INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6” x 9” black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

UMI
A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
313/761-4700 800/521-0600

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
THE CULTURAL CONTEXT OF PUERTO RICAN ADOLESCENTS' PERCEPTIONS
OF AIDS RISK

by

Delia E. Easton

Submitted in partial fulfillment of the requirements for the Degree of Doctor of Philosophy

Dissertation Advisor: Janet W. McGrath, Ph.D., Associate Professor

Department of Anthropology

CASE WESTERN RESERVE UNIVERSITY

January 1998
We hereby approve the thesis/dissertation of

Delia Easton

candidate for the Ph.D. degree.*

(signed)

[Signatures]

(chair of committee)

(date) 18 June 1997

*We also certify that written approval has been obtained for any proprietary material contained therein.
THE CULTURAL CONTEXT OF PUERTO RICAN ADOLESCENTS
PERCEPTIONS OF AIDS RISK

ABSTRACT

by

Delia E. Easton

This dissertation is an exploration of how Puerto Rican adolescents living in Hartford, Connecticut, perceive AIDS and rank it as a risk in relation to other perceived health concerns. The cultural context informing the teens' perceptions is examined. Specifically, the following cultural domains were evaluated to assess their relevance to the teens' constructions of risk: conceptualizations of gender, sexuality, religion, family, and ethnic identity. These particular domains were studied because previous research had hypothesized them to be influential in both the experience of AIDS overall, and the Latino experience of AIDS, specifically.

The study was divided into two phases. During Phase I, exploratory data on significant themes relevant to the teens' perceptions of HIV were collected. Six key informant interviews with staff at the Hispanic Health Council, two other community organizations, and three focus groups with a total of nineteen teens were conducted. Two key themes developed from the Phase I data: 1) the teens perceived violence in the community as a larger concern than AIDS, and 2) the teens' beliefs about AIDS were associated with, and shaped by, structural issues such as poverty and racism. During Phase II of the research, forty-two teens completed intensive interviews, which allowed for the further exploration of themes arising in Phase I. In addition, two interview instruments were developed to examine key themes arising from Phase II. The purpose of the first instrument was to evaluate how "proximity of relationship" to a person living with HIV affects AIDS risk perceptions. Fourteen of these interviews were completed. The second instrument, a survey, compared teens' perceptions of violence with perceptions of AIDS; fifty teens were surveyed. In total, one hundred twenty five teens were interviewed or surveyed during the entire study.

To understand the intersection between structural factors and cultural context in teens' construction of HIV/AIDS risk, their experiences of, and beliefs about living in Hartford's Puerto Rican community were explored through interview questions and participant observation in the community. Within this framework, teens' perceptions of competing health risks of equal or greater concern to them than AIDS, and their perceptions about competing health concerns in the community, were examined.
To some extent, all cultural domains explored were found to comprise the cultural context of the teens' perceptions of HIV. However, the link between the domains of family, gender and sexuality were articulated much more overtly by the teens than the domains of religion and ethnic identity. In fact, commonly, the participants perceived Puerto Rican ethnic identity as more integrally linked to violence than to AIDS.

In their descriptions of Hartford's Puerto Rican neighborhood, participants described several other health risks they perceived as of equal or greater risk than AIDS. Most often, the teens stated that violence was a larger concern for them than AIDS. Although they believed that they were more likely to be affected by violence than AIDS, some teens discussed an "abstract" fear of AIDS, rooted in the idea that AIDS ultimately causes more suffering and pain than violence.
ACKNOWLEDGMENTS

This research project received generous financial support from the National Science Foundation (Grant number SBR-9500730), The Wenner Gren Foundation for Anthropological Research, and the Armington Foundation.

I wish to extend my appreciation to the teenagers who allowed me to interview them, and assisted me in trying to understand their beliefs and perceptions about AIDS. In particular, I would like to acknowledge the efforts of Jessica Martinez, Candy Hernandez, and Glenda Gonzalez, who recruited participants, administered, and offered their insight about the project.

I thank Raymond Bermudez and Carmen Raye for allowing me to interview them and conduct focus groups with their teen clients.

In addition, I extend the utmost appreciation to the staff at the Hispanic Health Council, who welcomed me as a student intern, and assisted me with my research in a variety of different ways. I wish to thank Dorca Malave for serving as translator in several Spanish interviews, and guiding these interviews with thoughtful and insightful probes. I am appreciative to Dr. Nancy Romero-Daza for translating study consent forms into Spanish, and offering her support and advice throughout the dissertation process. I also thank Elizabeth Nieves, Betty Gonzalez, Ivonne LeBron, and Marta Torres for their time, and willingness to be interviewed. I am especially grateful to Elizabeth Nieves for allowing me to conduct a focus group with her teen group participants, and for recommending teens to assist with the research. In addition, I would like to thank Luzy Rohena for recruiting several participants for a portion of this study.

I am very appreciative of the support and assistance provided by Dr. Sheryl Horowitz, especially for her statistical analysis recommendations. Also, I thank Pushpinder Pelia for leading me to several participants, and offering her support and advice during my time at the Hispanic Health Council. I am indebted to Dr. Merrill Singer for providing me two internship opportunities at the Hispanic Health Council, supporting my research, and grateful for his expertise, advice and encouragement throughout the study.

I have had the good fortune of having Dr. Janet McGrath serve as my advisor and dissertation chairperson. I am extremely appreciative to her for the unflagging support, insight, and expertise she has offered in regard to all my academic endeavors, and wish to thank her for her patient encouragement in seeing this dissertation through to its completion. In addition, I wish to thank
Dr. Jill Korbin for serving as a member of my dissertation committee, sharing her expertise, and providing me solid support during throughout my studies Case Western Reserve University. I am further grateful to Dr. Atwood Gaines for agreeing to be a member of my dissertation committee, and for his insightful comments on a draft of this dissertation.

I would also like to thank Dr. Mark Luborsky for his interest in my research, and feedback on several drafts of grant proposals.
TABLE OF CONTENTS

Abstract
Acknowledgments
Tables
Table of Contents

Chapter I INTRODUCTION ...........................................................................................1
  Chapter Organization .........................................................................................5

Chapter II BACKGROUND AND SIGNIFICANCE ....................................................8
  Section 1: Medical Anthropology and AIDS.....................................................9
  Section 2: Anthropological Approaches to Risk Perception............................13
  Health Behavior Models of Adolescent Risk....................................................15
  Adolescent Invulnerability ..............................................................................18
  Section 3: Studies of Latino Knowledge About AIDS....................................20
  The Influence of Knowing Someone with HIV on HIV Risk Behaviors...........23
  Section 4: Cultural Knowledge Systems: Folk Interpretations of AIDS
  Information ...........................................................................................................26
  Section 5: Political Economy of AIDS.............................................................30
  Competing Health Risks ...................................................................................33
  Section 6: Puerto Rican History ......................................................................36
  Section 7: Latino Culture and AIDS...............................................................39
  Family ..............................................................................................................43
  Cultural Conceptualizations of Gender and Sexuality ....................................45
  Ethnicity ...........................................................................................................50
  Religion ...........................................................................................................53
  Section 8: The Research Setting ......................................................................56
  Puerto Ricans in Hartford ..............................................................................57
  Epidemiology of AIDS in Hartford ..............................................................63
  The Hispanic Health Council ......................................................................63
  The Organizational Structure of the Hispanic Health Council .......................64

Chapter III METHODOLOGY ..................................................................................67
  Introduction .......................................................................................................67
  General Procedures ..........................................................................................68
  Confidentiality ..................................................................................................70
  Consent Forms ..................................................................................................70
  Criteria ..............................................................................................................71
  Phase I ................................................................................................................72
# Table of Contents

## Phase I Findings

### Section 1: Staff Key Informant Interviews
- AIDS Knowledge Questionnaires
- Pre-focus Group Questionnaire Responses

### Section 2: Focus Groups
- Focus Group Questions
  - Focus Group 1
  - Focus Group 2
  - Focus Group 3

### Section 3: Summary
- The Development of the Phase II Instrument

## Phase II

### Intensive Interviews
- Preliminary Intensive Interview Analysis

## AIDS/Violence Survey

## Section 3: Analysis
- Intensive Interview Data
- AIDS Violence Survey Data
- AIDS Acquaintance Interview Data

## Section 4: Summary

## Intensive Interview Participants’ Sex Behaviors, Knowledge, and Attitudes About AIDS

### Section 1: Intensive Interview Participant Demographics and Reported Sex Behaviors

### Section 2: AIDS Knowledge and Attitudes
- Sources of Information About AIDS
- Participant Discussions About AIDS
- Perceptions of Peer Risk of HIV Infection
- Beliefs About Condom Use

### Section 3: Summary

## Cultural Context of AIDS Risk Perceptions

### Section 1: Religious Beliefs and HIV Perceptions

### Section 2: Perceptions of Gender Roles and the Division of Labor
- Household Gender Roles and Responsibilities
- Women’s Locus of Control in the Household

---

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
Chapter VII PERCEPTIONS OF HARTFORD'S PUERTO RICAN NEIGHBORHOODS AND DESCRIPTIONS OF COMMUNITY-DEFINED RISKS

Section 1: Life in Inner-City Hartford: Themes From the Intensive Interviews
- Fragmentation in the Puerto Rican Community
- Unemployment and Welfare
- Gang Violence
- Limited Educational Opportunities
- Perceptions of the Neighborhood
- Competing Health Concerns
- Angelina: A Case Study
- Perceptions of Violence Versus AIDS Risk

Section 2: AIDS/Violence Survey Results
- Teens' Experiences and Attitudes Toward Violence
- Teens' Experiences and Attitudes Toward AIDS
- The Perception of AIDS and Violence as Risk to Adolescents in the Puerto Rican Community
- Gender Differences in Participants' Experiences of Violence

Section 3: Comparison of Participant Attitudes Toward Violence From Two Instruments

Section 4: Summary
Chapter VIII Conclusion .............................................................................................240

APPENDICES ................................................................................................................252

Appendix 1: Participant Information Sheet .............................................................252
Appendix 2: Consent for Participation in Intensive Interviews Study (Phase II)
Appendix 3: Parental Consent Form for Participant in Intensive Interview Study (Phase II) .............................................................253
Appendix 4: Permiso de Los Padres Para Participar en Entrevistas Individuales (Key Informant Interviews) .............................................................255
Appendix 5: Key Informant Interviews for Staff .....................................................256
Appendix 6: Focus Group Discussion .....................................................................258
Appendix 7: Pre-focus Group Questionnaires .........................................................260
Appendix 8: AIDS Knowledge Questionnaire .......................................................263
Appendix 9: Intensive Interview .............................................................................266
Appendix 10: AIDS/Violence Survey ....................................................................271
Appendix 11: AIDS Acquaintance Interview .........................................................275
Appendix 12: Intensive Interview Codes and Labels .............................................279
Appendix 13: Intensive interview Participants ....................................................285

