Despite over two decades of research and innovation in HIV prevention [1], HIV prevalence rates remain highest among African-Americans when compared to any other racial/ethnic group. Similarly, the majority (61%) of women currently living with HIV are African-American [2]. While the number of new HIV diagnoses among African-American women have reduced overall since 2005, as compared to other women, African American women are still disproportionately affected [3]. In 2015, new HIV infections for African-American women were 3 times that of Caucasian women and 4 times that of Hispanic/Latino women [3]. Women at significant risk for HIV frequent the emergency department (ED). ED populations report high STI rates nationally [4-9], and our local ED-based HIV testing program reported an HIV incidence of 0.6% [10]. Clearly, HIV risk among African American women remains a public health problem and a prevention topic worthy of continued attention and intervention within an ED setting.

Over the last decade, the ED clinical environment has been established as a feasible venue for engaging young, sexually-active, substance-using African American women (YSSAAW) in prevention research. This subgroup of women are at significant risk for new HIV diagnoses [11-18] through the combination of active substance use

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and condomless sexual activity. Women with limited access to preventive or routine care often present to the ED seeking care for non-emergent conditions such as STI- and pregnancy-related symptoms. The ED affords such patients sufficient time for the administration of rapid and adaptive HIV risk reduction interventions [19,20], as waiting times for non-emergencies average over an hour at local private hospitals for non-emergent conditions and over 3 hours at local public hospitals [21-23]. While engagement in HIV/STI prevention intervention may not be a primary goal of populations presenting for care in the ED, there is evidence to suggest that similar health promotion interventions for other risk behaviours have been effective in this fast-paced, time-limited clinical environment [24-28]. As medical providers may have only one access time point to intervene with YSSAAW at risk for HIV infection [29], it is especially important for ED interventionists to utilize a nuanced approach with an informed perspective of the barriers to and challenges in engagement in HIV prevention faced by this population. Having such insight helps ED providers engage in brief, targeted, yet effective conversations about health behavior change with YSSAAW, in which their concerns about engagement in protective behaviours are addressed through an informed lens.

In that regard, it is important to consider that reasons for the continued disparity in HIV risk for African American women are likely multidimensional, encompassing cultural, interpersonal, and intrapsychic factors. HIV prevention literature has already recognized the importance of considering women's sexual scripts in addressing risk and prevention behaviours. Sexual scripts are cognitive schemas, or frameworks, that influence an individual's interpretation of another's behavior and guide one's own interactions within romantic and sexual contexts [30-32]. Traditionally, heterosexual women's sexual scripts have relegated them to be passive recipients of sexual attention and intentions (i.e., male partner as initiating and directing the sexual encounter). Additionally, for women, the function of sex is deemed as a relational or emotional conduit, rather than for the primary purposes of personal enjoyment, with added social reinforcement for women who reject the roles of sexual aggressor or skilled teacher [33-36].

In addition to sexual scripts, Wingood and DiClemente's interpretation of the Theory of Gender and Power offers a framework for understanding potential challenges to a woman's engagement in protective behavior at the partnership level [37]. As heterosexual partnerships can involve inherent differences in power, women may be at an interpersonal disadvantage in condom negotiation or assertive communication about sexual preferences [38]. Thus, programs that emphasize reducing risk may not be effective if they do not address this power differential (i.e., that women may request, but men may ultimately control, condom use). There is some evidence to suggest that the enactment of sexual scripts seems to be changing on the individual and/or relational level, such that young women are more empowered to challenge and/or reject stereotypical sexual scripts [39]. It is encouraging that the influence of oppressive sexual scripts may be waning in a way that protects women from the risks associated with accepting passive roles in protecting their sexual health. Yet, challenging these scripts still requires that a woman perceive herself to have a measure of influence (i.e., power or control) within the interpersonal relationship and independence when adopting components of a comprehensive HIV prevention strategy (i.e. pre-exposure prophylaxis, partner selection).

The sexual development of African-American women may be unique, in that this population may be exposed to a differing set of sexual scripts than women from other American subcultures. Stephens and Phillips have examined the unique sexualisation experiences of young African American women [40]. Influenced heavily by cultural tropes that suggest that a young African-American woman's primary relational value is in her ability to entice men (i.e., the Diva archetype), to sexually satisfy men (the Freak & Gold Digger archetypes), and/or to blindly support men even to the point of personal costs to herself (the Gangster Bitch archetype), young African American women may face unique socio-cultural influences that undermine public health messages that emphasize the role of self-protection, boundary-setting, and ultimately the potential loss of relationships in the service of eliminating HIV risk [38]. Moreover, the risk of the loss of the romantic partnership may be an especially salient interpersonal cost. The role of wife or girlfriend is elevated, but perceived as less attainable, within the African American community. Thus, partnered women within this community are afforded higher social status[18]. Hence, young African-American women may be more motivated than women of other race/ethnic groups to adhere to more traditional scripts that involve the relinquishment of influence (i.e., power) and undermine self-protection to ensure the added life value of being in a romantic partnership.

While heterosexual sexual contact remains the leading direct transmission route for newly-HIV infected African American women [41], the role of substance use in facilitating HIV exposure should not be discounted. Substance use has been linked to low perceived vulnerability to HIV infection; low perceived vulnerability increases the probability of a woman engaging in riskier sex behaviors (i.e. condomless sex) [42]. At the cognitive level, certain substances (e.g., alcohol, marijuana) suppress activity in brain regions associated with judgment and behavioral inhibition [43,44]. At the route functional level, acute substance intoxication also impairs engagement in complex, coordinated motors skills [45,46]. These fine motor skills are necessary for engagement in sexual risk management (e.g., the completed, correct placement of a male condom). At extreme intake levels, certain substances (i.e., alcohol) can induce "black-out," or a loss of consciousness, leaving the user literally defenseless and increasing susceptibility to non-consensual, and likely unprotected, sexual activity [47]. Finally, those who develop disordered substance use may engage in high-risk behaviors to ensure a continued supply of the addictive substance (i.e., trading sex for money or substances). The prevalence rates of substance use in Houston are substantial, as injection drug use prevalence is 13.4% and non-injection drug use is 32.1% [48], thus, it is especially important to consider substance-using populations, as they may have significant vulnerability to HIV exposure. As such, YSSAAW may be at exponential risk for HIV infection even as compared to their non-using counterparts.

Purpose

The data presented here was previously analysed in a prior publication in which three primary themes were revealed that seemed salient to sexual script development within this population – emotional wounds, cultural norms, and decision making [17]. Additionally, the data uncovered traumatic emotional experiences, such as relational/sexual infidelity, sexual abuse, and

unsupportive parental dynamics (i.e., parents' negative response to the subject's sexual debut) that impacted women's sexual development. Moreover, YSSAAW reflected on influential societal and/or cultural norms - such as active or passive communication about sex, acceptability of co-occurring substance use and sexual activity, and the pressure to maintain the romantic relationship - that seemed to closely reflect other literature on sexual scripts and perceptions of relational power in AA women [17,49-51]. Finally, YSSAAW mentioned idiosyncratic relational and medical history factors that influenced their sexual decision-making, such as relationship length and personal history of an STI infection. These findings led the investigators to posit a logic model of sexual risk-taking among YSSAAW, whereby traumatic emotional experiences and perceived social norms, in combination with a woman's assessment of idiosyncratic relational factors, contributed to sexual script development of YSSAAW.

