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## Fear, Trust, and Negotiating Safety:

### HIV Risks for Black Female Defendants

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## Abstract

Through in-depth interviews, this study examined the relational context of sexual HIV risk for 10 Black women aged 18–30 who were defendants in a community court setting. A qualitative data analysis identified themes of actual and feared intimate partner violence (IPV) and the expectations of demonstrating trust in a relationship as obstacles to negotiating the use of condoms. The findings speak to the broader structural factors and consequences of IPV and drug use. The article discusses the implications for HIV prevention for Black women who are involved in the criminal justice system.

## Keywords

Black women offenders; criminal justice system; sexual HIV risk

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Black women remain at a high risk for acquiring HIV with the rate of HIV/AIDS more than 10 times that of White women and 3–4 times that of Latina women (Centers for Disease Control and Prevention [CDC], 2008). In addition to intravenous drug use, the most common route of HIV acquisition for Black women is heterosexual contact (CDC, 2005; Lee & Fleming, 2001). Within gendered relationships, a woman's exposure to the risk of HIV is likely shaped by her social positioning and the imbalances of power within the dyad (Wingood & DiClemente, 2000). Social and contextual factors that contribute to the risk of HIV among Black women include the sex ratio imbalance, poverty, racism, and oppression (Adimora,

Schoenbach, & Martinson, 2001; Logan, Cole, & Leukefeld, 2002; McNair & Prather, 2004). The increased sexual HIV risk for Black women has also been associated with a history of trauma (Wyatt et al., 2002), recent intimate partner violence (IPV; Gilbert, El-Bassel, Schilling, Wada, & Bennet, 2000; Wingood & DiClemente, 1998), and perceptions of powerlessness (Sanders-Phillips, 2002). Taken together, this confluence of interpersonal and social stressors uniquely contributes to disparities in HIV between Black women and other women by influencing their decision making regarding sexual risk.

HIV risk factors are exacerbated among Black women who have contact with the criminal justice system. Black women represent approximately 32% of all incarcerated women and are 3.7 times more likely to be incarcerated than are White women (Sabol & Couture, 2008). Incarcerated Black women have a higher prevalence of HIV than does any other incarcerated population in the United States (Maruschak, 2004). Risk factors, such as victimization and drug abuse, are linked not only to sexual risk behaviors but to criminal involvement for Black women (Serk, Theall, & Elifson, 2005). Past studies have concluded that women with histories of incarceration are significantly more likely to exchange sex for money or drugs and to have been the victims of forced sex (Hammett, Harmon, & Rhodes, 2002; Kim et al., 2002). These structural and social mechanisms of oppression that weigh heavily on Black women are undoubtedly amplified by involvement in the criminal justice system and present unique stressors toward unsafe sexual behaviors.

It is clear that Black women in the criminal justice system have a higher prevalence and risk of HIV and are in need of targeted HIV prevention efforts. However, little research has incorporated the voices of these women to gain a better understanding of their perspectives and decision making around issues of risky sexual behavior. Given that sexual risk occurs within dyads, designing HIV prevention interventions for Black women who are involved in the criminal justice system requires an understanding of the relational and cultural context in which sexual HIV risk occurs. In addition, although 85% of the female population in the corrections system are placed in the community where they have greater opportunities to engage in HIV risk behaviors (Greenfield & Snell, 1999; Spaulding et al., 2002), most HIV research with female offenders has taken place in incarceration settings (Glaze, 2003). Effective HIV prevention efforts would therefore benefit by targeting women while they are still in the community and before they become heavily involved in the criminal justice system.

This article presents a study that examined the relational context within which Black women who are involved in the criminal justice system engage in sexual HIV risk behaviors. The qualitative study used in-depth interviews with Black female defendants in a community court setting who demonstrated a high risk for acquiring HIV to identify themes related to sexual risk behaviors, using the following research questions: Among a sample of Black female defendants, what prevents women from asking their sexual partners to use condoms? Under what circumstances are women more likely to engage in unsafe sex with additional partners? What strategies do women use to practice safer sex with their sexual partners? Integrating these women's lived experiences into the discourse on HIV risks among Black justice-involved women provides an opportunity for the women's often-neglected voices to be heard and better understood. As a result, the findings provide useful implications for designing HIV prevention interventions that target Black women in the criminal justice system.