BIBLIOGRAPHY .........................................................................................................286

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
TABLES

Table 1: Relationship Between Proximity of Teens’ Relationship to PLHA and Beliefs About Casual Contact .......................................................................................24
Table 2: Proximity of Teen Relationship to PLHA and Number of Sexual Partners ..............................................................................................................................................25
Table 3: Proximity to PLHA and the Likelihood of Rarely Using Condoms for Vaginal Sex .................................................................................................................................26
Table 4: Type of Interview and Number of Participants ..........................................................................................................................................................................................70
Table 5: Demographic Data for Focus Group Participants .................................................................................................................................................................................................94
Table 6: Focus Group Responses to the AIDS Knowledge Survey ..................................................................................................................................................................................96
Table 7: Issues Ranked as Number One Concerns ..........................................................................................................................................................................................103
Table 8: Intensive Interview Participants’ Responses to the AIDS Knowledge Surveys .................................................................................................................................................122
Table 9: Frequency of Sexual Activity and Condom Use Among Sexually Active Participants ..........................................................................................................................................................................................132
Table 10: Preferences for Partners’ Ethnicity ..........................................................................................................................................................................................187
Table 11: Number of Participants Affected By Specific Acts of Violence ............................................................................................................................................................................................218
Table 12: Type of Violence Participants Reported Experiencing ..........................................................................................................................................................................................219
Table 13: Number of Participants Witnessing Specific Acts of Violence ............................................................................................................................................................................................220
Table 14: Participants’ Fear of Violence in the Future ..........................................................................................................................................................................................220
Table 15: Participants’ Fear of Violence in Comparison to AIDS ..........................................................................................................................................................................................224
Table 16: Participant Perceptions of Being More at Risk for HIV or Violence in the Next Year ..................................................................................................................................................225
Table 17: Reasons for Low/High Rating of Risk for HIV ..........................................................................................................................................................................................228
Table 18: Perceived Likelihood of Puerto Rican Adolescents Being Affected By AIDS or Violence in Comparison to Adolescents from Other Ethnic Groups ..........................................................................................................................................................................................237
Table 19: The Relationship Between Gender and Likelihood of Being Afraid of AIDS of Violence More at Risk for HIV or Violence in the Next Year ..........................................................................................................................................................................................234
CHAPTER I: INTRODUCTION

This dissertation is an exploration of Puerto Rican adolescents’ self-perceptions of AIDS risk, and the cultural context that shapes these perceptions. This study examines the cultural basis of HIV/AIDS risk perceptions by specifically focusing on the experiences, beliefs, and assessments of AIDS along a continuum of health risks among a group of Puerto Rican teenagers living in Hartford, Connecticut. The goal of this research is to address unanswered questions about the relationship between adolescent AIDS knowledge and the practice of AIDS risk behaviors.

Specifically, this study addresses an unresolved issue in AIDS education and prevention efforts important for all age groups, but particularly crucial for adolescents who are vulnerable to peer pressure, and apt to experiment sexually (Bowler et al. 1992). At this point, it remains unclear why AIDS knowledge is a necessary component, but not entirely a sufficient impetus for behavioral change (Diclemente 1993). As a means of exploring the gap between AIDS knowledge and reduction of AIDS risk practices, this research provides an ethnographic case example of how a group of Puerto Rican teens—who have relatively high levels of AIDS knowledge—assess, rank, and negotiate the risk of AIDS in their lives.

---

1 The term HIV/AIDS is used here to refer to the entire spectrum of risks related to infection of HIV and the development of the disease stage clinically identified as AIDS. While HIV infection is not the same as AIDS, the two conditions represent stages on a continuum of infection and disease.
Puerto Rican adolescents' perceptions of AIDS risk are examined through several specific areas of inquiry: 1) the exact nature of their perceptions of AIDS risk; 2) the cultural context of these perceptions; 3) the extent to which the teens' folk theories about AIDS, drawn from culturally shaped notions of risk, reflect alternative cultural interpretations of popular information about AIDS; 4) how the existence of competing health concerns influence the teens' AIDS risk perceptions; 5) the social structural components of both AIDS risk perceptions and competing health concerns, and finally; 6) the appropriateness of the notion of adolescent invulnerability for understanding this group of teens' risk perceptions.

This study examines the extent to which teens' folk perceptions of risk and avoidance of AIDS risk reflect culturally influenced interpretations of AIDS information. Building upon Douglas and Wildavsky's (1982) and Douglas' (1993) work, findings are presented that illustrate how social and cultural context function to shape how individuals understand and interpret information about AIDS. This cultural context ultimately provides the basis for individuals to determine the relevance of AIDS as a health risk to them, as demonstrated in numerous anthropological studies about AIDS (e.g., Carrier and Bolton 1991; Carrier and Magana 1992; Clatts and Mutchler 1989; Douglas 1993; Farmer 1992; Ingstad 1990; Levine 1992; Worth 1988). In particular, the body of work devoted to understanding AIDS risk perceptions and beliefs among adults (Farmer 1992; Herdt and Boxer 1991; Magana and Carrier 1991; McGrath et

In order to understand the cultural basis of AIDS risk assessment, it is appropriate to consider the role of specific cultural domains. Several such domains previously identified as being salient to understanding Latino beliefs and behaviors (Marin 1989; Medina 1987; McGoldrick et al. 1989), significant to Latino perceptions of health in particular (Harwood 1981), or of AIDS specifically (Alonso and Koreck 1989; Bok and Morales 1991; Carrier 1989; Cunningham 1989; Flaksrud and Nyamath 1989; Flaksrud and Uman 1993; Magana and Carrier 1991; Mays and Cochran 1989; Menendez et al. 1990; Rapkin and Erickson 1990; Singer et al. 1990a, 1990b; Sufian et al. 1990; Wyatt 1991) are examined in this study to gauge their importance in Puerto Rican teens' formulations of AIDS risk perceptions. These are: 1) familial relationships; 2) conceptualizations of gender roles and dynamics; 3) ethnic identity; 4) views of sexuality; and 5) religious beliefs. Although these domains overlap to an extent, findings will demonstrate which of these domains appear to most significantly influence the teens' assessments of AIDS risk, and why. Past research has suggested that fatalism, an acceptance of fate embedded in Latino Catholic tradition, plays a role in how Puerto Ricans perceive AIDS (Bok and Morales 1991; Sufian et al. 1990). Within the larger cultural domain of religion, this dissertation questions the existence and implications of fatalistic attitudes toward HIV among this group of teens.
The function of cultural and social context as a lens highlighting which health issues are viewed as risks among this group of teens cannot be well understood without looking at competing health concerns in Hartford's Puerto Rican community. Anthropologists have underscored the importance of considering what other health issues may be more threatening than AIDS for a particular population (Clatts 1993; Worth 1988). This study looks at which competing health concerns exist for Puerto Rican adolescents living in Hartford, Connecticut.

This research also explores the interrelationship between these competing health concerns and social structural forces, as depicted in the teens' description of their experiences of living in Hartford. A further impetus for the teens' assessment of the importance accorded to AIDS in their lives, these social structural elements impinge on the extent to which AIDS is deemed a community risk. Research delving into the political economy of AIDS (Ankrah 1991; Connors 1996; Farmer 1992; Farmer and Kim 1991; Farmer 1996; Lindenbaum 1992; McCombie 1990) as well as Critical Medical Anthropological AIDS research (Singer 1991; Singer et al. 1990a; Singer 1996), offer examples of how social structure influences AIDS perceptions, beliefs and behaviors among adults. Findings which will be presented here provide examples of how the political economic atmosphere of Hartford's Puerto Rican community colors how this sample of Puerto Rican adolescents prioritize the importance of AIDS among various health risks, and concerns about health and well-being in their future.
Another theoretical area of relevance this study addresses is the notion of adolescent invulnerability. Elkind (1967) and other behavioral social scientists have proposed that teens are unlikely to realistically perceive, and therefore assess, their own vulnerability to risk because of their supposed psychological immaturity. Drawing theoretical support from the large body of AIDS and anthropology research, findings from this study provide alternate ways of interpreting adolescent beliefs and behaviors about health risks, that might otherwise appear to be indicative of a perception of invulnerability.

Together, the investigation of these questions will provide a clearer understanding of how Puerto Rican adolescents perceived risk of AIDS in Hartford, Connecticut. As such, this study will contribute to the growing body of work examining “risk” within diverse cultural contexts.

**Chapter Organization**

Chapter II situates this study within medical anthropology and behavioral research, drawing upon relevant literature to describe past and current approaches utilized to evaluate perceptions of risk. The setting of the study, focusing primarily on the history of the Hispanic Health Council, and a brief background of Puerto Rican history in Hartford are also presented in this chapter.
Chapter III explains the methods used to collect and analyze the data and describe the two phases of the study. Phase I of the study comprised of Key Informant and focus group interviews; phase II included Intensive Interviews, AIDS/Violence Surveys, and AIDS acquaintance interviews. This chapter also presents a brief description of the demographic characteristics of the study sample.

Chapter IV details findings from Phase I of the study through a presentation of data from staff key informant and focus group interviews.

Chapter V presents Phase II findings. It describes the intensive interview participants' reported sex behaviors, alcohol and drug use, and explores their basic knowledge, beliefs, and perceptions about HIV/AIDS, representing the nature of teens' risk perceptions.

Chapter VI presents findings to illustrate the cultural context of this group's perceptions of AIDS. The salience of cultural conceptions of gender, sexuality, the role of the family, and religious and ethnic identity in the formations of AIDS risk perceptions is covered. In addition, the teens' cultural logic systems for assessing the possibility of a potential sex partner being infected with HIV is discussed.

Chapter VII presents findings on the social structural basis of the teens' ranking of AIDS as a health risk. The focus of this chapter is how the teens in this study
perceive Hartford's Puerto Rican community. Within the context of the teens' perceptions of life in Hartford it explores their prioritization of AIDS among other competing health risks. Other health risks they experience and attempt to cope with are discussed to provide a background for understanding how they assess and prioritize the risk of AIDS among these other issues. In particular, findings comparing the teens’ perceptions of the risk of AIDS to the risk of violence, are presented as an example of a competing health concern perceived as a larger problem than AIDS. Finally, the relevance of the notion of “adolescent invulnerability” as a model for understanding how the teens in this group perceive AIDS is examined.