The current paper extends this work by more fully discussing factors that contribute to both sexual risk taking as well as factors that influence protective behaviors among YSSAAW. For the purpose of this paper, sexual risk behaviors are defined as the circumstances of their sexual debut (i.e. early onset, nonconsensual acts), engaging in concurrent sexual partnerships, and/or engaging in condomless sex acts; preventive behaviors are acceptance of responsibility for sexual health, knowledge of partner's sexual history and/or their HIV status. The overall goal of this extension of the prior paper [17] is to further contribute to the emergency medicine literature on the unique experiences of a subpopulation within the EDs patient volume (in this case, YSSAAW) who are at high risk for HIV. This subgroup tends to go unnoticed in the absence of public health practitioners skilled in offering ED-based prevention interventions. Ultimately, the current work aims to influence the design of population-tailored intervention programs in order to "meet patients where they are" in the process of behavioral change toward regular engagement in HIV risk reduction and prevention behaviors.

Methods

This is a descriptive qualitative study. The study was approved by the institutional review board at the University of Texas Health Science Center at Houston (HSC-MS-14-0819). As a part of standard care, research-credentialed staff have access to medical records at select hospitals. These records were reviewed and patients were screened on the basis of specific demographic (female, between 18-29 years old, and African American) and medical (sexually active and active substance use) data. Eligible subjects were approached for study participation in private rooms of the ED by trained researchers. To confirm screening information, eligible subjects were asked, 'Do you currently use any substances, including alcohol and/or illicit drugs like marijuana, cocaine, methamphetamine, heroine, or any other substances?' All women acknowledged active substance use and, in some cases, substance use was captured by the triage nurse and confirmed by the researcher in the electronic medical record under social history. After eligibility confirmation, each woman was given more detail about the nature of the qualitative study and was provided an opportunity to participate. After formally obtaining written consent from each subject, enrolled subjects completed a 20-40 minute interview using an adapted, validated, in-depth interview tool [52].

Variables	Emergency Departments	
	Private (n=15)	Public (n=15)
Age		
18-21	6	6
22-25	7	7
26-29	4	3
Marital Status		
Single	13	14
Married	1	1
Missing	1	0
Race/Ethnicity		
African American	15	15
Chief Complaint		
Primary Care	12	11
Dental Care	0	1
Pregnancy Related	2	3

Table 1. Sociodemographic profile of study subjects.

Semi-structured, in-depth interviews were conducted in private rooms within an ED over a seven month period (September 2015- April 2016) to a convenience sample of 30 African American women who presented to either a public ED (n=15) or a private ED (n=15) for a non-emergent condition (see Table 1 for full demographic data). Interviews were tailored to subject's responses with some flexibility in standard question administration to elucidate factors that contributed to either high risk sex or prevention behaviors. All interviews began with the question, "What does sex mean to you?" Based on the response, questions about emotions related to sex (i.e., "What do you feel when you have sex?"), sexual history (i.e., "Please describe your first sexual experience."), and the physical nature of sex (i.e., "What are your expectations of pleasure during sex?") were explored next. For instance, if a subject responded negatively to a question about transactional sex, all follow-up questions related to decision-making and risk assessment as it pertained to engagement in transactional sex were skipped in the interview, and the next main interview question was presented. Interview questions were viewed and recorded by the interviewer on an iPAD device. Interviews were audiotaped using an iPAD application [53] with each subject's permission and consent. Each subject received a $25 gift card at the conclusion of the interview for their participation. Clinical care was not interrupted for any patient that participated. Further methodological details can be found in our previous publication [17].

Data Analysis

Field notes were taken during each interview and content was coded independently by each interviewer. Units of analysis were based on the words and colloquialisms used by study subjects. The PI outsourced transcription of interviews to professional transcribers. Accuracy of transcriptions were verified by comparing the taped audio to the professionally transcribed version. Transcriptions were analyzed to categorize and identify relevant codes and themes using content analysis. A trained coding team (n=3) coded quotes from one interview to create the codebook. All 30 transcripts were coded by the team. Codes were determined during the development of the codebook based on the most detailed transcript. Coders added new codes during separate sessions. All codes used were compiled and

collapsed during an in-person session. Selected codes were then organized into themes by the group during face-to-face meetings. Codes were collapsed into themes informed by Wingood and DiClemente's interpretation of the Theory of Gender and Power, as pertinent to the impact of perceived powerless on sexual decision making in African American women [37,54-56] as well as Stephens and Phillips' research on the development of sexual scripts among African American women [50,57-67]. The research team then conducted a frequency analysis on emerging themes using NVIVO11 and Microsoft Excel software, organizing the data by designated variables (i.e. setting, text, code). When performing the reliability assessment, IBM SPSS 24.0 was used to organize study data for quantitative analysis using qualitative data from the transcribed text identified by nodes (i.e. codes) in NVIVO 11 (Table 2). Data were matched among coders to assess inter-observer agreement and/or disagreement. A kappa statistic of 1 indicates perfect agreement; whereas a kappa of 0 indicates no agreement [68]. The kappa statistics demonstrated no agreement between coder 1 and 3 (K=-.034) among 40 cases, coders 1 and 2 (K=-.059) among 24 cases, and coders 2 and 3 (K=-.059) among 24 cases (Table 3). The p-values for all kappa statistics were not significant. Crude agreement was found in 37/40 (92.5%) of cases between coders 1 and 3, 21/24 (87.5%) of cases between coders 1 and 2 as well as between coders 2 and 3 (Table 3). The difference in the number of cases amongst reviewers is due to incomplete coding by reviewer 2.

Results

Basic demographic information was collected on enrolled subjects, which revealed a normal distribution of age, marital status, and chief complaint category across both study sites (Table 1). Most of the subjects (86.67%) were ages 18-25 years, single (90%), and sought primary care in an ED setting (76.67%).

Themes

Six primary themes were identified from the interviews. The primary themes were: 1.1) emotional wounds, 1.2) norms, 1.3) decision making, 1.4) sexual scripts, 1.5) behavioral risk and 1.6) prevention. While substance use was mentioned by some respondents as an aspect of sexual decision-making, it was not as frequently discussed as the aforementioned themes. A quantitative assessment of code frequency per theme by coder is delineated in Table 2. Each theme is explored, and illustrations of each through quotes are provided verbatim from the taped interviews.

Emotional wounds

YSSAAW participating in interviews often reported emotional

Theme	Code	# of sources	Coders		
			Coder 1	Coder 2	Coder 3
Emotional Wounds	22 codes				
	Self-worth	12	21	4	4
	Fear	19	35	12	23
	Regret after sex	6	7	6	5
Norms	11 codes				
	Gender differences	22	39	42	14
	Relationship norms	20	14	22	31
	Peer norms	16	31	29	27
Decision Making	29 codes				
	Partner attractive qualities	20	43	12	17
	Relationship dynamics	20	43	27	1
	Trust	17	31	23	15
Sexual Scripts	20 codes				
	Gender identity during sex	23	28	10	3
	Boundaries	18	28	22	8
	Age at sexual debut	21	23	17	13
Behavioral Risk	12 codes				
	Sexual debut	18	26	10	4
	Condomless sex	17	25	23	11
	Concurrent relationships	11	14	13	5
	Sex as a partner pleasing tool	9	13	9	4
Prevention	16 codes				
	Responsibility for sexual health	13	15	28	15
	Knowledge of partner' sexual history/status	13	16	17	5
	HIV or STI testing	19	30	28	24

Table 2: Summary of themes and related codes found in interviews.