## Method

### Study Site

Midtown Community Court in New York City was the first community court in the United States and was established in 1993 through collaboration between the Center for Court Innovation and the New York City and state court systems. Community courts represent a new

and innovative approach to addressing criminal behavior by problem solving and emphasizing tangible outcomes for victims, defendants, and the community (Feinblatt & Berman, 2001). In lieu of incarceration, alternative sentences are often given, including a treatment-readiness group, group counseling for commercial sex workers, job-readiness sessions, individual counseling, and community service. Midtown Community Court's emphasis on low-level misdemeanors and prostitution cases was a good match with the study's focus on early entrants to the criminal justice system and women who may be at a high risk for HIV.

### Recruitment and Eligibility

Female defendants were recruited from Midtown Community Court from July to December 2006. Women were approached by a trained female graduate research assistant outside the courtroom after their arraignment or court appearance and were invited to participate in a 10-minute screening interview to ascertain their eligibility for an in-depth interview. The screening interview included questions on demographics, involvement in the criminal justice system, and sexual risk factors for HIV and sexually transmitted infections (STIs). Standardized measures assessed IPV (Straus, Hamby, Boney-McCoy, & Sugarman, 1996), emotional and verbal abuse (Tolman, 1999), and drug and alcohol use (Sobell & Sobell, 1996). Screening interviews were conducted in a private room after the participants gave their consent to be interviewed and were given US\$5 in compensation.

Of the 157 women who were approached at Midtown Community Court, 91 (58%) agreed to participate in the screening interview. The most common reasons for nonparticipation were that a participant was younger than age 18, did not identify as Black or African American, and did not have time to partake in a screening interview. After completing the screening interview, those who met the criteria were invited to participate in an in-depth interview. A participant was eligible for the in-depth interview if she met the following criteria: She (a) self-identified as female, (b) self-identified as African American or Black, (c) was at least 18 years old, (d) was arraigned or appeared before a judge at the community court in the past 90 days, (e) reported at least one HIV/STI risk factor in the past 90 days (defined as having sex with multiple partners, injecting drugs, having an STI or HIV, or suspecting any of these risks for her sexual partner), (f) reported experiencing one or more incidents of IPV in the past six months, and (g) reported one or more incidents of illicit drug use in the past 90 days.

Of the 91 women who were screened, 11 (12%) met all the eligibility criteria. The primary reason for women's ineligibility for the in-depth interview was not reporting the co-occurrence of IPV, illicit drug use, and HIV risk, although most screened women reported one or two of these risk factors. Ten eligible women agreed to participate in the in-depth interview. Each interview was digitally recorded, and the participants were given a US\$40 gift card in compensation. If any participant expressed the need for additional services, such as medical services or classes to obtain a general equivalency diploma, she was referred to the Social Services Department at Midtown Community Court. The study was approved by the institutional review boards of Columbia University and the Center for Court Innovation.

### Protocol for the In-Depth Interviews

The interview format centered primarily on women's sexual relationships linked with the use and nonuse of condoms and other sexual HIV-related risks. The interview was semi-structured with follow-up probes and focused on challenges that women face in protecting themselves against HIV and STIs. For example, some of the questions were as follows: "In terms of protecting yourself from HIV and STIs, what prevents you from using a condom?" "Does this happen to your friends or people in your community?" "Tell me what it is like to ask your partners to wear a condom," "What do you do to protect yourself from HIV and STIs?" and "Do other women protect themselves this way?"

## Coding and Construction of Themes

The digitally recorded interviews were transcribed and subjected to constant comparative analysis—an element of grounded theory (Glaser & Strauss, 1967). Constant comparative analysis requires researchers to take each piece of data (e.g., an interview or a statement) and to compare it to other pieces of data that are similar or different to identify emerging patterns or themes (Glaser, 1992). During this inductive process, researchers critically examine concepts that explain people's behavior, actions, and experiences.