Chapter VIII presents a summarized discussion of the findings.
CHAPTER II: BACKGROUND AND SIGNIFICANCE

This research will contribute to an anthropological understanding of the cultural context of Puerto Rican adolescents' perceptions of AIDS risk. It provides an ethnographic record of how HIV/AIDS has influenced the lives of Puerto Rican adolescents in a Northeastern U.S. city, and adds to the larger body of literature exploring the connection between cultural context and risk perception, through an investigation of which constellation of cultural beliefs inform teens’ perceptions of AIDS risk. On a theoretical level, as a case study of the intersection between culture and health, the data from this study will contribute to the growing body of medical anthropology research about AIDS.

The intent of this study is to address some of the unresolved questions about the relationship between AIDS knowledge, and changes in AIDS risk behavior practices, by focusing on the AIDS risk perceptions of a group of Puerto Rican adolescents in Hartford, Connecticut. On a broad level, this study investigates the cultural, and political economic context of these teens’ AIDS risk perceptions. Exploration of these cultural and social structural bases will permit the identification of those health issues defined by community norms as greater threats than AIDS, and the teens’ folk cultural interpretations of AIDS information.

To address these questions, this study has drawn upon prior research in several
different areas. First, a review of anthropological and social science approaches to understanding risk will establish the theoretical origins of this study. Second, anthropological approaches to AIDS are presented in order to show how cultural and political economic elements of AIDS have been identified and operationalized for other ethnic and age groups. A discussion of this literature also clarifies the relevance of examining both competing health concerns and folk cultural interpretations of AIDS information for an assessment of the relationship between AIDS knowledge and AIDS risk practices. Third, psychological theories about adolescent risk behavior are presented and contrasted with the anthropological approaches, to examine the possible utility of these models for understanding adolescent AIDS risk behavior. Finally, the epidemiology of AIDS among adolescents, and cultural domains of Latino culture salient to researching the cultural context of AIDS risk perceptions are discussed.

Section 1: Medical Anthropology and AIDS

of HIV transmission have been described (Carrier and Bolton 1991; Carrier and Magana 1992; Farmer 1992; Ingstad 1990; Levine 1992; Lindenbaum 1992; Worth 1988); AIDS risk perceptions and beliefs among adults have been documented (Farmer 1992; Herdt and Boxer 1991; Magana and Carrier 1991; McGrath et al. 1993; Schoepf 1991 and 1992; Sibthorpe 1992; Sobo 1993; Swanson et al., 1992); and the impact of stigma on cultural ideologies of AIDS has been explored (Clatts and Mutchler 1989; Douglas 1993; Friedman et al. 1987; Taylor 1990). The political economy of AIDS will be discussed in greater detail in Section 5. Importantly, anthropological research has been used to alleviate some misconceptions about HIV transmission and risk categories (e.g., Farmer and Kim 1991, Farmer 1992), and to directly stem the spread of the epidemic. Early in the 1990s, Stall (1991) made the argument that anthropological methods greatly enhance the efficacy of AIDS prevention efforts by allowing for an assessment of cultural context.

Farmer and Kim (1991) suggest that cultural tradition and experience affect individual perceptions of AIDS. Farmer argues that perceptions of AIDS risk arise from “core cultural constructs” (1992:311), which can be elucidated through ethnographic research. In Haiti, for example, perceptions of AIDS are rooted in the remnants of colonialism, the lack of solidarity among the poor, and the political corruption of the elite (Farmer 1992). In the U.S., AIDS is a disease associated with the deviant and disadvantaged (Farmer 1992), thus creating a tendency for those who do not perceive themselves as practicing “stigmatized” behaviors, or of being economically
disadvantaged, to deny the potential of risk from HIV (Douglas 1993).

Connors et al. (1992) have proposed that it is essential to evaluate the ways in which the values and norms of the dominant culture in the U.S. are incorporated into the values of ethnic groups, to most accurately capture the multiple factors in addition to culture influencing HIV risk in the U.S. Aside from dominant and sub-cultural values, these researchers suggest that ethnic and economic factors further shape HIV risk perception (Connors et al. 1992). Also, an individual may have seemingly contradictory beliefs about HIV, that reflect circumstantial and contextual variation in the attribution of values to behavior (Connors et al. 1992).

The work of McGrath et al. (1993) exemplifies both the impact of cultural tradition and gender power differentials on AIDS risk perception and behavior. Women in Uganda reported accurate perceptions of their risk of HIV infection and accordingly reduced their number of partners. However, since it is culturally acceptable for Bagandan men to have multiple sexual partners, women perceive themselves at risk for HIV infection through their male partners (McGrath et al. 1993).

Magana and Carrier's (1991) research on Mexican-American men in Southern California offers an example of how cultural norms about sex, and the concomitant stigma surrounding homosexuality, have resulted in a cultural reconceptualization of which behaviors are regarded as homosexual, thus destigmatizing them. Southern
Californian Mestizos do not define men who engage in insertive anal sex with other men as homosexual, while men who engage in receptive anal sex are so defined (Magaña and Carrier 1991). These cultural definitions destigmatize homosexuality to some extent by permitting men to have sex with men without necessarily experiencing the shame associated with being gay in many cultures. However, these cultural interpretations of homosexuality also impact mestizo men's perceptions of AIDS risk, because if those who participate in insertive anal sex are not thought of as homosexual, and therefore do not see themselves at risk for HIV infection, they will be less likely to respond to AIDS risk reduction information.

Another important aspect of an anthropological focus on cultural diversity within the field of AIDS research has been the elucidation of, and attempts to eradicate, prevailing stereotypes about people living with HIV. Early in the epidemic, attention was drawn to a widespread misconception that certain groups of people, namely gay men, intravenous drug users, and Haitians, comprised groups “at-risk” for HIV because of their so-called “promiscuity” (Bolton 1992a); their perceived deviance (Brandt 1987; Clatts and Mutchler 1989); and, in the case of Haitians, their nationality (Farmer and Kim 1991, 1992). The concept of “at-risk” groups is problematic because it stereotypes HIV risk on the basis of identity alone (Sabatier 1988). This definition of “at-risk” results in groups of people (e.g., gay men, IV drug users) being scapegoated for the existence of HIV. Although the concept of “at-risk” groups has been largely corrected within the medical community and social science...
literature, and the category “Haitian” has been removed from the CDC’s categories of risk groups (Sabatier 1988), much of the stereotyping and stigma surrounding AIDS in the U.S., and internationally, remains. Puerto Ricans in the U.S. are marginalized as a result of their ethnicity and language differences; because of this, Puerto Ricans living with HIV may be doubly stigmatized.

These examples of anthropological studies examining AIDS beliefs and behaviors demonstrate that it is not possible to fully understand individual and collective beliefs and behaviors about AIDS without investigating the cultural basis of AIDS. Despite their status as U.S. citizens, Puerto Ricans living on the U.S. mainland are to a large extent culturally and economically marginalized (Singer et al. 1990a). Few studies have examined Puerto Rican adolescents’ perceptions of AIDS from an emic perspective. This dissertation attempts to identify the cultural context of Puerto Rican adolescents’ perceptions of AIDS risk.

Section 2: Anthropological Approaches to Risk Perception

Risk perception research in the social sciences examines the perceived risk of numerous health concerns and hazards, including environmental risk, technological and chemical risk, risk of automobile injury, risk of injury to children and the risk of contracting a chronic disease, including AIDS (Glik et al. 1991; Kronfeld and Glitz 1992; MacDonald and Smith 1990; Moatti et al. 1990; Mondragon et al. 1991; Moore
and Rosenthal 1991, 1992; Nelkin 1989; Van der Vlede and Hooykaas 1992). Risk perception also has been approached as a socially constructed concept, its validity assessed cross-culturally (Johnson 1991; MacDaniels and Gregory 1991), and its social construction operationalized through cultural theory (Dake 1992; Douglas 1993; Douglas and Wildavsky 1982).

For the purposes of this study, risk perception will be defined as “the judgments people make when asked to evaluate hazardous activities and environments” (Kronenfeld and Glitz 1992:307). Social scientists have acknowledged the importance of analyzing the concept of risk, and risk perceptions, from a cultural standpoint (Dake 1992; McDaniels and Gregory 1991; Nelkin 1989; Wildavsky and Dake 1990). Much of this work is premised on the basic idea of cultural variability: because each culture assigns different meanings to situations, events, relationships, and behaviors, it follows that what constitutes risk also varies culturally (Dake 1992). It remains unclear whether the concept of risk is even universally applicable. Further, these researchers propose that cultural norms themselves shape and influence what specifically is considered a risk (Douglas and Wildavsky 1982; McDaniels and Gregory 1991). In turn, the selective attention individuals pay to specific risks designated as such, based on these cultural norms, reinforces cultural ideologies, and serves as a social control through the sanction of risk reduction behavior (Douglas 1985; Wildavsky and Dake 1990).
Aside from being culturally determined, Douglas and Wildavsky (1982) state that risk perception is inherently political. They suggest that assessing the distribution of power in a social setting is essential to understanding risk. They pursue this idea further, presenting the argument that what is considered a risk reflects institutionalized differentials of wealth and power. Nelkin (1989) concurs that what is considered risky in a culture or community is not only a reflection of cultural norms and biases, but also of the political and economic context, rather than a gauge of the real degree of danger presented by the risk itself.

Incorporating the above orientation, “risk” in this dissertation is conceptualized as a reflection of cultural values, norms, and the political and economic environment within which risk is constructed. This dissertation will provide insight into the cultural norms, arising from specific cultural domains, most influential to Puerto Rican teens’ conceptualization of AIDS risk. In addition, the political and economic context of their AIDS perceptions will be discussed. Bearing in mind that cultural norms also affect what behaviors or health concerns are considered risks within a community, the possibility that other health issues provoke equal or greater concern than the prospect of HIV infection among these teens also will be considered.

Health Behavior Models of Adolescent Risk

In contrast to anthropological literature on risk, health behavior and epidemiological
research on AIDS risk is more specifically focused on the relationship between risk perception and risk behavior. In health education research, the concept of risk perception has been used as a component of health belief and behavior models, through which the link between risk perception and risk behavior is explored (Basen-Enquist 1992; Brown et al. 1991; Hingson et al. 1990; MacDonald and Smith 1990; Van der Velde and Hooykaas 1992; Weinstein and Nicolich 1993; Widdus et al. 1990).