Coders		No agreement	Agreement	Total	Kappa	p-value
Coder 1	Coder 2	3	21	24	-0.059	0.758
Coder 1	Coder 3	3	37	40	-0.034	0.816
Coder 2	Coder 3	3	21	24	-0.059	0.758

Table 3. Analysis of agreement.

wounds stemming from historical relationship experiences (i.e. former physical and emotional abuse). The coding team decided to use the term "emotional wounds" for this theme based on the use of similar laymen terminology in the sexual script development literature [69]. Early childhood experiences build every individual's perception of themselves, of what can be expected of others, and of the world around them. When an imbalance between one's expectations and one's experience occurs, this can be emotionally jarring. The women enrolled discussed feelings of low self-worth, fear, and regret after sexual encounters, indicating the existence of emotional wounds in their respective lives. Some women indicated that they felt coerced to engage in acts that did not align with their sexual desires. Further details on patient responses that reflected the impact of emotional wounds on sexual risk can be found in a prior publication [17].

Self worth: While discussing historical sexual situations, current and former reasons to engage in sexual acts, partner selection, and relationship dynamics, a majority of subjects shared that their sexual decisions were related to perceptions of their inherent value. Self-perceptions influenced their perceived level of power in sexual decision making, and what they allowed in sexual relationships was a reflection of that perceived power. One subject shared her perspectives on how her engagement in prior sexual activities with multiple partners early in her sexual development was fueled by a desire for external validation of her worthiness, which left her with doubts about her self-worth at this stage in her life:

'But, I'm not that old, and I've had quite a few sex partners. And it's not because I was in love with them or like them, I just thought that's the way that they would like me… or love me… or something. So I did it, and now that I'm an adult, I feel like my body is worn out. Or now that I'm of age, and I should be okay to doing it, be good in a relationship, I feel like my body isn't worthy. So I can't keep a good man or a good boyfriend, like my body is worn out now, and I'm not even 30. So, I don't know, that's just the way that I thought that okay well maybe I'll be his girlfriend if I mess with him, because you know, that's what they want.'

In a separate interview, a subject reflected on the pressures of the perceived expectation to engage in sex when embarking upon a romantic relationship. She reflected on celibacy and the decision to define sexual boundaries without the input of the romantic partner, as difficult to engage in when dating. There is some underlying suggestion that the choice to withhold sexual favors - favors which are perceived as a desired and expected aspect of modern dating – negatively impacts her relational worth in dating situations. She expressed:

'So it makes it hard when that's what they're looking for, or they-that are what they're waiting for. Sometimes they're not just trying to get that on the first date. They'll do everything much fast to try and get it. And then it's that. So it makes it hard, because when you do practice celibacy, you, um-I meditate every now and then. So you get to know self. So you get to know what self likes, and you get to know what turns self-off, and you to know more about people. You pay attention more to your surroundings, so you know what they're looking for, what they're waiting for. So you end it quickly instead of wasting everybody's time. Because they would rather waste your time. So dating is particularly hard.'

The majority of subjects seemed to express feelings of diminished self-worth in the context of sexual relationships; however, a fair amount of women valued themselves highly and their behavior and expectations coincided accordingly. In the quote below, one woman described her expectation that even casual sexual partners will demonstrate a certain level of respect in their interactions with her, commensurate with perceptions of her own value and worth, before embarking on a sexual relationship. She articulated:

'It's the way they act. The way they present themselves to me. Um they don't just have to be my husband material but I mean it's the respect for myself and if they can respect me as much as I respect myself, then I'm willing to, you know…because I'm a young adult so the hormones are there but um I don't…I'm not the type to kind of like just give it away. Um you actually have to…it's like prove yourself worthy of me actually opening up my body saying like here...so.'

The self-worth code systematically captured the variability in perceptions of self-worth among YSSAAW in this study, as well as discovered how individuals' internal assessment of their value impacted their respective ideals, expectations, and boundaries in sexual relationships.

Fear: In addition to perceptions of self-worth, the YSSAAW in this sample reflected on fear as a salient emotional theme in their sexual development and in sexual decision making. The code fear referred to diverse factors that included fear of sexual outcomes (i.e. HIV and STIs), fear of partner learning of other partners, and fear of parents learning of their sexual debut during teen years. The most relevant fear noted in the women's current lives related to their fear of sexual outcomes. One subject stated:

'I think about STDs. I think about HIV. I think about AIDS. I think about all the things that you wouldn't want to happen. I think about, you know, some diseases that you can't get rid of, right? Um, herpes is one of the main ones that scare me because like you know you just don't know what somebody had had before you or you don't really-you're really scared because you don't want to sit up there and like find out two, three weeks later you have something and it wasn't your fault. It was somebody else. So I'm like I try to, try to make sure that I know what I, who am I sleeping with and what, who they've been sleeping with.'

This young lady describes a breadth of fears for negative sexual outcomes, carefully considering each STI and noting them separately. The fear she described here appears to motivate her to engage in the positive preventive strategy of vetting potential partners prior to sexual debut with new partners. However, fear is a complex stimulus, with the power to both motivate and inhibit behavior.

The complexities of the relationship between fear and HIV risk behavior are elucidated in another respondent's description of her engagement in certain preventive behaviors, but not others. On one hand, she is afraid of her partner's reaction to her request for his engagement in STI testing, inhibiting her engagement in the protective behavior of partner vetting. On the other hand, like the subject noted above, her own fears of negative sexual health outcomes seems to motivate her regular engagement in a different form of self-protection (routine STI testing for herself). She described the situation by saying:

'Oh God. HIV test, yes, but no other test, because I'm scared I don't

know how to say you know "go get that done" without causing a conflict especially with my fiancé because it's like okay you don't trust me.'

Regret after sex: A third type of emotional wound described by YSSAAW encountered in the ED was inflicted by feelings of regret after sexual encounters. Most of the regret expressed by subjects was after the women's sexual debut and in response to partners' dismissive acts, poor partner selection, and unmet expectations. In the example below, the study subject regretted engaging in sex as a futile effort to increase partner attachment:

'So [psst sound], when that didn't work out, I stop where I first started, I just stopped messing around and then it's just like I just went on a spazz, like oh, we talk, we cool, you like me, I have to have sex with you, cause I know you will like me more if I do that, and that's not the case, you know. Through the years, that's what I was doing when I was like well maybe someone'll [will] like me. But, you know, it's not all that. If I could turn back the hands I would. I really would.'

In a separate case, one respondent described regret related to her first sexual experience with her husband, which was less enjoyable than she anticipated:

'Um… it was painful. It was not fun. It was not-we were hugging and kissing and all that and think it's going to be like okay, we were going to have sex, it's going to be- no, it was horrible. (laugh) It hurt, it was painful. It didn't last that long. And I was just like, when I look back, I wish I would have saved that experience and made it more special. I would go back and change it all.'