Data coding consisted of three phases (Strauss & Corbin, 1990). First, the third author conducted open coding of the transcripts on the basis of the women's description of sexual HIV risks. Second, axial coding was used to examine the contexts that influenced what the women stated about HIV, STIs, and sexual behavior. Last, selective coding was used to compare and contrast subthemes across the participants, situations, and settings. After the initial coding of the transcripts and the construction of first-level codes, themes were identified and coded from each transcript using NVivo software. The first three authors analyzed the data to ensure interrater reliability, and quotations from the transcripts were used to exemplify the themes that emerged from the data. We extracted text using the Nvivo node "women's challenges to condom use" from the full transcripts. The primary text coded under this node came from the interview questions noted previously. A codebook with broad categorized themes was developed. Four primary themes emerged from the data that focused on sexual relationships and HIV/STI risks, and quotations were used to illustrate each theme.

## Results

Table 1 summarizes the characteristics, involvement in the criminal justice system, HIV and STI risk factors, history of IPV, and drug use of the 10 women who participated in the in-depth interviews. Per the eligibility requirements, all 10 participants reported having been arraigned for a misdemeanor, at least one HIV/STI risk factor, a history of IPV, and drug use. Arraignment charges for the participants included prostitution ( $n = 2$ ), possession of illicit drugs ( $n = 1$ ), open (alcohol) container violation ( $n = 2$ ), petit larceny ( $n = 2$ ), assault ( $n = 1$ ), trespassing ( $n = 1$ ), and reckless endangerment ( $n = 1$ ). The demographic characteristics of the 10 participants did not vary greatly from those of the larger group of 91 women who were screened, although the screened women as a group were more likely to be married (12% vs. 0%) and less likely to be unemployed (49% vs. 80%). The total screened sample demonstrated similar criminal justice characteristics to the interview participants, with lower levels of previous arrests (53% vs. 70%) and incarceration (19% vs. 40%).

Through constant comparative analysis of the interviews, we identified the following four themes: (a) fear of IPV prevents women from asking their sexual partners to use condoms; (b) demonstrating trust in the relationship prevents women from asking their sexual partners to use condoms; (c) substance abuse, engaging in prostitution, and a partner's incarceration influence sexual risk behaviors with additional partners; and (d) women defendants are concerned about strategies to reduce the risks of HIV/AIDS and STI. These themes demonstrate the challenges of women involved in the criminal justice system in the contexts of their sexual relationships.

### Fear of IPV

When the women were asked why they could not ask their partners to wear a condom, fear of IPV emerged as a barrier. This theme suggests that fear of violence prevents the participants from negotiating what they need to protect themselves from sexual HIV-related risks, as the following comments indicate:

Being safe, that's hard to do .... I got raped and I had a boyfriend and I wanted him to use a condom. He was actually my boyfriend for three years—he didn't have any [condom]. I didn't have any [condom], and I got raped. (ID: 015)

If I was to say no when he wanted to have sex without a condom, I was scared that he would go and try to hurt somebody in my family or hurt me. They might be scared. I know that my ex-boyfriend would threaten me a whole bunch, and I was scared and I believed that he would do something. He would say, "Now I'll do this, I'll kill your family," and I would be scared that he would do it. (ID: 053)

Domestic violence and intimacy ... sometimes maybe women get it confused; he may be touching you, you know, relaxing you, but you might be thinking that he is gonna hit you. Some women go through that, and I have friends that been there—"I don't know if he's gonna hit me or he's gonna hug me" type of stuff .... Yea, you don't know if he's trying to love you or he's trying to hit you ... After being beaten so much, going through that so much, they might be scared to use it [condom], or she might be scared she might say the wrong thing, and he might slap her. He might just force her to not use it, you know. And there would be a big argument and hence a whole bunch of nonsense after that. (ID: 079)

For women who engage in prostitution, conflicts with their managers ("pimps") may lead to violent interactions and unprotected sex:

I correspond with the girls who work in the section that I used to work in. They tell me how they have been kidnapped by pimps. [The pimps] have sex with them and make them go back out on the street and work for them, beat them up .... Then my aunt that lives up here, she does good with her HIV/AIDS, but she got it doing the same thing that I was out there doing. Prostitution. And she got it from a pimp. (ID: 015)

Although this participant later reported that her manager supplied her with condoms as a way to make sure she was "working," conflict with a pimp may lead to physical violence, coerced and/or unprotected sex, and the potential transmission of HIV.