Health belief and behavior models also have been the primary frameworks utilized to assess AIDS risk perceptions (Bowler et al. 1992; Boyer and Kegeles 1991; Brown et al. 1991; Caron et al. 1992). Specifically, AIDS risk perception has been explored through: 1) Rosenstock’s health belief model (1974); 2) Azjen and Fishbein’s theory of reasoned action (1977); and 3) Bandura’s social learning theory, within the realm of health education. The utility of the health belief model for accurately predicting AIDS risk and risk-reduction behaviors has been challenged (Brown et al. 1991; Hingson et al. 1990; MacDonald and Smith 1990; Widdus et al. 1990). Brown et al. argue that the health belief model is inadequate for predicting adolescents’ AIDS behaviors because it neglects to include: 1) emotional aspects of decisions about AIDS; 2) the impact of peer group influence; and 3) developmental variables. A further problem of the model raised by several researchers is that perceived susceptibility does not consistently predict AIDS preventive behaviors, particularly so in lieu of speculation that adolescents reportedly perceive themselves invulnerable to
most health risks (Brown et al. 1991; Basen-Enquist 1992; Widdus et al. 1990). These models may be more effective for understanding AIDS risk behaviors used in conjunction with anthropological research assessing the cultural context of risk perception in general, and exploring such factors as the emotional aspects of AIDS-related decisions. For example, Sobo’s (1993, 1996) studies about women’s decisions concerning condom use identifies the role of emotion in intimate relationships, among other issues, as an important factor to examine in order to understand reasons why people do not consistently use condoms.

The theory of reasoned action holds that behavioral intention, determined by an individual’s attitude toward the behavior in question, in conjunction with his or her perception of peers’ attitudes toward the particular behavior, can predict actual behavior (Azjen and Fishbein 1973). The assessment of peer attitude is believed to enhance the accuracy of this model for predicting adolescent AIDS risk behaviors because it encompasses the peer group as a viable behavioral influence. This model remains problematic because it is premised on the idea that individuals are conscious of their decision-making process, make decisions based on rational criteria, and can accurately gauge the impact of peer influence (Van Landingham et al. 1993).

Finally, social learning theorists argue that preventive health behavior hinges on an adequate sense of self-efficacy (Bandura 1977). Bandura suggests that self-efficacy is necessary to enact behavioral change. Among adolescents, the construct of self-
efficacy has been found to be related to adolescents’ ability to discuss AIDS with their peers (Basen-Enquist 1992). However, self-efficacy has not been found to be predictive of condom use, an extremely important variable in AIDS risk reduction (Basen-Enquist 1992).

**Adolescent Invulnerability**

An influential theory in much of the adolescent AIDS risk perception literature is that of adolescent invulnerability; the idea that adolescents are especially vulnerable to health risks, precisely because they do not perceive themselves to be at risk. This theory proposes that adolescent risk-taking is an inevitable phase of biological and psychological maturation (Arnett 1992; Irwin 1993; Jessor 1990; Millstein and Irwin 1993; Leavitt et al. 1991; Widdus et al. 1990), and a variety of variables, such as cognitive egocentrism, and hormonally induced sensation seeking, all interact to create a risk-taking proclivity among adolescents (Arnett 1992; Millstein and Irwin 1986). Accordingly, adolescent psychological immaturity impedes the ability to conceptualize mortality and vulnerability to danger, fostering what Elkind (1967) refers to as a “personal fable,” of invulnerability to risk among adolescents. Some research, however, has argued that adolescents are no more likely than adults to perceive themselves invulnerable to risk (Dolcini et al. 1989; Millstein and Irwin 1993; Sobo 1993), and the existence of this sense of invulnerability among teens, and the applicability of this theory, remains unclear (Leavitt et al. 1991). To date, no
substantial comparative research exploring the feelings of invulnerability between children and adults has been done (Dolcini et al. 1989).

The theory of adolescent invulnerability has been used by some AIDS researchers to explain why adolescents are unlikely to accurately assess their risk of AIDS and thus apt to believe themselves insusceptible to HIV (Bowler et al. 1992; Hansen et al. 1990). Consequently, adolescent predisposition toward risk-taking and underestimation of potential dangers have also been implicated as barriers to the reduction of AIDS risk behaviors among teens (Moore and Rosenthal 1991, 1992). The pervasive use of this theory in AIDS knowledge and risk perception studies underscores the importance of evaluating it.

Nonetheless, the utility of the theory of adolescent invulnerability across cultures is as yet unclear. The notion of adolescent invulnerability is premised on the concept of adolescence "egocentrism," which may not be cross-culturally valid. The state of adolescence, itself a cultural construct, is cross-culturally variable and involves different socialization processes (Whiting and Whiting 1975). Therefore, adolescence may not necessarily engender a sense of egocentrism. Mead (1949) originally developed her theories about the cross-cultural variability of the state of adolescence during her fieldwork in Samoa. On the basis of her research there, Mead proposed that what constitutes adolescence in a particular culture largely reflects cultural norms and attitudes. More recently, Schelgel (1995) argued that the state of "social
adolescence as a distinct period between childhood and adulthood appears to be present in each of the 186 cross-cultural cases she studied. Also, several recent ethnographies of adolescence have explored how it manifests cross-culturally, and how expectations of adolescents shift in accordance with changes in government policy and the incorporation of western ideals. Burbank (1988), for example, describes how Aboriginal female adolescents intentionally become pregnant as a means of gaining more control over traditionally arranged marriages. Addressing the applicability of the theory of adolescent invulnerability for diverse ethnic groups is an essential part of evaluating the usefulness of this concept as a means of understanding adolescent risk perception. This study will examine the relevance of the theory of adolescent invulnerability for Puerto Rican teens.

Section 3: Existing Studies of Latino Knowledge About AIDS

There have been differing reports about the extent of AIDS knowledge among Latino groups as a whole. A disproportionate number of Latinos in the U.S. are infected with HIV, relative to the population size, than either Anglos or African Americans (Menendez et al. 1993). Despite this fact, some of the literature on risk perception reports that many Latinos don’t regard AIDS as a threat. A study of low-income Latino women in L.A. indicated that the women believed HIV was not a common disease among Latinos (Flaskerud and Calvillo 1991). Similarly, Arguelles and Rivero (1988) suggest that Latinas in L.A. have low levels of perceived HIV risk. In
contrast, other research proposes that across ethnic, gender, and age groups the perception of the risk of HIV infection reflects the actual prevalence of HIV (Flaskerud and Uman 1993; Ford and Norris 1991; Van der Velde and Hooykass 1992; Worth 1988).

These apparently contradictory findings reflect individual and intra-ethnic variation in AIDS risk perception (Alonso and Koreck 1989; Strunin 1991). One problem with much of the existing AIDS risk perception literature is that it is based on the assumption that all members of an ethnic group with a disproportionate number of AIDS cases, such as Latinos, are at equally high risk of HIV, and therefore should consider themselves at risk on the basis of their ethnicity alone. In other words, the assumption is that if there are high infection rates among Latinos, then all Latinos are at high risk and should so perceive themselves. This fails to distinguish an epidemiological concept of risk which is based on statistical probabilities, from both actual risk based on individual behavior, and perception of risk, which derives from many things, including cultural context.

Another unresolved issue in AIDS knowledge studies, apart from the failure to differentiate epidemiologically defined risk from perception of risk, is the gap between AIDS knowledge and the reduction of HIV risk behaviors among adolescents (Diclemente 1993). Some existing data suggests that this discrepancy may exist among Hartford Latino teens, especially among males.
In Hartford, a consortium of organizations involved in AIDS research, including the Hispanic Health Council, collaborated on a survey examining adolescent AIDS risk perceptions and behaviors among Latino, African American and Anglo adolescents in the Hartford area. The YOUTH (Youth Outreach Understanding and Training in Health) Project Survey was administered to 246 teens, aged twelve to twenty-two, all of whom were regarded as being vulnerable to HIV risk because of various criteria (e.g., teens who were no longer in school; teens who were homosexual, bisexual, or questioning their sexual orientation; teen gang members, and teens reporting heavy use of alcohol, drugs or frequent sex, etc.) (Horowitz et al. 1996). Although these teen respondents reported fairly high levels of condom use, they do not report consistent condom use. Although 50% of Latino male adolescent respondents used alcohol and reported having multiple partners, 40% used protection for vaginal sex only some of the time (Horowitz et al. 1996). Previous research has shown that alcohol consumption can increase the tendency to engage in AIDS risk behaviors among adults (Stall et al. 1990). Among the YOUTH survey respondents, 30% of Latino males engaged in anal sex, using condoms nearly 45% of the time (Horowitz et al. 1996). The intent of this dissertation is to discover potential reasons why the Puerto Rican teens in this study, who have adequate knowledge about AIDS, do not necessarily reduce their HIV risk behaviors.
The Influence of Knowing Someone with HIV on HIV Risk Behaviors

One factor which may influence the reduction of risk behaviors is acquaintance with someone living with HIV/AIDS. Fisher (1988) and Fisher and Misovitch (1990) have proposed that contact with people living with HIV is a significant predictor of behavioral change. Fisher first made this observation about a sample of gay men, and later speculated that the same may be true of primarily heterosexual college students. However, the actual contact with people living with HIV was relatively low among the sample of students he studied, making it difficult to test this theory. While it seems an intuitive deduction that knowing someone with HIV/AIDS may make the possibility of HIV infection less of an abstract notion, the exact nature of these relationships, and the impact they do have on the adolescents associated with people living with HIV or AIDS (PLHAS), has not been closely examined for younger teens in other ethnic groups.

Data for a Latino sub-sample from the previously mentioned YOUTH Project Survey are also relevant to this study. Of the total number of survey participants, 133 were Latino. Eighty-two of these Latino teens knew someone with HIV; thirty-seven were closely connected to someone living with HIV, and forty-five were more distantly connected to a person living with HIV or AIDS (PLHA). This is important, given the theory that adolescents who know someone with HIV or AIDS are less likely to engage in HIV risk behaviors (Fisher 1988; Fisher and Misovitch 1990; Hein 1989).
From this survey there are several significant findings about Latino teens who had more proximate relationships with PLHAs. Importantly, they were less afraid of HIV infection through casual transmission. Eighty-one percent of these teens, versus sixty-nine percent of teens who did not know anyone with HIV, and 69% who had more distant connections to PLHAs, respectively, stated that they could kiss and hug a PLHA without fear ($P = .05$) (see Table 1).

Table 1: Relationship Between Proximity of Teens’ Relationship to PLHA and Beliefs About Casual Contact*

<table>
<thead>
<tr>
<th>Can You Hug and Kiss a Person With HIV Without Fear?</th>
<th>N=133</th>
<th>Yes</th>
<th>No/Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knows no one with HIV (N=51)</td>
<td></td>
<td>68.6% (N=35)</td>
<td>31.3% (N=16)</td>
</tr>
<tr>
<td>Distant Relationship to PLHA (N=45)</td>
<td></td>
<td>68.9% (N=31)</td>
<td>31% (N=14)</td>
</tr>
<tr>
<td>Close relationship to PLHA (N=37)</td>
<td></td>
<td>81.1% (N=30)</td>
<td>18.9% (N=7)</td>
</tr>
</tbody>
</table>

* Percentages are based on a sub-sample of 133 Latino YOUTH Survey Respondents (Horowitz et al. 1996).