Norms

The norms theme was used to describe how society, culture, family, peers, and other spheres of interpersonal influence shape the ideals, behaviors, and decisions of the individual. In an earlier publication, we limited our discussion of norms to aspects of interpersonal communication with sexual/romantic relationships and the specific influence of African American culture on romantic/sexual relationships. Further details on those norms can be found in our earlier publication [17]. For the purpose of this paper, we offer a new contribution to the discussion of norms among YSSAAW that relate to perceived differences in sexual experiences based on gender and how respondents viewed their own behavior in comparison to others in their age-based peer group.

Gender differences: Within this sample, gender differences from the perspectives of YSSAAW were explored. YSSAAW described gender-related behavioural expectations in heterosexual relationships from a variety of vantage points, including partner fidelity and maturation with age. Of gender-based expectations of faithfulness, one woman stated:

"Actually it's the same. Women cheat too. So it's like, you get together with your girls and talk about the dudes that you talk to. Like "girl, yeah, yeah, he went good" and all of that. But when you get around men, you act so like you haven't been doing nothing. (laugh) Oh, but I don't cheat unless someone cheats on me though. Like, I don't cheat. I'm a very faithfully woman to my man but Like, when I find out you cheating, I'm like "ok". Two can play that game."

In this example, the subject reflected on her willingness to "level the playing field" by responding to the male partner's infidelity with her own infidelity. Another subject's view on partner infidelity was quite different. She reflected on the emotional aspect of sex for women as inherently different from men in a way that inhibits their engagement in sex for physical pleasure. She stated:

'We think with our hearts. We feel with feelings. We actually have feelings, we get attached. And me personally, I can't just have sex with someone and not have feelings. And guys, that just like, they can just hit, go home and lie in bed with their spouse and act like nothing ever happened. And it's hard for me.'

This respondent seems to perceive male partners as having an emotional disconnect that allows them to engage in unfaithful (potentially risky) sexual acts without emotional consequences. Moreover, another subject asserted that modern sexual scripts were rife with gender-based differences in expectations of maturity:

'Well its some men and women that not mature.. my age. I think I'm a little more mature because over the years they say you learn from your mistakes so you try to do better (sigh). Men my age, nowadays, they just don't care… they don't care. Even if you try to have values and try to have morals, they make you feel like that's not right. Like it's okay for you to go out and be a whore or do whatever and so some girls my age is more mature and they know better. But the guys my age, they just real disrespectful nowadays, they don't care about nothing.'

This description of gender differences illustrates her perceived difference in expectations of "sexual maturity" in heterosexual relationships, whereby men are allowed to be less sexually discriminant without concern about any real relational consequences of their behavior. Conversely, she also indicated that women who are interested in adhering to personal or moral values that discourage engagement in indiscriminant sexual behaviour are actively punished by the men in their peer group for their sexual choices, as compared to women who might take a less restrictive stance on sexual engagement. From her purview, men attempt to make women feel guilty for enforcing their power in sexual relationships via the establishment of sexual limits. She deduced from this power differential that men lack respect for women's choices and withhold emotional investment (or care) to demonstrate their lack of respect.

Peer norms: Many respondents reflected on the behaviors and attitudes of their peer group as they considered the normalcy or appropriateness of their own sexual behavior. To clarify, the subjects tended to focus on their age cohort, with less distinction made between men and women based on racial/ethnic group or social status. Interviewers inquired about the women's perception of how their peers mitigate HIV/STI risk. One described the social conditions that would prompt others to obtain an HIV test. She said:

'Like if you go to jail you get tested automatically. So if they end up in jail, they're getting tested or if they end up going to the hospital you know they test them for all that, because you know they're already scared for what's about to happen. Or if they think it's a yeast infection and it's not then that's when they freak out…'

Another respondent correlated a lack of education with erroneous perceptions of risk in her peer group. She expressed the misperception of trust as a tremendous risk factor for her

peers. She also described the questionable prospect of judging sexual "cleanness" (or lack of STI diagnoses) based strictly on acquaintanceship or reputation. She said:

'I don't know I guess people are not really educated. They -- they may be educated but I don't think -- they have, like that won't happen to me type of thing. Like, yeah it happens but I know him, he's clean or I know her she's not that type of girl. And you just never know. So I just think people get so caught up on thinking they know a person or a person's lifestyle to where they trust them and they don't feel the need to have that conversation. And some I feel like they may not even be comfortable with having the conversation. I do think it's more of a convenience thing like I know her she's not -- she's not a dirty girl. You know kind of dumb like that type of the thing.'

Decision making

The decision making theme broadly described here reflects contributors to relationship and sexual decisions. Respondents reflected on how they chose partners, how they interacted within sexual/romantic relationships, and how their level of emotional investment (i.e., the trust they felt) impacted their decision-making. The codes within this theme, which included partner attractive qualities, relationship dynamics, and trust, all reflect individual, partner-based perceptions. These perceptions influence the decision to engage in sexual behavior or not. Further details on the decision making code can be found in the former publication of this study [17].

Partner attractive qualities: Partner attractive qualities offers a broad description of tangible (i.e., physical appearance) and intangible (i.e., nice, charismatic, genuine) attributes that women found appealing in a potential sexual partner. Among women in this sample, partner attractive qualities were deemed a predictor of the decision to engage in sexual acts with romantic partners. Factors described as attractive in partner selection and relationship maintenance were discussed. In one case, the subject said:

'At first, it was like the looks. But now, as I've gotten older, it's the way that you do your personality, the way that you act. The uh… I guess the maturity you are… like the maturity I guess…Because at first I just want people for the way they look. And then when I got with them they so childish and you know, immature and stuff like that so I had to stop doing that…And just find somebody that… I feel, you know, treated me well and I feel well about them.'

In this quote, this subject speaks of how her assessment of attractiveness has evolved over time. When she was younger, the partner's physical presentation was the determining factor for partner selection. At this stage in her life, she is more attracted to internal qualities, such as personality, maturity, and the way that she is treated in the relationship. We noticed this process of evolution in a few subjects, including one woman who said:

'I mean the way he treat me or like shows me respect and you know, treat me as a woman and a lady. That's why like the other person.'

Importantly, another subject described realness, trust, and friendship as a gauge for attractiveness to potential partners. Her response illustrates the influence of trust on perceptions of factual information (i.e. partner fidelity). She described her attraction to her partner and investment in the relationship in this way:

'He's real. Just like he said. He's real about putting on condoms. Like, it's like no female can ever say, "Hey, I slept with him and he didn't use a condom". Except one other than me. And I listened to that, and I took heed to that. And then at the same time, like I said, before our relationship even started we were friends. We just built the friendship. That's why he said, "She can tell me the truth", cause [because] he knew everything. He knew about my past. He knew everything. So with him knowing that, I trusted him.'

Relationship dynamics: Relationship dynamics was a code used to describe the way women and their partners behave in relationships, which could include dynamics such as monogamy, polygamy, transactional sex, and friendships. In one inquiry of transactional sex, the study subject described a transactional experience in which she received money for sex. She said:

No… I never paid no one. But I've received money before. [how did it make you feel?] (long pause) At the time, it didn't make me feel no kind of way. I was just like I need the money for this or whatever. But when I think back, it's very hurtful. Um, but it's like I said, I'm gonna get emotional about it, because I've been carrying this for like 27 years [all of her life], so. It gets me when I look back on stuff like this like it's not even worth it. And none of that was worth it for me for that fifty dollars or those hundred dollars or it wasn't - it wasn't worth it. He don't love me, he only loved me enough for these pennies, because it was no money. And it was like… I just talked to myself, and I said I just wish I would love myself more instead of letting people abuse me like that. At the time, it wasn't - I didn't think of it like that, I was like I need to get my nails done or I want to go hang with the girls so let me just give him thirty minutes or something like that and he give me the money and I go on about my way. But as I just think back on life, on my life, then that's when it hit home and I feel like this and I cry and I try to get it out and move on.'