A general fear of their sexual partners' reaction to the use of condoms was a consistent theme for the women in the study. The participants indicated that they were scared to ask their sexual partners to use a condom:

I didn't think about asking for a condom, but I've thought about it, I tried to pull the words out of my mouth, but I couldn't because I was so scared .... I was so scared, and I felt so alone, what am I to do? (ID: 004)

I didn't want to ask about condoms. Scared of how he might react. He might be like "whatcha mean" yelling "whatcha mean, I gotta wear a condom?" No. He might say "I am not wearing one" and expect me to listen. (ID: 088)

The participants described sexual relationships that were greatly influenced by power imbalances that were manifested in actual or feared IPV. Fear of a sexual partner's reaction and the feeling of powerlessness have been well documented in the literature as obstacles to requests for safer sex and are consistent with this study's findings (Sanders-Phillips, 2002; Wingood & DiClemente, 1998). For the women in this study, their lack of power in relationships and the fear of physical or emotional violence were key factors in engaging in unprotected sex.

### Demonstrating Trust in the Relationship

Displaying trust by engaging in unprotected sex in their intimate relationships was a consistent theme for the participants. According to the women, suggesting that their partners, particularly their steady partners, should wear condoms, implied a lack of trust in the relationship. The women found it difficult to communicate about sex and condoms with their sexual partners without issues of trust emerging:

She wouldn't be able to ask him to use condoms because he would also [say] ....  
 "What, you don't trust me? You don't trust? What are you saying?" It's like him always trying to have the upper hand. (ID: 008)

Personally for me, I've had this conversation before with my boyfriend, like "Why won't you use condoms?" and his thing was "Oh, I feel like after three months, we don't have to use condoms." "Why is that?" "Oh, because I trust you." They feel they can trust the person. (ID: 057)

It was easy to communicate at the beginning of the relationship; it becomes more difficult when trust is established. You build so much trust, if you did something, you're scared to tell the other person because you may lose the person or you have to bring the trust back. (ID: 053)

In addition, 8 of the 10 women knew or suspected that their primary sexual partner was having sex with additional partners. The participants reported that engaging in multiple sexual partners was also common among women:

The females I know, they have multiple partners ... it looks like the majority of them. Sometimes he makes me feel like he's cheated on me because I know that we all play a lot. Just like, for example, one of his friends, his girlfriend, that's pregnant, she is pregnant by his best friend. Yesterday, an incident happened: The father was messing with another female. She told him that was very disrespectful; you shouldn't be doing that. She said, "You don't even touch me that way," so she told me that they broke up. (ID: 048)

Yea, he doesn't want to be with her any more, trap him off. Yea, them one-night stands, those are the most dangerous, dangerous, because you don't know the person, and the person doesn't know you. You don't know their background, and they don't know your background. You can't tell what's going on with their insides right there at that time. And that one night of passion could lead you to so many years of pain. (ID: 057)

Although it appears that engaging in sex with multiple partners was not uncommon for the participants or their male partners, upholding an image of mutual trust in the relationship was an important theme. The participants said that this mutual trust was displayed by not using condoms. The maintenance of the appearance of trust remained, despite high levels of reported risky sexual behavior by each partner outside the primary relationship. In light of the previously stated findings on fear associated with power imbalances, this dynamic further illustrates low levels of relationship power, which has been described as the ability to negotiate and communicate appropriate sexual practices, including the use of condoms (Pulerwitz, Gortmaker, & DeJong, 2000).