These data also show a trend for teens who are acquainted with PLHAs, in contrast to those who don’t know anyone living with HIV, to be slightly more likely to be sexually active, and have multiple partners (see Table 2).
Table 2: Proximity of Teen Relationship to PLHA and Number of Sexual Partners*

<table>
<thead>
<tr>
<th>Number of Partners</th>
<th>N=130</th>
<th>0</th>
<th>1</th>
<th>2 - 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knows no one with HIV (N=50)</td>
<td></td>
<td>58% (N=29)</td>
<td>18% (N=9)</td>
<td>24% (N=12)</td>
</tr>
<tr>
<td>Distant Relationship to PLHA (N=44)</td>
<td></td>
<td>38.6% (N=17)</td>
<td>29.5% (N=13)</td>
<td>31.8% (N=14)</td>
</tr>
<tr>
<td>Close relationship to PLHA (N=36)</td>
<td></td>
<td>25% (N=9)</td>
<td>41.6% (N=15)</td>
<td>33.3% (N=12)</td>
</tr>
</tbody>
</table>

*Percentages are based on a sub-sample of 130 Latino YOUTH Survey respondents (Horowitz et al. 1996).

This information alone does not indicate that these teens are at increased risk for HIV infection. Yet, when compared to YOUTH Survey Respondents with distant associations to PLHAs, there appears to be a parallel trend for more of the teens with proximate relationships to PLHAS to “rarely” use condoms during vaginal sex (see Table 3). Teens who didn’t know anyone with HIV reported more frequent condom use. There are no conclusive results from these data because of the small sample size, but because they suggest that Fisher’s (1988) theory may not apply to teens across ethnic and class groups, these findings are important for the assessment of how living with HIV infected family members affects teens living with HIV positive family members.
Table 3: Proximity to PLHA and the Likelihood of Rarely Using Condoms for Vaginal Sex*

<table>
<thead>
<tr>
<th>N=133</th>
<th>% Who Rarely Use Condoms for Vaginal Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knows no one with HIV (N=51)</td>
<td>1.9% (N=1)</td>
</tr>
<tr>
<td>Distant Relationship to PLHA (N=45)</td>
<td>4.4% (N=2)</td>
</tr>
<tr>
<td>Close Relationship to PLHA (N=37)</td>
<td>13.5% (N=5)</td>
</tr>
</tbody>
</table>

* Percentages are based on a sub-sample of 133 Latino YOUTH Survey respondents (Horowitz et al. 1996).

The fact that more than half of the Latinos from the YOUTH Survey knew someone living with HIV suggests that in Hartford, Puerto Rican teens are likely to be familiar with HIV. This supposition is supported by research comparing the AIDS knowledge among four groups of Latinos in the U.S., Mexico and Guatemala, through Consensus Analysis (Trotter et al. 1997). The results of this research showed that of respondents from all four sites, Puerto Ricans in Hartford were the most apt to know someone with HIV/AIDS, and also, to score highest in AIDS knowledge (Baer et al. 1997; Trotter et al. 1997). This study will explore whether or not knowing PLHAs has any influence on the AIDS risk perceptions of a sample of Puerto Rican teens.

**Section 4: Cultural Knowledge Systems: Folk Interpretations of AIDS Information**

In the past, anthropological research has been used to examine and explain why individuals may engage in AIDS risk behavior and not perceive themselves at risk, why they may consider other facets of their life to be more important than the
potential for HIV infection, and why they may understand the ramifications of HIV risk behavior and still engage in it (Herdt and Boxer 1991; Magana and Carrier 1991; Sibthorpe 1992; Swanson et al. 1992). Individual ways of interpreting AIDS information and education so that it presents less of a threat, or no threat to oneself, or one's peer group, have been referred to as "cultural logic" (Swanson et al. 1992). The concept of "cultural logic" resembles Lutz' "ethnotheories of cultural knowledge systems" (1985) and Good and Good's "semantic illness networks" (1980; also Good 1977).

For example, Lutz depicts ethnotheories as the basic components of "cultural knowledge systems." These ethnotheories allude to cultural idioms of distress in several ways. According to Lutz, ethnotheories first of all reflect the distinction between culturally defined deviant and normal behavior. Secondly, they allow a distinction to be made regarding what existing information about an illness, disease or disorder is ultimately real and relevant. Thirdly, ethnotheories encompass guidelines of normal response to "universal" experiences such as loss.

On a more symbolic level, semantic illness networks represent the interrelationships of medical terms, illness categories, and symptoms (Good 1994). Since semantic illness networks by definition are composed of intrinsic cultural values, Good (1994) argues that the semantic illness networks of relatively new diseases, such as AIDS, are built upon already existing ones. Importantly, as representations of cultural
values, semantic illness networks can convey the politics surrounding a disease or illness, in contrast to the more neutral concept of “folk belief” (Good 1994).

The concept that will be used in this dissertation to explore Puerto Rican teens ethnotheories, or semantic illness networks relevant to AIDS, is that of a “cultural logical system,” which has been utilized before to understand response to AIDS information. Swanson et al. (1992) developed the notion of “cultural logic” in a study with a group of HIV-educated methadone maintenance clients who were able to continue high-risk behaviors, such as sharing used needles, through the creation of their own logical systems of risk. These logical systems represented AIDS information which had been operationalized and altered according to concepts important to street survival (Swanson et al. 1992). Thus, although the clients had adequate knowledge of AIDS risk, they reconstructed risk in such a way that they did not perceive themselves at risk for infection through their behavior (Swanson et al. 1992).

Categories of beliefs that could theoretically be encompassed within these cultural logic systems about AIDS have been developed based on focus group findings among East African adults. Nicoll et al. (1993) define five types of lay health beliefs people potentially develop about AIDS based on both cultural beliefs and media information available to them. Alternative transmission beliefs, for example, refer to lay beliefs about casual transmission of HIV. Lay beliefs also arise around notions of treatment
of HIV, condom use, and the origins of AIDS. Finally, Nicoll et al. (1993) suggest that people create “false reassurance” beliefs about AIDS, such as the idea that HIV positive people can be easily identified.

This categorization of lay beliefs can be applied to other AIDS research. In particular, ideologies that could be categorized as “false reassurance” beliefs have been previously identified. Sibthorpe (1992) reports that female IV drug users were unlikely to use condoms with partners in whom they were emotionally invested, in order to preserve the sense of a monogamous, committed relationship. Sobo (1993, 1996) similarly suggests that for disenfranchised young adult females, to acknowledge their own risk of HIV infection through unsafe sex is to admit that their relationships fall short of the mainstream monogamous ideal. Wanting their relationships to conform to this ideal, the women maintain that their partners are faithful and there is no need for precaution, sometimes despite evidence to the contrary (Sobo 1996). Sobo refers to the thinking that these women employ to conceptualize their relationships as adhering to a romantic ideal, and to reassure themselves that they are not at risk for contracting HIV as a “monogamy script” (Sobo 1996). Examined this way, monogamy scripts can also be interpreted as components of cultural logical systems, or more specifically, as false reassurance beliefs.

Clearly, the relationship between AIDS knowledge and AIDS risk behaviors cannot be thoroughly analyzed without identifying how AIDS information is understood and...
interpreted. Using Swanson's definition of "cultural logic," this dissertation will
explore if and how Puerto Rican adolescents reinterpret information about how HIV
is transmitted, based on their own logical systems of risk. Although it is possible that
patterns of thinking may exist among this group of teens, the size of the sample may
not be large enough to reflect patterns in the teens' logical systems. Nonetheless,
these data may assist in the development of anthropological understanding of Puerto
Rican teens’ logical systems of risk for HIV.

Section 5: Political Economy of AIDS

From the beginning of the AIDS epidemic, AIDS has been a highly politicized
disease, primarily because of the associative stigma of the groups who were initially
perceived as being "at-risk" for HIV, specifically gay men, and IV drug users. A
decade and a half into the epidemic, AIDS is still perceived as being a disease of
marginal and deviant groups (Douglas 1993). Similar to the anthropology of AIDS,
political economists studying AIDS concern themselves with exposing and debunking
myths about AIDS and people living with AIDS. In addition, they examine the
relationship between gender, class, and ethnicity to AIDS in the U.S. and cross-
culturally. Because impoverished individuals with less access to material and health
care resources are vulnerable to HIV infection, and have a shorter time of survival
after being infected with HIV, AIDS has been called a "disease of poverty" (Ankrah
There is an abundance of work focused on the political economy of AIDS (Ankrah 1991; Cunningham 1989; deZalduondo 1991; Farmer 1992; Farmer and Kim 1991; Lindenbaum 1992; Mays and Cochran 1989; Quam 1990; Quimby 1992; Schoepf 1991 and 1992, Singer 1991; Singer 1997; Singer et al. 1990a; Taylor 1990; Worth 1988). In general, this work analyzes how macro social structural forces and processes, within a historical context, impact the social relationships of the individuals in question (Morsy 1990). Although theoretically similar to the political economic perspective, one set of researchers chooses to categorize their work as Critical Medical Anthropology (CMA) for reasons which will not be elaborated here (Singer 1986; Singer and Baer 1995). However, this orientation has been criticized for several reasons. Gaines (1991) has noted that both the political economic and critical medical perspectives are overly deterministic, focusing on macro analysis to the exclusion of micro-level processes. He states that this perspective attacks capitalism as the root of modern illness and disease, while failing to address health improvements and advancements within capitalist systems, and the existence of most diseases before the development of capitalism (Gaines 1991). Several points in this critique have been rebuked (Baer 1997).

In regard to AIDS, anthropological studies incorporating political economy draw attention to the political and economic forces, that in combination with cultural context and historical tradition, exert a strong influence on the spread of HIV infection, and shape AIDS risk behavior (Bolton 1989, 1992a, 1992b; Carrier and
Bolton 1991; Clatts 1993; Clatts and Mutchler 1989; Day 1988; Farmer 1990 and 1996; Farmer and Kim 1991; Lindenbaum 1992; Magana and Carrier 1991; Sibthorpe 1992; Singer et al 1990a, 1990b, 1991a, 1991b; Strunin 1991; Worth 1988). These studies explore in various facets the impact of institutionalized racism, differential access to material goods and health care, power differentials in class and gender relations, colonialism, and political infrastructure, on HIV transmission (Simmons et al. 1996; Connors 1996; Singer et al. 1990a). Farmer, for example, refers to the historical and structural factors which often impede poor women’s ability to protect themselves from HIV as a “structural violence” (1996:23) that renders these women more vulnerable to HIV.