This particular response is also integrated in the regret after sex code under the emotional wounds theme, as the subject's relationship dynamics impact the way that she perceives her self-worth. This subject recognizes that her former behavior in allowing monetarily-based sexual access to men conflicts with the way she would like to value herself currently.

Often times amongst members of this study sample, sexual relationships evolved from friendships and acquaintanceships within the same social network. In one instance, a woman said:

'*We were friends. We talked for a long time, just talked about problems and everything and then it led to that point.'*

Similarly when describing her sexual debut, one subject described the dynamic between her child's father and herself prior to the debut. She stated:

"it was my son's-my older son's dad. He was my first. Um, it was-it was a lot that led up to it. Um, we did sports together, so we saw each other a lot. And, um, um, my sport lasted year round, so I would see him all the time. Uh, it led up to just, uh, when I would get sick, … he was there, he would comfort, massage, um, yeah. That led up to it. Foot massages on the bus. On the way to track meets. When I tore my ACL, he was on the ambulance with me. All of that led up to it. Um, when I broke my hand when I was playing softball. I couldn't feed myself, so my mom would be there and he'd have to

feed me. So that-that kind of led up to it. And yeah. That was my high school sweetheart.

Her description of her child's father emphasizes their mutual support of each other in friendship, a relationship foundation that gave her the confidence to explore a sexual relationship with him. Similar to the former quote, this quote aligns with the code of perceived attractiveness, as the emotional support she gained during their relationship as friends seems to have fostered her attraction for him in a romantic sense.

Trust: Trust was primarily described in the context of the relationship, illustrating a dynamic where the women felt preventive behaviors (i.e. condom use, HIV/STI testing, PrEP) were not necessarily needed. One subject stated:

'Mainly trust, yeah. I don't trust, you know, people. Especially if I'm trusting you with me, my body, my… you know, I feel like I have to know you to trust you with those things, so if I don't know you, I can't give you all of me like that. (laugh)'

Trust was a major determinant in the decision to stop condom use within long-term relationships. In one instance, the woman said:

'[Do you use any form of contraception?] We did in the beginning, we do not now. [So what do you think led to that change?] Trust. And, you know, me being comfortable knowing, you know, my… our life together, you know, is… it made me comfortable or okay enough to go there.'

In some cases, trust was all encompassing and encouraged subjects to dismiss their doubts about their partner's potential infidelities. One woman stated:

'[Are you aware if he has other sexual partners?] Yes. [and how do you feel about this?] I mean we got two different separate houses so like sometimes I wonder who is over there and he wonder who over here, so it's like a whirlwind time but I trust him so….basically.'

Sexual scripts

Women were asked about their definitions of masculinity and femininity, their perceptions of appropriate gender roles, as well as acceptable sexual and romantic behavior to get a sense of whether their sexual schema aligned with more stereotypical sexual scripts for heterosexual women. In some cases, the women's responses reflected very traditional sexual scripts. Codes within this theme included gender identity during sex (or, how women perceived their own gender role during sex), sexual boundaries (or, the sexual acts that respondents deemed appropriate based on sexual and gender identity), and age at sexual debut (or, the age at which they initiated sexual intercourse).

Gender identity during sex: In terms of gender expression, most of the women self-identified as feminine and emphasized how their adherence to a more submissive role within relationships and during sex was a manifestation of their gender identity or "womanhood". For instance, one subject differentiated masculinity from femininity as:

'Okay, so my definition of masculine, masculinity would be like macho, like the leader, in control, decision maker. Ummm, the person giving direction. Ummm, the person who has the power in the situation. Feminine is more like the receiver, more like following his lead, um, you know.'

Similarly to the above respondent, another woman described her preference for the less dominant role during sex as related to her femininity:

'Because I am kind of submissive when it comes to intercourse. I kind of like being handled. You know, being told what to do.'

Boundaries: Women were not specifically asked about their sexual boundaries; however, this information sometimes surfaced during their descriptions of acceptable sexual acts. Of note, the boundaries code is distinct from the decision making theme. This boundaries code focuses on the sexual behaviors that the individual will and will not engage in based on what they think is appropriate, as guided by their current sexual scripts. Conversely, the decision making theme above focuses on the thought processes that influence mate selection.

With regards to sexual boundaries, the majority of the sample stated that they did not engage in anal sex due to perceptions of sexual risk. In one case, a woman said:

'Uh, I don't engage in anal….Only because I just don't believe it's supposed to go up there. Because stuff comes out, and, um, my mom used to work in a hospital, and I've been around patients that have had, um, HIV, AIDS.'

It seems that, as a heterosexual woman, she does not view receptive anal intercourse as an acceptable sexual act. Moreover, it also appears that she is attributing HIV transmission risk solely to anal sex, basing her rationale for not engaging in this sexual act on her beliefs about anatomy and appropriate physiological functioning (i.e., anus/rectum as an orifice solely for elimination, not reception).

Of note, boundaries described by women enrolled were concurrently emotional and sexual. Below, a subject describes how her current emotional and sexual boundaries are a result of past sexual experiences where she did not have healthy boundaries and engaged in undisclosed sexual acts. She stated:

'No, it's like now, um, I'm at the point where I shut a lot of stuff down now because, like I said, I carry so much from when I was younger, so I know, like I pick up on the signs more now, and I just be like if that's all you want from me then leave me alone….If that's all you want then just leave me alone. But then it's the ones that try to go under like when you know, and I kind of fall back a little bit, but it's like I'm not ready for that, so why are you still asking me? I don't want – I don't want to. So now I have – I am way stronger and I was like I pick up on the signs and I'm like you know what don't call me no more or I'll block the number out or something like that.'

Age at sexual debut: The age of sexual debut is the age at which the study subject had sex for the first time. This finite variable is an indicator of development and is used in the sexual research literature as an objective proxy for years of sexual experience and experience with making sexual decisions.

Many subjects noted sexual debut in their early teens, with significantly older (sometimes adult) partners. Traditional sex scripts support the older male-younger female pairing. As such, in many cases, the older age of the sexual partner was regarded as normative, even for women who were very young at the age of their sexual debut. It should be noted that interviewers did not probe for subjects' perception of forced or coerced sexual acts versus active consent for sexual encounters with these significantly older partners. In one instance, the subject described

her excitement about her older partner as:

'I was just hyped up on the fact that an 18 year old was dating me, like you know, I was 13 at the time, I was young."

In a separate interview, the subject reported that her sexual debut took place during adolescence with an unintended outcome:

"My first time having sex, I was 14, and I wound up pregnant.'

Behavioural risk

The behavioural risk theme identified several factors that place YSSAAW at risk for HIV and other STIs, including situational factors surrounding one's sexual debut (or, initial time engaging in sex with a new partner, regardless of age), engagement in condomless sex at any point in sexual contact with a partner, and participating in sexually concurrent relationships (i.e., having more than 1 sexual partner during the same time period, ex. within the same day or week).

Sexual debut: Sexual debut is a code used to describe the environment, chain of events, and/or situations that led to a sexual act.