### Substance Abuse, Engaging in Prostitution, and a Partner's Incarceration

The third theme focused on situations that place participants at risk of HIV and STIs outside their primary sexual relationship. All the participants reported that drug and alcohol use influenced their risky sexual behavior. They said that drugs and alcohol allowed them to feel



carefree, hindered their ability to use condoms, and contributed to their engagement in risky sexual behavior with multiple partners, as the following comments indicate:

When I smoke weed, it's like you get more carefree, like you just let the moment take control of you. You get a little horny, I am not gonna lie. Some people say "Oh, when I drink or when I smoke, I don't know what I am doing," but I don't believe that. Me per se, I know what I am doing; it's just whatever feels better for me at the time. (ID: 004)

I know that where I live, most of the people are on drugs. Most of it is crack and heroin and stuff like that, and that leads to HIV. You don't know who you're sharing with. You don't know who's giving you what or what needle is clean. Where I live at, they don't care; as long as they're getting what they get, they don't care. (ID: 053)

The women indicated that using drugs and alcohol allowed them to live in the moment. They also reported that substance use influenced their ability to use condoms and have sex with additional partners, as is evident in the following comments:

When somebody is high, they're not using no condom because that's the last thing on their mind. And they're probably not in the right state of mind to think about a condom. Only thing they probably could think about is have another experience. (ID: 057)

Like I've been in a situation when my friend, he's 20, he has his own apartment, and everybody is always up there, going up there to party and drink and smoke and dance and everything like that. And there's been plenty of times when girls [have] gotten drunk and high and you know have sex with a few guys or have sex with somebody they just met, they don't know them. Or had a train ran on them. A train is like you know, when one girl is there and there's a whole bunch of guys having sex with her, back to back to back, that's what that is. (ID: 004)

Drug and alcohol use appear to have contributed to the participants' exposure to the risk of HIV by not using condoms and having sex with multiple partners concurrently. Moreover, drug use is a major route of exposure to HIV-related risk among African American women—a point that has been well documented in the literature (Lee & Fleming, 2001; Sanders-Phillips, 2002; Stevens, Estrada, & Estrada, 1998).

Women who also engage in prostitution face unique challenges regarding the use of condoms with multiple sexual partners. Two participants who had recently been charged with prostitution described their difficulties using condoms within the context of sex trading:

Researcher: What about women who occasionally go out on the street to make money, what are some of the strategies they use to protect themselves?

Respondent: Condoms.

Researcher: Are clients willing to use condoms?

Respondent: Yeah.

Researcher: Are there times when they are not?

Respondent: For oral sex. A lot of people ask you, but you personally have enough contact; but, I am sure there are girls who'd do it if they needed the money. (ID: 088)

I have had dates that have tried to pay me 5, 6, 7 hundred dollars to go without a condom .... I don't accept the money; it's nothing I give away. But some of the girls out there, they don't have condoms. I guess when they are out there, they're used to doing it without them or have dates go get condoms. But 9 times out of 10, the dates

don't go get condoms. So I guess the ones that didn't have condoms, I guess they dated without a condom. (ID: 015)

The negotiation of condom use while sex trading is influenced by financial compensation and presumably by the financial needs of the woman. Black women, who often experience unequal occupational and financial opportunities, may thus be subject to what has been termed an "economic exposure to HIV risk" on the basis of financial hardship or need (Wingood & DiClemente, 2000).

The women described scenarios in which the likelihood of engaging in risky sex with additional partners increased when their partners were incarcerated and hence unavailable. One participant discussed her partner's incarceration this way:

My baby's father, he got arrested, and I was talking with somebody else and we had unprotected sex. That was risky because I could have got something from the other male and ... my baby's father [would not know] that I had it. See, in my community, the only time when somebody really messes with somebody else is when their boyfriends go to jail. (ID: 014)

Another participant also reported that she had multiple sexual encounters when her partner was incarcerated. The health effects of having a partner who is incarcerated and the association with HIV-related risk behaviors by girlfriends or wives of prisoners have not been well documented in the literature (Freudenberg, Daniels, Crum, Perkins, & Richie, 2005; Lichtenstein, 2005). Grinstead et al. (2005) found that recently incarcerated men demonstrated high rates of postrelease unprotected sex with primary female partners. Having a partner with a history of incarceration was associated with increased STIs and forced sex for women (Kim et al., 2002). However, research has focused primarily on the HIV-related risk behaviors of male offenders (Grinstead, Zack, & Faigeles, 1999) and female offenders (Staton-Tindall et al., 2007) but not on their sexual partners.