Schoepf (1991, 1992), for example, argues that poverty and lack of education among women in Central Africa have contributed to the spread of HIV infection there. She proposes that women’s disenfranchisement has roots in western colonialism, subsequent economic stagnation, and labor migration, which are all disruptive to family relationships (Schoepf 1992).

Political economic analysis yields insight into AIDS risk behaviors at several different levels. One example is the context surrounding the high rates of IV drug use in poor ethnic communities, especially among Puerto Ricans (Bourgois 1996; Singer et al. 1990a). Political economic analyses of IDU (intravenous drug use) provide evidence that it is unlikely to decrease since drug trafficking remains one of the few consistent

Singer (1994) and Singer et al. (1990a) have previously demonstrated the applicability of a political economic framework, interwoven with ethnography, for understanding the dynamics of AIDS among Puerto Ricans living in the Northeast U.S. It is particularly important to place the AIDS epidemic among Puerto Ricans in a political economic framework because Puerto Ricans are the Latino group most likely to be poor in the U.S. (Zambrana et al. 1995). Singer et al. note that ethnicity, social class, and the ramifications of racism are all essential factors to assess to fully understand the course of HIV/AIDS among Puerto Ricans (1990a). This study will incorporate a political economic perspective to explore the role of class, poverty, and racism in Puerto Rican adolescents perceptions of AIDS risk.

Competing Health Risks

In order to explore the political economic context of Hartford Puerto Rican adolescents’ lives, this study will evaluate how teens rank AIDS as a risk among other competing health concerns. Competing health concerns constitute a continuum of perceived health risks, in addition to AIDS, as experienced and conceptualized within a larger context of survival needs (Herdt and Boxer 1991; Mays and Cochran 1989). Identifying these teens’ perceptions of health risks that are deemed of equal or greater
importance to survival will serve to both illustrate the larger political context of the teens' lives, as well as demonstrate how they perceive AIDS in relation to other health issues.

Competing health concerns can include threats to health and well-being that are not overtly health related. For example, the threat of alienating sex partners, through condom use or discussions about sexual histories, is perceived by some women as more disastrous than potentially contracting HIV (Sobo 1996). For these women, angering their partners may result in the threat of physical abuse, actual abuse, or an emotional threat to well-being (Cochran and Mays 1989).

Elder-Tabrizy et al. (1991) point out that concern about AIDS among a sample of Anglos, African-Americans, and Latinos was not related to either the prevalence or severity of HIV among these groups. These authors emphasize their finding that levels of concern about HIV are similar between Latinos and Anglos in the study, despite the higher prevalence of HIV in Latino communities (Elder-Tabrizy et al. 1991). Possible competing health concerns are discussed, but the reasons for the discrepancy between perception and risk and prevalence of HIV are not explored.

When considered within a political economic framework, however, possible reasons why the Latinos in Elder-Tabrizy et al.'s study would not consider AIDS to be their greatest concern are elucidated. The idea of being faced with several simultaneous
health risks that demand one’s attention, or of perceiving one health issue as more of a concrete concern than a more abstract health fear is experienced by individuals of both genders, and of any ethnic or class group. Possibly, the situation is more extreme for impoverished people likely to be simultaneously coping with such issues as unemployment, poor housing conditions, and unequal access to health care (Singer 1994). Corby et al. (1991) reported similar findings among a group of IDU women. These women, who engaged in HIV risk behavior, nonetheless thought of the possibility of being infected with HIV an “abstract” rather than an immediate, potential reality, despite being reasonably knowledgeable about AIDS.

That competing concerns to health and well-being are salient to adolescents in Hartford, Connecticut has been demonstrated by the findings from the YOUTH sample (Horowitz et al. 1996). Among the sub-sample of Latinos surveyed, 60% thought that family problems were of equal or greater importance than AIDS, 50% thought this about school problems, 37% about money problems and 34% about their relationships with their friends. The Latino sub-sample also raised concrete health concerns. Seventy percent perceived teen pregnancy as an equal or greater concern than AIDS, 73% shared this perception about sexually transmitted diseases, and 50% thought this about violence (Horowitz et al. 1996).

Previous studies have proposed that the following health concerns may be perceived of greater concern than HIV/AIDS: violence (both domestic abuse and street
violence), unemployment, teen pregnancy, sexually transmitted diseases aside from AIDS, and drug and/or alcohol use (Fullilove et al. 1990; Horowitz 1996; Mays and Cochran 1989). This dissertation will evaluate the significance of these, and any other health issues, raised by a sample of Puerto Rican teens to their perceptions of AIDS risk.

Section 6: Puerto Rican History

This section, a brief overview of Puerto Rican history, establishes a backdrop for the next section, which presents aspects of Latino culture. Puerto Rico, one of the Greater Antilles Islands in the Caribbean, was colonized by the Spanish from 1493-1888 (Fitzpatrick 1976). There are four main influences on Puerto Rican culture as it exists today: 1) the Taino and the Carib Indians who originally inhabited the Island; 2) the Spanish colonialists; 3) the enslavement of both Africans and Puerto Ricans on the island as early as 1511; and 4) the United States' use of Puerto Rico for economic and military development (Carr 1984; Fitzpatrick 1976). After Spanish colonization, numerous Tainos died of hunger and overwork, which prompted the Spanish to bring African slaves to the island to work on sugar cane production (Garcia-Preto 1989).

Prior to Spanish colonization, evidence suggests that Taino women were accepted as local leaders in the matriarchal Taino culture (Comas-Dias 1982). After colonization,
Spanish ideals of patriarchal superiority were imposed on the Taino Indians.

Today, remnants of Spanish culture are evident in Puerto Rican emphasis on the family, the cultural ideal of male superiority and domination (Fitzpatrick 1976; Weeks et al. 1996), and in Puerto Rican art and literature (Garcia-Preto 1989). Spanish colonists also forced the native Puerto Ricans to convert to Catholicism (Carr 1984). Catholicism remains the predominant religion on the island and among mainland Puerto Ricans today, although both Protestantism and Pentacostalism are gaining popularity (Carr 1984). Over 99% of Puerto Rican islanders are estimated to be Catholic (Wagenheim 1970). The Catholicism practiced on both the island and mainland is mixed for many people with forms of Espiritismo, and Santeria, although the church formally discourages spiritist practices (Wagenheim 1970; Harwood 1977).

In 1889, the U.S. took Puerto Rico from Spain at the end of the Spanish American War through the Treaty of Paris (Dinnerstein and Reimers 1975). The U.S. government regarded the inhabitants of Puerto Rico as “unfit for self-government” (Carr 1984:34) because of their poverty and illiteracy. This presumption of U.S. dominion over Puerto Rico set the tone for the largely negative reception toward Puerto Ricans on the U.S. mainland. The U.S. government granted Puerto Ricans U.S. citizenship without voting privileges in 1917 (Marin and Marin 1991), so that they could be drafted to fight in World War I (Aguirre-Molina and Caetano 1994).
Munoz Marin, the leader of Puerto Rico’s Popular Democratic Party, and the former president of Puerto Rico, worked to establish Puerto Rico as a commonwealth of the U.S. during the 1940s (Wagenheim 1970). In practical terms, this has resulted in Puerto Rico remaining in a position of political and economic dependence on the U.S: in essence Puerto Rico is a colony of the U.S. Most of the profit generated in Puerto Rico’s manufacturing industry leaves the island so that Puerto Ricans cannot accrue sufficient capital to break the cycle of financial dependence on the U.S. (Dominguez and Dominguez 1981). As a result, many Puerto Ricans are forced to move to the mainland in search of employment (Padilla 1985). Yet unemployment rates among Puerto Ricans on the mainland are high. The manufacturing positions that were once plentiful in the 1950s have been phased out (Tienda 1989), and Puerto Ricans have difficulty acquiring professional positions because of several factors such as language barriers, institutionalized racism, and incomplete education (Davis, Hoob and White 1988; Jorge 1988; Padilla 1992). Ironically, many Puerto Rican adolescents leave school prior to obtaining a diploma in order to find employment. Also, public education in Puerto Rico is not well funded (Acosta-Belen 1988).

In the past, Puerto Rican migrants living in the U.S. mainland have been concentrated in the Northeast. Puerto Rican communities are now growing in Florida, Michigan and California. Aside from New York City, other sizable Puerto Rican communities are in Hartford, Connecticut; Philadelphia, Pennsylvania; Chicago, Illinois; and Newark, New Jersey (Wagenheim 1970). The last three decades of the nineteenth-
century gave rise to the early Puerto Rican community in New York City (Acosta-Belen 1988). New York became a haven for revolutionary exiles who oppose U.S. domination over Puerto Rico, merchants, students, and factory workers (Acosta-Belen 1988). The current "Nuyorican" Puerto Rican culture in New York also reflects aspects of African-American culture (Safa 1988). Hartford’s Puerto Rican community will be described in Section 8.

Section 7: Latino Culture and AIDS

Latino adolescents, especially Puerto Ricans, appear to be at particular risk for HIV infection (Castro and Manoff 1988; Singer et al. 1990a). As a group, adolescents have a high HIV infection rate. One-fifth of all AIDS cases reported through 1995 were adults between the ages of twenty and twenty-nine, most of whom were likely infected during adolescence (CDC 1995). As of 1995, 2,354 cases of AIDS were reported among thirteen to nineteen years-olds (CDC 1995). Although Latino adolescents comprise only 13% of the U.S. adolescent population (1990 U.S. Census Data), they represent 18% of AIDS cases between 13 and 19 year olds (Carrillo and Uranga-McKane 1994). It remains unclear exactly why AIDS appears to be particularly widespread among these teens. Suggested potential interrelated factors influencing the disproportionately high HIV rates among Latinos range from sociocultural and religious beliefs (Cochran and Mays 1989), degree of acculturation and subsequent belief differences between generations (Boyer and Kegeles 1991), to
poverty, institutionalized racism (De La Cancela 1988; Mays and Cochran 1989; Singer et al. 1990a), and higher rates of injection drug use (Selik et al. 1988).