Descriptions of contextual factors related to sexual debut included setting, relationship dynamics, sexual readiness, accounts of abuse, and enjoyment or displeasure with sexual experiences. In one account of a sexual debut, a young woman described a forced incident with an adult during her childhood. She said:

'Well actually, it was my butt, somewhere like 9 or 10….I didn't do it like really [during] my childhood. And kept my virginity.'

The disconnect between engagement in anal sex and the concept of virginity is noted here. Also of note, the same study subject later mentioned her avoidance of anal sex (as opposed to unprotected vaginal intercourse) as a sexual risk reduction strategy.

In a separate description, one subject described an unpleasant experience that did not meet her sexual expectations. She described the experience as:

'Um… it was painful. It was not fun. It was not-we were hugging and kissing and all that and think it's going to be like okay, we were going to have sex, it's going to be- no, it was horrible. (laugh) It hurt, it was painful. It didn't last that long. And I was just like, when I look back, I wish I would have saved that experience and made it more special. I would go back and change it all.'

This subject's feelings of regret has potential to influence her sexual decision making going forward and may inform her willingness to delay future sexual debuts with future partners, allowing her to make more informed decisions in the future, and to have more meaningful sexual interactions.

Concurrent relationships: Concurrent relationships – or involvement in more than one sexual partnership during the same time period - is a known behavioral risk for STI transmission. Still, partner concurrency was often discussed as normative among these respondents. In the quote below, the subject described her pattern of concurrent sexual relationships as a strategy to resolve hurt feelings from a previous partner. She said:

'That's how it have been most of the time. Like if you being so nice to me, why not have sex with you, you're nice to me, you didn't show me any bad signs, or nothing like that so why not? And then once they get it, it's just like whatever. I done got you now, like everything I was doing, taking you out to eat or to the movies or wherever. I don't have to do that no more because I did already got the prize that I wanted. And then it's like I have to talk to him to get over him and then to him to get over that one. And it just like… it keep going.'

This same dynamic was identified with another subject who stated:

'It's mostly just one partner but there was a time where I had two but it was getting over one and stepping into another relationship.'

A woman described a situation where she inadvertently had concurrent sexual relationships with friends and the resulting emotional wounds that stemmed from them identifying her as a sexual partner of them both. Her account of the situation is described here:

'I had more than one partner and thing about it was it was really those incidents when they around their friends, where they're making fun of me, or I don't like him or whatever the case may be. But when y'all get together, oh we both slept with her. But y'all act like y'all don't know each other. So in this case it was friends. So in this time period when I was dealing with the both of them, I developed two different relationships. I developed one with him, when you're not around your friends, it's something totally different, but when your friends come around. Uhh… they called me one time, "both of us wanna train on you" … So I feel humiliated, I feel embarrassed, I feel stupid, it was just a real low point in my life. And I was like well what am I even doing, when are you gonna - you can't keep abusing your body and all this other kind of stuff. But I thought it was love then and clearly it was just lust or - I don't know.'

Condomless sex: Participation in condomless sex is a well-known behavioral risk for becoming HIV positive. Among this sample, this behavior was identified in 56.67% (17/30) enrolled subjects. The prevalence of this risky sexual behavior among YSSAAW is an indicator of the prevalence of this behavior in this subpopulation of women. In many cases, condomless sex was the planned outcome of entering a certain phase in a long-term relationship in which women felt that they could trust their partners. In other situations, engagement in condomless sex was an impulsive decision, as depicted in the subject's response here:

'No. It was in the moment. It was me. He didn't want to, but it was me… It was in-it was in the moment, and … Um, and I took it off… Yeah. And then I took it off. I just got on top, and… He tried-he tried to grab it. I'm not going to lie. He tried to, but I did it to him… Yeah. I don't know what I'm thinking. I'm scared when it comes-that's my biggest fear…STIs and STDs.'

Prevention

The prevention theme reflected known factors likely to mitigate HIV transmission risk. Most frequently, strategies mentioned by the YSSAAW in this sample were taking accountability or responsibility for their own sexual health through regular testing and condom use and having knowledge of their partner's sexual history and HIV/STI status.

Responsibility for sexual health: Acceptance of responsibility for one's own sexual health was expressed in statements by YSSAAW who felt a sense of autonomy in their sexual decisions and boundary setting. Subjects' willingness to have difficult conversations with partners and to enact boundaries related to condom use was commonly discussed. Often, these discussions related to the woman's initial sexual encounter with a new partner. Boundary maintenance sometime varied thereafter. Of this variance in ownership versus deferring responsibility to the male partner, one subject said:

'Most of the time the guys have it [condoms], especially if we first starting. I normally have it sometimes but I ask like I said if we've been messing around I really don't even use it. But most of the time, the first time we be having sex with someone the guy always have it.'

While the subject above seemed to want to share responsibility with the male partner, in another case, a woman felt the responsibility for her sexual health belonged solely to her, and her consistent condom use was a direct reflection of this perceived responsibility. She stated:

'[Who generally provides the condoms?] I do because I like I said, I am concerned about who I'm sleeping with or what, who have they been sleeping with so I'm always using protection. I'm always making sure that I'm good. If anything I worry about my well-being.'

Knowledge of partner's sexual history/status: Knowledge of the partner's sexual history and/or HIV/STI status is also considered a prevention action in this study, as it allows the subjects to be more informed and aware of their exposure to HIV/STIs. One subject seemed very comfortable with obtaining the information that she needs about her partners to ensure she is making healthy sexual choices:

'[are you fearful of HIV or any other diseases?] Nooo… [why not] Because before you have a sex with a person, you should get to know the person. You and him, ya'll should both feel comfortable enough to go and get tested together.'

Another woman said:

'yes, my boyfriend is aware of my previous partner and I let him know that I was always safe with him. I used condoms and stuff like that and made sure that I got checked up before we engaged in anything.'

In her case, she discussed her sexual history with her partner, informing him that it was a standard part of her sexual practice to have open communication, to consistently use condoms, and to be tested for HIV and STIs before sexual debut with a new partner. In another case, it appears that this subject's prevention behaviors were compromised by an inaccurate risk perception. She misconstrues hygiene for sexual risk. However, she does inquire about testing histories and clinical visits with new partners prior to sexual debut. She said:

'and uh…do you got papers on you? I ask when is the last time you been to the doctor…don't lie. And then they'll tell me…I'll say are you clean down there? I mean I can smell it and find out if you are or not, come on. You got HIV, STDs please let me know right now. Please don't lie to me…it's so sensitive.'

Discussion

Despite increased awareness about HIV transmission and risk in the African-American community, young African American women remain at an increased risk for new HIV infections as compared to other female populations. Substance use serves to compound transmission risk, as individuals may underestimate their true risk level or be less able to engage in protective practices under an altered mental state. As such, young, sexually-active, substance-using African American women (YSSAAW) may be subject to exponential risk for acquiring HIV. It is paramount that clinicians in the emergency medicine field become more aware of the risk factors identified by this vulnerable population, a demographic that routinely seeks clinical care in the emergency department (ED) setting. As such, the researchers specifically sought out this unique population to understand more about their perceptions of risk. This paper is one of few that contributes to this effort by providing insight into the sexual decision making process of YSSAAW, making it clear to the ED physician how each thematic area contributes to the decision to engage in sexual behavioral risk or prevention practices.