### Strategies to Reduce the Risk of HIV/AIDS and STIs

The participants agreed that HIV is a serious issue in their neighborhoods, and each reported knowing at least one person who was living with HIV. When asked about the strategies that they used to reduce the risk of HIV and STIs, they reported the following: using condoms, reducing the number of sexual partners, abstinence, being tested regularly, improving verbal communication in relationships, and distributing condoms to friends and family members. This theme suggests that the participants were concerned about HIV and STIs and were looking for ways to reduce their risk. Most participants reported that using condoms is the best method to reduce risk:

Just use condoms, not try to sleep around and be a slut. But I mean you can sleep with just one person and get AIDS, so I would just say try to use a condom but not have sex at all, but who am I to tell somebody not to have sex? But the condom right now is the best way .... All these diseases, it's crazy. I don't even know, just try to wrap up; that's what I would say. (ID: 004)

I use protection if I am having sex with other people, but I have a main person that I am having sex with, and I know he's clean and he knows I am clean, and that's how we keep it. Using protection it helps a lot; it does because I am pretty sure I could have ran into a lot of things that I didn't run into, thank God. Protection is, that's what's up, and you gotta make sure you know how to use it right. (ID: 079)

Having one sex partner is how to stay clean. Using a condom with every guy, including your boyfriend, and carrying one. Or using a diaphragm. Make sure every guy that you have sex with, they have their condom, their own condom. And make sure that



you and him both have enough. That's really it. Females should have a bagful of condoms if they're gonna have partners like that. (ID:088)

As the comments indicate, most women acknowledged that the use of condoms was a primary method of reducing the risk of HIV and STIs, although perceptions about the need to use condoms varied by the type of partner. In addition to their own use of condoms, some women reported distributing condoms and information on safer sex to their family members and friends:

When I go to health clinics and places like that, they give out condoms, and my cousin lives there, too; she is a female, I bring them back. I'll give them condoms, anything I get back; [I say] "Hey, got condoms, hey, here you go." I am the one who got condoms, got little pamphlets that I got from the hospital on diseases and infections and stuff like that. (ID: 008)

Even when I am on the street, and they handing out condoms with the packets about HIV, I take them, I take them. Girls be looking "that's not ladylike, that's not ladylike," but I am safe. Like I am gonna be so safe. I don't care what ya'll think about me, ya'll could think of me as a freak because I am walking around with a bunch of condoms, but I just may be the one. (ID: 057)

Although some women attempted to promote safer sex to family members and friends, they perceived that others view women who possess condoms negatively. Most participants believed that women who carry condoms are not perceived to be "ladylike," and this perception may decrease the likelihood of women having condoms available or asking their sexual partners to use condoms. This is an important barrier to HIV/STI prevention for women, which was supported by previous research. These perceptions of femininity illustrate how women's vulnerability to HIV should be considered within the broader context of social norms and gender roles (Connell, 1987). In this instance, the issue of women's sexuality (evidenced by carrying condoms) appears to be attached to social concerns, such as impurity and immorality—attributes that are commonly associated with more traditional or patriarchal gender norms.

## Discussion

Although Black women are overrepresented in the criminal justice system and have alarming rates of HIV, to our knowledge, no previous studies have explored the cultural and relational contexts of sexual HIV risk behavior for Black women at early stages of involvement in the criminal justice system. This qualitative study focused on Black female defendants with overlapping risk factors and their HIV-related risk experiences, which provide a rich understanding of the barriers to the use of condoms, the circumstances that are associated with the risk of HIV outside the primary relationship, and the strategies that the women used to practice safer sex.

The findings are consistent with those of prior research that demonstrated the relationship among IPV, alcohol and drug use, and sexual HIV-risk behaviors (El-Bassel et al., 1998; El-Bassel, Gilbert, Rajah, Foleno, & Frye, 2000; Gilbert et al., 2000). In addition, the data are consistent with previous findings of the low use of condoms in noncasual intimate relationships and unprotected sex as sign of trust in a committed relationship (Catania et al., 1994; Misovich, Fisher, & Fisher, 1997; Morrill, Ickovics, Golubchikov, Beren, & Rodin, 1996). The women reported that they experienced and witnessed physical abuse by their sexual partners and that fear of the recurrence of IPV often kept them from negotiating safer sex. Previous research has repeatedly noted that IPV is one of the core experiences that put Black women at risk of victimization and sexual HIV risk behavior (El-Bassel et al., 2000; Kalichman, Williams, Cherry, Belcher, & Nachimson, 1998; Sterk et al., 2005). IPV is a particularly relevant issue

for Black female offenders, given that women who experience violence are overrepresented in the criminal justice system.