Because this study explores the cultural context of AIDS risk perception, it is appropriate to consider what Latino cultural factors may potentially impact HIV risk perception. There exist a number of anthropological studies of Puerto Rican health, history and politics (i.e., Gil 1982; Harwood 1977, 1981), as well as accounts of life among Puerto Rican island and mainlanders (Alers 1978; Berle 1958; Christenson 1979; Fitzpatrick 1976; Guzman 1980; Lewis 1968; Rogler and Cooney 1984; Singer et al. 1990a) that provide descriptive data on Latino culture with respect to the family, gender roles, sexuality, degree of acculturation, and religion (Andrade 1982; Espin 1986; Harwood 1981; Medina 1987; McGoldrick et al. 1989, Singer 1995). These factors have been examined to determine their role in both HIV risk behavior and perception of risk among Latinos (Cunningham 1989; Marin 1989; Menendez et al. 1989; Bok and Morales 1991; Singer et al. 1990a and 1990b). Although there are numerous aspects of culture that may influence perceptions of AIDS risk (see Singer et al. 1997), this study will specifically explore the family, gender roles, sexuality, degree of acculturation, and religion because previous research has suggested that these factors may be linked to AIDS knowledge and risk behaviors (Flaskerud and Nyamathi 1989; Flaskerud and Uman 1993; Marin 1989; Mays and Cochran 1988; Menendez et al. 1990; Bok and Morales 1991; Singer et al. 1990a; Strunin 1991; Worth 1988; Wyatt 1991).
In the past, Latino researchers have cautioned about the complexity of elucidating the cultural bases of HIV transmission among Latinos (Carrillo and Uranga-McKane 1994; De La Cancela 1989). Undoubtedly, establishing the cultural factors relevant to HIV transmission is problematic among any ethnic group. Drummond (1980), for example, advocates the conceptualization of "culture" as a continuum of interrelated components, rather than a static and uniform structure with predictable traits and behaviors. The strength of Drummond's paradigm is that it allows for the existence of heterogeneity and change within a particular cultural system. Conceptualized this way, it is not immediately possible to know whether the distinctions of particular cultural domains, such as those selected for this study, are accurate or appropriate in the eyes of the group being studied, or whether they actually exist beyond a theoretical realm. The five domains used here were selected in an attempt to operationalize facets of Latino culture in order to investigate the cultural basis of teens' risk perceptions. Regardless, there are clear limitations to operationalizing culture in this way. Namely, the study participants may not have perceived the relevance of expressing ideas about the connection between culture and perceptions of HIV risk if they did not view them as being encompassed by the operationalized categories.

Further, cultural profiles of Latino beliefs and customs that overlook intra-group and individual variation have come under scrutiny for being largely stereotyped (Alonso and Koreck 1989; Andrade 1982; Cromwell and Ruiz 1970; Singer et al. 1990a). To avoid these stereotypes, the relationship between stated cultural ideals and actual
lived behavior among individuals should be assessed to the degree that this is possible (Rosario 1982, Weeks et al. 1996). Also, in a vein similar to Drummond’s conceptualization of culture, De La Cancela and Martinez (1983) have denounced descriptions of Latino culture that portray it as a static and ahistorical configuration of prescribed traits and characteristics. Most troubling to the latter two authors is the neglect of structural and socioeconomic analysis in many existing depictions of Latino culture. De La Cancela and Martinez (1983) argue that the neglect of historical and structural context in the exploration and application of Latino cultural practices inadvertently reifies colonialist attitudes. For example, they suggest that the promotion of Latino folk healing practices may inadvertently result in clients of folk healers unquestioningly accepting their life circumstance as God’s will, thus discouraging them from working to improve their life situations through the development of solutions that address material inequities and discrimination (De La Cancela and Martinez 1983).

Specifically, these authors caution about the indiscriminate use of concepts such as machismo, marianismo, familism and fatalism as “inherent” aspects of Latino culture without attention to the role of class, sex, history and social structure. They draw attention to Zavela’s theory that an analysis of class issues can elucidate how behaviors that appear to be rooted in cultural patterns are instead responses to the current socio-economic order. Further problematic, these cultural attributes have often been used to explain HIV/AIDS risk among Latino populations, without the
provision of adequate structural and class context (De La Cancela 1989; Singer et al. 1990a). Therefore, to more fully contextualize the role of cultural domains in perceptions of HIV/AIDS risk, this study explores both structural factors and class issues relevant to the Puerto Rican teens in this study.

While recognizing that problems with depictions of Latino culture exist, it is the goal of this study to examine if and how these cultural factors affect perceptions of AIDS risk. In light of both Drummond’s (1980) and De La Cancela and Martinez’ (1983) qualifications about the use of culture as a general concept and in relation to Latinos specifically, it is recognized that the cultural domains to be employed in this study do not reflect the only aspects of Latino culture necessarily related to HIV infection, and that these domains are not necessarily always salient to the group of teens being studied on the basis of their being Puerto Rican. Importantly, the diversity of lifestyles among Latinos indicates that there is likely a wide range of attitudes and behaviors significant to AIDS risk among specific groups of Latinos. Because there is not a large body of research specific to Puerto Ricans and AIDS, more general Latino cultural factors are discussed here instead, with specific Puerto Rican references where these are available.

**Family**

The traditional Latino family is composed of biological members as well as
compadres, or companions (Harwood 1981). *Familismo* refers to the exceptional importance of family cohesiveness and loyalty to Puerto Ricans (Harwood 1981; Medina 1987; Rodriguez-Trias and Ramirez de Arellano 1994; Vega 1995). In addition, self identity and sense of security are provided by the family, as reflected in a willingness to place family needs above personal needs (Singer 1995). Commonly in Puerto Rican families, an individual in crisis is surrounded by members of the extended family who become involved in determining the best response to the crisis (Harwood 1981). The salience of the family in relation to HIV risk, for example, has been researched in terms of injection drug use and familial responses to AIDS.

Researchers have proposed that needle-sharing networks among Puerto Rican IV drug users often are formed with other family members, or within the community, because of the close-knit nature of Puerto Rican families (Menendez et al. 1990).

Having HIV positive immediate family members, or knowing of relatives living with HIV also may shape Puerto Rican teens’ perceptions of AIDS. Some researchers have noted that the Puerto Rican family is willing to absorb members with HIV, regardless of strong cultural stigmatization of homosexuality, and support them emotionally and financially (Bok and Morales 1991; Cunningham 1989). In contrast, unpublished survey results found that the majority of survey participants, all Hartford Puerto Ricans living with HIV, thought Puerto Rican families would be less likely to assist relatives with HIV than they would relatives with other illnesses (Mendez 1996). This study will explore how attitudes toward AIDS, superimposed on familial
obligations of the Puerto Rican families of these participants, shapes the adolescents’
own risk perceptions. The exploration of the relationship between familial bonds and
AIDS risk perceptions also provides a context for examining Fisher’s theory that
knowing someone living with HIV is a determinant of HIV behavioral risk reduction
(Fisher 1988). While this study is concerned with risk perceptions and will not
report on behavioral change, perception of risk clearly is a component of change in
risk behavior.

Cultural Conceptualizations of Gender and Sexuality

Latino gender roles, like those within other ethnic groups, encompass
multidimensional ideals and behaviors (De La Cancela 1989; Weeks et al. 1996). In
the past, description of Latino gender roles has tended to focus exclusively on
discussions of “traditional” cultural ideologies (Weeks et al. 1996). Machismo, a
male behavioral ideal rooted in Spanish and Mediterranean cultures (Vigil 1980), has
been broadly defined as a complex set of masculine traits prized among men in Latin
American and Caribbean countries (Aguirre-Molina and Caetano 1994). These traits
include: fearlessness, physical and moral strength, pride, honor, leadership, the
capability of drinking large quantities of alcohol without losing control, and provision
for one’s family (Aguirre-Molina and Caetano 1994; McGoldrick et al. 1989; Vigil
1980). However, it is often difficult for male Latino U.S. migrants to support their
families and thus fulfill their cultural role, because there are more economic
opportunities for women in low-paying domestic and textile work (Cromwell and Ruiz 1970).

Because machismo is premised on the notion of male superiority; it has also been described as a form of gender inequality (Medina 1987; Singer et al. 1990a). Research suggests that machismo legitimates and exacerbates male expression of dominance, authoritarianism, and violence among Latinos (Espin 1986; McGoldrick et al. 1989), although these expressions of masculinity are not unique to Latino culture alone. Machismo also encompasses the expectation that Latinos demonstrate their sexual prowess by having multiple partners before and after marriage (Espin 1986; McGoldrick et al. 1989). If condoms are not used, sex partners of men having multiple partners are placed at high risk for HIV infection (Singer et al. 1990a). Because this behavior is culturally sanctioned, it may not be regarded as risky.

Traditional gender roles, as well as the gap between traditional expectations and actual roles, may further influence AIDS risk behaviors and perceptions. Weeks et al. (1996) note that a common theme in existing literature exploring Latina AIDS risk is that women have a limited ability to initiate discussions about sex and condom use. Traditional Latino culture places a premium on the female obedience, subservience, passivity toward male counterparts, as well as the maintenance of family bonds embodied within the concept of marianismo (Espin 1986; Medina 1987). Sexual naivete and chastity among women are particularly valued (Comas-Dias 1982;
Medina 1987). It is possible that Latinas adhering to traditional role expectations may perceive themselves less able to protect themselves from HIV within the confines of the sexual passivity expected of women according to traditionally defined gender roles (Alonso and Koreck 1989). It may be difficult for Latinas to request condom use by their male partners, even those who may have multiple partners, because doing so challenges traditional Latin notions of approved gender roles based on sexual passivity (Marin 1989; Mays and Cochran 1988; Singer et al. 1990a; Worth 1988). For example, using results from a study of 1,173 Latinas and African American women, Nyamathi et al. (1993) showed that traditional Latinas were more likely than less traditional Latinas to contract HIV through their husbands or partners. Yet gender dynamics relevant to HIV/AIDS are also rooted in historical patterns of male dominance (De La Cancela 1989; Vigil 1980). In other words, Latino or Puerto Rican cultural values alone do not result in women being at risk for HIV/AIDS because male dominance may make it difficult for women to negotiate condom use. This aspect of gender dynamics, therefore may result in women being at risk for HIV/AIDS (De La Cancela 1989).

Gender dynamics are further complicated by negative connotations of condom use among Puerto Ricans that are also evident in other cultural contexts (Sibthorpe 1992). For both genders, condom use has been historically associated with promiscuity, prostitution, and the uncleanliness connoted by sexually transmitted diseases (Sibthorpe 1992). Hence, a Latina asking her partner to use condoms may be seen as
an unfaithful or promiscuous partner (Mays and Cochran 1989), while the associative stigma of condoms may further impede attempts to assert the need for condom use (Weeks et al. 1996; Worth 1988). Exemplifying how gender dynamics may influence risk perceptions, women in this situation may then weigh the risk for HIV infection with the risk of losing their partners (Mays and Cochran 1989). Also, condoms may be negatively viewed as impediments to reproduction, and therefore to male virility and female fertility (Weeks et al. 1996). It is as yet unclear exactly how gender-defined roles have bearing on sex attitudes and behaviors relevant to HIV transmission (Carrillo and Uranga-McKane 1994). Findings from this study will illustrate how Puerto Rican teens' beliefs about gender, and their conceptualizations of gender roles, influence the ways they perceive HIV. The teens' perceptions of gender in relation to AIDS will be introduced by their interpretations of gender roles in a more general sense, to show the cultural ideologies informing these perceptions.