Before the Decision

Researchers intentionally recruited a diverse sample of young, African-American women. While the women in this sample did not explicitly reflect on the intersectionality of race and gender and its impact on sexual script development or sexual behavior, in light of the sample, that intersectionality is important to consider when further interpreting their responses about their attitudes towards sex and sexual behaviors. These women provided their responses through the filter of their lived experiences. The authors are left to wonder how their lived experiences as African-American women align with (or differ from) Stephens and Phillips' Diva, Freak, & Gold Digger archetypes [14], the "good girls" vs. "bad girls" examination of African American female sexuality [70,71], or other theories about the nuances of African-American female sexual development. For example, one subject called herself sexually "worn-out", further suggesting that her current and future relational value is related to her lack of past sexual chastity. Is this belief a result of unique messages that she received as an African-American female? How does that impact her sexual decision making moving forward? While these inquiries were beyond the scope of the current study, further qualitative investigations of the impact of race- and gender-based messages about sex and sexuality on risk perceptions and protective behaviors is an interesting line of further research.

Further, past emotional wounds and their impact on current sexual behavior was a topic of frequent discussion amongst study subjects. At times, this was presented in the form of non-consensual sexual assault. This kind of trauma may impact the way individuals later experience, interpret, and respond to the world, themselves, and others [72]. One can easily understand how victims of sexual assault may engage in later romantic/sexual interactions with a sense of powerlessness about influencing others' behavior (in this case, engagement in protective sexual practices), detachment from the act of sex or ownership of their bodies (a connection that is needed to ensure protective practices or refuse engagement), or shame about past experiences (which can lead to a sense of defeat about changing any future behavior).

Although it was not a primary theme, many women who reported a sexual debut in their early teen years also described their initial romantic/sexual debut as their consensual involvement with significantly older adult male partners (coded as age of partner at sexual debut). In many of these cases, due to the adult male partner's age, the act is legally interpreted as sexual abuse, commonly called "statutory rape". This is a young cohort of women; the establishment of legal statutes related to age-of-consent predate these young women by several generations [73]. Though women seemed to describe these interactions as normative, even exciting and validating at the time, one is left to wonder how (or if) these women have processed the clear power differential present in their past adult-minor sexual relationships, the role of sexual grooming or manipulation as a facilitator of these relationships, and whether those experiences have continued impact on the adherence to sexual scripts that might undermine protective practices in adulthood. In African-American communities, normalizing the adult-minor relationship between males and females often involves the blaming and shaming of the minor female. The culture- and gender-specific pejorative term "fast" is commonly used to describe African-American girls deemed as intentionally demonstrating sexually mature behavior that should be reserved for older women [74]. There seems to be less consideration for the level of responsibility that the adult in these partnerships has in initiating sexual relationships with minors. A significant age gap between adolescent female and adult male partners is associated with more inconsistent condom use [75]. As many women in this sample noted a history of relationships with adult males, it could be the case that the lack of power or autonomy in their early relationships influenced later adult practices, making significant contributions to their emotional wounds including a diminished self-worth and regret after sex.

Finally, it should be noted that not all subjects had a history of trauma or potentially coercive relationships in their youth. However, they were still emotionally impacted by prior relational experiences in a way that influenced their later behavior. For example, one woman described her emotional experience of fear as both resultant from prior emotional wounds (i.e., fears of the partner's negative reaction based on similar past interactions with this partner) and as an influencer of her engagement in certain self-sacrificial health behaviors (i.e., her choice to then avoid asking him again to get tested for fear of his response, instead focusing on routine testing for herself only). Her chosen HIV prevention strategy reveals the gender-based power differential between her and her partner, where she is deferring to his emotional comfort [76-78]. Her strategy also depicts traditional sexual scripts as reflected in the Theory of Gender and Power, whereby men have ultimate control over sexual decision-making. It also subtly reflects her fear of the expected outcome of relational abandonment as a consequence of her partner's interpretation of her request for testing as an accusation of his infidelity or her lack of trust in him [58,79-81]. Preferring to not threaten the stability of the relationship, the subject allowed her fear to silence her voice, perhaps inflicting emotional wounds that may manifest in diminished self-worth. As noted above, fear is an interesting and paradoxical motivator that can both inhibit and prompt engagement in either protective strategies (i.e., in fear of STIs, use condoms consistently) or risk behavior (i.e., in fear of partner's negative reaction, do not request condom use) [49,50,82-84].

The Decision

The decision of YSSAAW to engage in either behavioral risk or prevention practices related to sexual activity is pre-determined by several factors. We identified that this decision-making process among YSSAAW is largely driven by past experiences that reinforced social norms, created sexual expectations, and influenced the solidification of sexual scripts. For example, some viewed sex as the physical manifestation of a pre-established, deep emotional and/or spiritual connection with a partner, where open communication about sexual histories and expectations of monogamy was encouraged, which is well-aligned with prevention practices. Distinguishing between factors that influence either behavioral risk or prevention practices within this population is vital to the development of culturally-informed interventions and/or the adaptation of existing, validated HIV risk management interventions [85]. Such insights are very likely to increase relatedness and patient-provider communication in a way that could bolster the effectiveness of brief HIV prevention interventions with diverse populations in ED settings.

Sexual scripts - including beliefs about what the sample perceived as "normal" sex or "risky" sex – were also reflected in the women's responses. Many normalized having sex with known partners, with whom they had built some sort of familiarity. In some cases, the length of their acquaintanceship with eligible partners seemed to influence the level of trust in their partner's "clean-ness" (or, lack of STI infection), whether or not they had an actual conversation about the partner's sexual history. In other cases, the women took it upon themselves to engage in practices despite the level of acquaintanceship or trust. Many women discussed the avoidance of receptive anal sex as a presumed high risk mode of transmission. This assumption is correct, yet incomplete, as they failed to recognize that unprotected receptive vaginal sex is also a relatively high risk transmission mode. Another young lady mentioned her assumption of foul genital odor from the male partner as a sign of an STI infection. While a foul genital odor may be a sign of an STI infection or yeast infection in women, the same does not apply to males [86]. The misperception that foul genital odors is a sign of an STI infection in both men and women was commonly discussed within this study sample and YSSAAW enrolled in other ED based studies (M. Hill, personal communication, February 27, 2017). As it relates to sexual scripts in particular, these are important examples of how a person's sexual scripts can impact later behavior, sometimes in ways that individuals believe are appropriate or protective, but are not.

Interestingly, despite this population being selected on the basis of their current substance use, not many women associated substance use with sexual risk, nor did they mention the impact of substance use at the time of the sexual encounter as undermining protective practices. It is important to note that the researchers only inquired about any substance use and did not assess for a substance use disorder, as defined by the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM-5) [87]. It could be the case that these women engaged in "low risk" drinking (i.e., less than 3 servings of alcohol per day and no more than 7 servings weekly) [88], which might have less impact on sexual risk. Moreover, though some endorsed illicit drug use, similarly, there was no assessment of the duration, frequency,

intake amount, dyscontrol, compulsivity, physiological impact, or functional impact of their illicit substance use. In few responses, a substance abuse history could be assumed from the engagement in transactional sex, but even this cannot be substantiated. Future research specifically involving substance-using populations should be more explicit in gaining subjects' insights into whether they perceive a connection between their substance use and sexual risk.