The themes that emerged from the study emphasize how power structures and cultural norms may influence Black women's risky sexual practices. Power imbalances that are associated with emotional or physical violence appear to be directly connected to a reduced likelihood of women effectively negotiating safer sex behaviors. These findings suggest that a focus on women's cultural ideologies and how women interpret their feelings of trust, love, and risk are important in understanding the social inequalities that place these women at risk of acquiring HIV. When a woman cannot communicate effectively with her partner, her power is lost, and she is often unable to restore that power (El-Bassel et al., 2000). Women are affected by this power imbalance and often engage in HIV-related risk behaviors because of fear of abuse or abandonment.

A unique finding of this study is that women may engage in (often unprotected) sex with additional partners when their primary partners are incarcerated. Considering the fear associated with violence for the women in this sample, it is understandable that their partners' incarceration presents a unique opportunity to assert themselves sexually without immediate fear of their partners' reaction. Previous research suggested that incarcerated men place their female partners at an additional risk for HIV by engaging in risky activities outside the primary relationship (Allwright et al., 2000; Mahon, 1996). This finding offers an additional perspective—that women, particularly women in violent relationships, may engage in risky sex with additional partners during their partners' incarceration, which may place both them and their partners at an increased risk of acquiring HIV and other STIs. Further research on this matter is needed to explore women's decision making regarding sexual behavior while their partners are incarcerated.

A limitation of the study was its small sample of nonrandomly selected female defendants with multiple HIV risk factors. As a result, generalizations cannot necessarily be made to Black female defendants as a whole. The themes that were developed from the sample and interview protocol paralleled many of the eligibility criteria for the study, so that the identification of additional themes may have been restricted. However, given the remarkable burden of HIV risk and disease faced by Black female defendants, continued examination of the HIV risk context for this population is an important area of social research.

## Implications

Despite these limitations, the findings suggest implications for social work practice and HIV prevention with Black women who are involved in the criminal justice system. HIV has disproportionately affected Black female offenders, as is evident in the high prevalence of HIV among incarcerated Black women (Maruschak, 2004). The study further demonstrated multiple HIV-related risks that Black female defendants face within the context of their sexual relationships while they are in the community as well as additional risks that are associated with having an incarcerated partner. Although no woman in the study reported being HIV positive, the participants reported high levels of sexual risk behaviors, indicating a substantial danger of acquiring HIV and other STIs. These findings highlight the urgent need for targeted interventions for female defendants, particularly women of color, while they are in the community and at early stages of involvement in the criminal justice system.

By nature of their limited contact with the criminal justice system, women with low-intensity involvement in the criminal justice system may be difficult to recruit and retain in HIV prevention efforts. Community courts and other alternatives to incarceration settings could serve as prime settings for HIV prevention interventions for female defendants. Defendants in

programs that are alternatives to incarceration are uniquely positioned to receive HIV risk-reduction strategies because they are able to put the strategies into practice immediately in the community. Community courts and other problem-solving courts also recognize the importance of addressing problems that influence behaviors through education and focused intervention. HIV prevention interventions could be successfully integrated into existing court treatment protocols and offered to female offenders who are at risk of acquiring HIV. In this way, the criminal justice system could make a vital contribution toward reducing the risk of HIV for Black women who are caught up in the criminal justice system.