After the Decision

Regarding the decision to engage in sexually risky behavior among this population, it should be emphasized that sexual script development is an iterative process, influenced by early exposures and reinforced or undermined by continued interpersonal interactions and observations of "how the world works" throughout one's sexual lifespan. These influences, reinforcements, and/or deterrents can either be desirable (i.e., an expectation of respect and consideration as normative within romantic/sexual relationships, the expectation of mutual participation in a vetting process before sexual engagement) or undesirable (i.e., emotional wounds, history of sexual abuse, substance use during sex, and/or partner infidelity [17,18,89]), in terms of their impact on the enactment of sexual risk mitigation behaviors. As individuals continue to build their internal repertoire of what is considered normative, socially appropriate, or personally acceptable responses to these stimuli, individuals can choose to either maintain or abandon their prior sexual decisions in later romantic interactions. While it may be particularly difficult for some African American women to confront or challenge long-held, broadly reinforced, or interactively complex negative sexual scripts. In some cases, these sexual scripts typify an African American woman's inherent worth as tied to her sexuality, sexual choices, and ability or willingness to please men sexually. It should be emphasized that the women in this study gave details about their engagement in such a process of internal and behavioral change. They reflected on their perceptions of an expectation of male partners as immature sexual hunters always looking for the next sexual conquest, and the female partners as sometimes reluctant prey. This ultimate assessment of this interactive dynamic was deemed insufficient to meet their needs for emotional connection. The need for sexual safety and satisfaction was also unmet. Some women gave detail about how they have changed the way that they assess and interact with men in order to ensure their needs are met.

In this sample, it seems that the decision to incorporate prevention practices in one's sexual script, even in the context of active substance use, is related to perceptions of inherently strong self-worth, engagement in assertive communication skills where the woman is comfortable with establishing and maintaining boundaries for sexual practices with partners, and routine participation in self-care in the form of HIV and/or STI screenings. When discussing one's responsibility for their sexual health among condom users, there was somewhat of a dichotomy in perspectives among the sample. Some women felt men should accept responsibility for consistent condom carrying and use. Others saw themselves as accountable for their own sexual health. Outside of this dichotomy were women who used condoms at the onset of their sexual relationships then ceased condom use with relationship longevity. Within this subset of women were those with complete trust for their partners and strong beliefs that their partners would not hurt them in any way. In other studies done among women, realization that their sexual partners were unfaithful was commonly found [58,79-81]. However, these women believed that they were at least engaging in risk management practices in alternate relationships to avoid transmission of HIV to them. They were less confident about their sexually-concurrent partner's engagement in preventive strategies and expressed that they were vulnerable to curable STIs, but not HIV. The perceived distinction between the routes of HIV and STI transmission was not biologically-based; however, it was created as an extension of trust. In order to tolerate partner infidelity [58,79-81], these women created a coping strategy of partial denial or minimization, that reduced perceived vulnerability to HIV. This inaccurate vulnerability perception may ultimately jeopardize these women's sexual health. While the women themselves chose to practice monogamy as a risk management strategy, individual monogamy in the absence of partner fidelity is still a behavioral risk. However, this realization seemed to be ignored by the YSSAAW enrolled in this study. Again, these findings underscore the importance of fully understanding patients' perspectives in their assessment of risk in order to accurately educate them on the fallacies of their prevention practices.

Ultimately, the validity of these results as it relates to factors that influence behavioral risk or prevention practices in YSSAAW is rooted in its ability to inform academic emergency medicine clinicians about the social norms of a subpopulation that they serve daily. This information is intended to improve physician-patient dialogue and appropriateness of recommendations through increasing cultural sensitivity and attention to psychological and social influences of patient's engagement in self-directed health practices and engagement in clinical follow-up care.

Limitations

The primary limitation of the study is the small sample size. It was not possible to perform a regression analysis to adjust for any potential confounders in the relationship between behavioral predictors and the behavioral outcome of either engagement in risk or protective behaviors.

An important and secondary limitation was the low inter-rater reliability amongst coders. Two of the coders have two decades of experience working with young, African American female populations, while one of the coders had none. Thus, the varied experience of the coders aligned with low inter-coder reliability. In several cases, the coded text had multiple codes. There was significant variance in the number of codes assigned to text between coders (i.e. coder 1 assigned 5 codes for line 52 and coder 2 assigned 1 code to the same text; (Table 2). The kappa statistic was based on a finite sample of the codes, not the entire transcripts; thus, it is possible that the coded data chosen is not the best representation of the congruence between coders.

Thirdly, lack of cultural awareness and knowledge by the company who provided the team with professional transcription services (prior to coding) contributed to minimal transcription errors that were easily corrected by study team members through review and correction.

Fourthly, missing data from coder 2 compromised our ability to demonstrate strong agreement amongst all three coders.

Coder 2 had 16/40 (40.0%) missing values and agreement on 21/24 (87.5%) of coded data and no agreement on 3/24 (12.5%) of coded data. Thus, the disagreement was minimal, and the integrity of the data remains uncompromised. This pilot study should be replicated with a larger sample size and at other EDs.

Another study limitation is that the data was based on self-report. Self-reported data during in-person subjects the data to interview bias and social desirability bias where subjects feel undue pressure to provide desired responses. However, the comfort of the subjects in truth telling is obvious given the details provided during the interviews and the lack of responses that would be deemed socially desirable.

Lastly, the population is not representative of the general population in the Houston area, as there was undocumented diversity in the sample based on education and health care access. Some subjects expressed (although the information was not systematically captured) that they were in college or had completed college and had a usual source of medical care. These limitations challenge the generalizability of study findings. Regardless of limitations, findings of this pilot study paves the way for additional research in this area.

Future Research

As indicated above, future qualitative studies should ask ED patients more specifically about the perceived role of substance use on sexual risk behaviors. As patients build insight into the connection between substance use and risk, acknowledgment of substance-use related risks can be incorporated in comprehensive HIV prevention strategies targeting vulnerable populations, specifically minority women. Moreover, similar studies should inquire more explicitly about the positive and negative influence of African-American culture on sexual decision making. YSSAAW require interventions that provide information and tools that align with their cultural values and beliefs [42]. Tailored interventions are capable of averting future HIV/STI infections, a likely outcome if risky sexual behaviors persist in the absence of intervention due the prevalence of HIV within African American sexual networks. In order for these interventions to become effective, YSSAAW with sexual scripts that encourage sexually risky behaviors (or that do not accurately outline what constitutes risk) must perceive HIV/STI infection as a real threat. Previous researchers found risk perception to be the most important factor to be addressed through HIV prevention [42]. The interview findings presented are the initial steps towards building a program that will directly address perceived risks among YSSAAW.

Conclusion

YSSAAW recruited from a Houston-based public ED would benefit from clinical trials of behavioral interventions that address sexual health during clinical visits in the ED setting. Factors that contributed to sexual decision-making were discovered through in-depth interviews with YSSAAW who obtained non-emergent care through the ED, demonstrating that emotional wounds, social norms, pre-established sexual scripts, and idiosyncratic assessments of the characteristics of potential partners prompt either preventive or risky sexual behaviors. HIV prevention clinicians and researchers should attune to these factors when discussing risky sexual behaviors with their minority female patients, as they remain most vulnerable to HIV/STI infections when compared to counterparts of all other race/ethnic groups.

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