HIV prevention models targeting Black female offenders will benefit from addressing the unique constellation of HIV risk factors for women within the context of their sexual relationships. The women in our study reported considerable experience with victimization and other social stressors, including substance abuse. For advocates of prevention whose clientele include women offenders, a psychosocial evaluation that explores the consequences of abuse for women's involvement in the criminal justice system and sexual decision-making practices may provide a richer assessment than addressing only women's sexual practices (Wyatt et al., 2004). Including an appraisal of power imbalances that are associated with gender to examine the HIV-related risks and inequalities that Black female defendants face has the potential to enhance community-based HIV prevention interventions. Because the relational themes of fear and trust apply uniquely to women, HIV prevention programs for female offenders should be developed in a gender-specific context. For female defendants who are involved in primary sexual relationships, couples-based HIV prevention interventions could be an effective model, provided that the interventions are designed to assess issues of power and violence in the relationship and allow for women to develop safety planning vis-à-vis their safer-sex negotiation practices.

Although notably at high risk for HIV and other STIs, many of the women in this study demonstrated considerable knowledge of safer sexual practices. One issue that emerged as a barrier to these practices, however, was the perception that women who assert themselves regarding safer sex may be seen as impure and unladylike. HIV prevention efforts with Black female defendants should explore how meanings are informed and constructed around issues of femininity and morality and provide a perspective that encourages women to protect their health and sexual relationships by instilling a sense of empowerment and developing positive group norms regarding safer-sex behaviors. In addition, the distinctive risk factors that are associated with sex trading, such as financial oppression and increased exposure to violence, should be discussed in the milieu of developing sexually healthy behaviors.

In addition to building risk-reduction skills, such as communication and negotiating safer-sex skills (El-Bassel et al., 2001), a focus on additional contributors to sexual risk for Black women in the criminal justice system can inform effective and culturally sensitive interventions. The findings from this study highlight the importance of relational and cultural meanings around issues of trust within longer-term sexual relationships. The maintenance of trust as a motivator for unprotected sex should be stressed as a relational factor that impedes safer-sex behaviors, and alternative means of demonstrating trust in relationships could be explicated. Given that drug use is prevalent among female offenders, the connection between drug use and reduced inhibitions leading to compromised sexual decision making is a key component of preventive messages. Moreover, providing access to substance abuse treatment could reduce the potential not only for HIV risk but for criminal recidivism as well. Last, a discussion of the unique opportunity for risky sexual partnerships presented by a partner's incarceration may help Black women effectively anticipate and plan for such scenarios that may serve as exposures to the risk of HIV.

## Conclusion

This study provided the unique perspective of Black female defendants in describing their relational contexts for sexual behaviors and HIV risks. Women defendants, particularly those who are women of color, bear the weight of many stressors, including exposure to violence, drug use/abuse, and social hardships, that contribute to and are a result of involvement in the criminal justice system. Investigating policies that support alternatives to standard criminal justice practices in reducing recidivism is a key element of social work with this population. The empowerment of Black criminal justice-involved women through HIV prevention and other culturally sensitive social work interventions is greatly needed. These interventions must integrate an understanding of the distinct personal, social, and structural factors that Black women defendants face if the interventions are to be effective and meaningful. Taken together, this work has the potential not only to improve individual and public health for women of color but to promote social justice for a population that has historically received far too little.

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**Table 1**

## Characteristics of the Sample

Variable	% or range ( <i>M</i> )
Sociodemographic characteristics	
Age	18–30 years (21.5 years)
Single, never married	100%
Children aged 18 and younger	50%
Educational level	9–14 years (11.7 years)
Criminal justice involvement	
Prior arrests	70%
Prior incarceration	40%
HIV risk in the past 90 days	
Intercourse	
Condom use every time	40%
Condom use half the time	20%
Never use condoms	40%
More than one sex partner	40%
STI diagnosis	10%
Partner's HIV risk	
Know/suspect partner is having sex with others	80%
Partner diagnosed with STI	40%
Partner is HIV positive	10%
IPV in the past 6 months	
Partner threatened to hit or throw something at me	50%
Partner twisted my arm or hair or threw something	40%
Partner forced sex without a condom	40%
Drug use in the past 90 days	
Marijuana	100%, 1–90 days ( <i>M</i> = 40.3)
Crack or cocaine	30%, 2–65 days ( <i>M</i> = 22.3)
Alcohol (4 or more drinks at once)	80%, 1–90 days ( <i>M</i> = 18.9)
History of drug use	30%

Note: IPV = intimate partner violence; STI = sexually transmitted infection.