Overlapping to a large extent with beliefs about gender, cultural concepts of sexuality may further influence HIV risk perceptions. As discussed above, traditional gender role expectations have a direct bearing on how sexuality is perceived and expressed. Despite differences between expressed cultural ideals and lived experience, and inter- and intra-ethnic variation, most AIDS researchers agree that Latinas are particularly vulnerable to HIV infection because of their socialization to be more passive and less knowledgeable about sex (Carrillo and Uranga-McKane 1994; Singer et al. 1990a; Singer et al. 1997; Weeks et al. 1996).
Yet despite a prevailing theory that sexual attitudes are highly resistant to change in Puerto Rican culture (Keefe 1980), other studies have found differences in attitudes toward sexuality to vary between island and mainland Puerto Ricans, although both groups have been found to be more conservative than other ethnic groups living in the U.S. in this regard (Rosario 1982). For example, in contrast to island Puerto Rican women, mainland Puerto Rican women are more likely to emphasize sexual exclusivity rather than virginity (Rosario 1982). On the whole, younger Puerto Rican women tend to adhere less strictly to traditional cultural attitudes (Rosario 1982).

Homosexuality is strongly stigmatized in Latino communities (Alonso and Koreck 1989; Carrillo and Uranga-McKane 1994; Espin 1986; Singer et al. 1991; Weeks et al. 1996), including Puerto Rican communities on the island and mainland (Cunningham 1989; Bok and Morales 1991). In Latino communities, there is a tendency to view homosexuality as a lifestyle practiced mainly by Anglos (Singer et al. 1991). As a result of this stigmatization, Puerto Rican gay and lesbian communities are less likely to publicly identify themselves, or perceive AIDS prevention messages as relevant to them (Carrillo and Uranga-McKane 1994; Singer 1995). An example of how Latino culture influences perceptions of AIDS, through perceptions of sexuality, is the mestizo categorization of sex roles among Latino men who have sex with men, in which men practicing insertive anal sex are not considered homosexual (Alonso and Koreck 1989; Carrier 1989; Magana and Carrier 1991; Marin 1989). Singer (1995) states that the same perception holds among some Puerto
Rican men who self-identify as heterosexual, but nonetheless have sex with other men. Among adolescents who are apt to experiment sexually, and be preoccupied with peer approval (Bowler et al. 1992; Hein 1989), cultural beliefs about sexuality are likely to have a strong impact on perceptions of AIDS risk. Also, homosexual Latino teens may be less comfortable admitting to friends and family members their sexual preference, thus decreasing their likelihood of enacting risk-reduction strategies.

Ethnicity

Degree of identification with ethnic background may also shape HIV risk perceptions. Ethnic identification is influenced by acculturation. Although the assessment of the degree of acculturation among the group of teens in this sample is beyond the scope of this study, acculturation in combination with other factors such as migration and level of education, has been shown to affect belief in the importance of fatalism and familism among generations of Puerto Ricans living in New York City (Cortes 1991). In addition, higher levels of education among Latinas has been shown to be associated with more liberal perceptions about women’s gender roles (Keefe 1980; Weeks et al. 1996). Currently, however, it remains unclear whether or not familistic values are altered as a result of acculturation, and to what extent these values change (Singer 1995).
This study employs Harwood’s definition of ethnicity. Harwood broadly describes “ethnic collectivity” as a group of people with “common origins, a sense of identity, and shared standards for behavior, (1981:1),” but notes that similarities of standards of behavior vary according to region and class, and between individuals. Sharing a sense of identity, having common standards for behavior, in addition to interacting with other members of the ethnic group within a larger social system comprise three basis components of the concept of ethnicity. Harwood further distinguishes between behavioral and ideological ethnicity. He sees behavioral ethnicity as representative of the values, beliefs, and norms members of an ethnic group learn during the process of enculturation. Ideological ethnicity refers more to a sense of identity founded upon customs and rituals that are symbolic of the ethnic identity in question. Although these activities are learned through socialization, Harwood sees them as representing ethnic identity. According to Harwood, food preferences and holiday celebrations are two examples of activities that represent ideological ethnicity.

In this study, the role of ethnic identification in the formation of Puerto Rican teens’ AIDS risk perceptions has been examined using two domains which have been used primarily to measure acculturation in the past (Keefe and Padilla 1987). The first, “ethnic loyalty,” refers to an individual’s preference for a particular ethnic group; the second, “cultural awareness,” reflects knowledge of the cultural traits representative of an ethnic background and preferences for social behavior (Keefe and Padilla 1987; Padilla 1980). A study conducted with Southern California Chicanos suggests that
"cultural awareness" is a more ubiquitous feature of acculturation, while "ethnic loyalty" arises primarily in response to perceived discrimination (Padilla 1980). Also examined in this study are three of the four points in Rogler and Cooney's (1984) model of factors influencing ethnic identity: 1) the age of arrival on the mainland; 2) number of years of education, and 3) the ethnic composition of the participants' neighborhood.

Identification with ethnic background has been associated with knowledge and beliefs about HIV in several studies (Flaskerud and Nyamathi 1989; Flaskerud and Uman 1993; NCHS 1989 and 1990; Rapkin and Erickson 1990; Strunin 1991; Wyatt 1991). In these studies, a strong identification with ethnic heritage was linked to having less knowledge and more misconceptions about AIDS. For example, Nyamathi et al. (1993) report that fifty less-acculturated Latinas, strongly identifying with their ethnic and religious backgrounds, perceived themselves less at risk for HIV infection than thirty Latinas having a less developed sense of ethnic identity. The less-acculturated women had more misconceptions about HIV, less power for negotiating condom use, and were more apt to contract HIV through their husbands and partners than Latinas who were more acculturated, and less familiar with ethnic tradition (Nyamathi et al. 1993). Given that adolescence is a time when identity is challenged and established (Muir 1991), ethnic identity may have an important bearing on Puerto Rican teens' lives. The influence ethnic identity has on these teens' perceptions of AIDS, if any, will be presented in the findings.
Relevant to the discussion of ethnic identity is the use of the term "community" in the study. Harwood (1981) proposes that ethnicity reinforces social ties through commonalities in regional origin. Although he does not define the term "community" per se, this study draws upon his use of ethnicity as a collectivity as a parameter for the term "community" used in this study. As a result, the term "community" in this study is based on ethnic identity, and not political or economic factors. Therefore, "community" is defined in this study by the participants' perceptions of the ethnic boundaries of the Hartford Puerto Rican community.

**Religion**

Some religious values also may impact on perceptions of HIV risk (Espin 1986), although the extent to which religiosity may influence attitudes relevant to HIV transmission has not yet been determined (Carrillo and Uranga-McKane 1994). General links between religious values and teens' perceptions of AIDS will be presented in the findings. In particular, the relationship between fatalism and these perceptions will be addressed.

The phenomenon of fatalism is by no means uniquely Latino, nor a trait inevitably intrinsic to this group (De La Cancela and Martinez 1983). Previously, fatalistic attitudes have been linked to HIV infection among several different populations studied. Hooper (1987), for instance, posited that the devastation of AIDS in Uganda...
has reinforced existing “inherent leaning toward fatalism and religiosity (1987: 471).” Similarly, Streibel (1996) found a sense of fatalism to be one response of a group of South African women to AIDS, and Magura et al. (1992) argue that fatalism, deriving from the knowledge of already being seropositive, is a barrier to risk reduction among IV drug using women. Finally, degrees of fatalism, representing attitudes of powerlessness about AIDS, have been measured among Australian college students (Moore and Rosenthal 1991). The results of this study showed that young men, specifically those with more partners, expressed more fatalism than young women.

Latino fatalismo, to the degree that it can be found in particular Latino groups, refers to an acceptance of one’s life circumstance, and is a phenomenon rooted in religious tradition (Fitzpatrick 1976; Medina 1987). Fatalism implies that because events are preordained, the efforts of individuals are ineffective (Rogler and Cooney 1984). Researchers examining AIDS in Puerto Rican and Latino communities have previously documented the relationship between fatalistic attitudes and beliefs about AIDS among Latinos (Bok and Morales 1991; Sufian et al. 1990), and posited that the failure of Latino community leaders to respond to AIDS sufficiently may have resulted from “ingrained” fatalism. Regardless, it is necessary to examine the impact of class, gender and structural factors on individual lives to avoid the implication that fatalism, as an isolated cultural factor, places Latinos at risk for HIV infection (De La Cancela 1989; De La Cancela and Martinez 1983; Singer et al. 1990b).
Previously, Lewis (1959, 1961, 1968, 1969) proposed that fatalism was one of the many components of his model of a “culture of poverty.” Based on research with Latinos, he argued that the mere existence of several qualities in individuals, including helplessness, weakness, provincialism, and fatalism (Lewis 1968), interacted to create a “culture of poverty,” among groups. This model is problematic because of its determinism: Lewis suggests that living in conditions of poverty creates a binding subculture among people affected by it. Thus, as exemplified by the depiction of “fatalistic” Puerto Ricans and Mexicans in Lewis’ work, the concept of fatalism has at times been inappropriately used in Latino research to imply that Latinos are responsible for the socioeconomic conditions in their communities.

The use of the concept of fatalism to perpetuate cultural stereotypes underscores the importance of considering class and structural issues surrounding behavior which can be interpreted as fatalism. Competing health concerns, such as alcoholism, poverty, drug addiction, and violence, that are more prevalent in Latino communities, proportionate to population size, than among many other ethnic groups in the U.S. (Elder-Tabrizy 1991; Harwood 1981), may further contribute to what appears to be fatalism toward AIDS. De La Cancela (1989) argues that living with daily concerns about poverty, racism, and inadequate health resources may incline people to develop fatalistic attitudes.

In summary, this study will examine the cultural domains of family, sexuality, gender.
ethnicity and religion to understand how each may influence AIDS risk perceptions among Hartford Puerto Rican teens. It is possible that some of the domains may overlap to the extent that it may be difficult to discern the influence, or significance of one cultural domain in shaping perceptions, over another. The greatest limitation of this operationalization of Puerto Rican culture into these five categories is that, to the extent that the interview instruments are structured around their construction, and interpretations of the findings shaped by them, the categories themselves have been imposed onto the study participants’ perceptions. Consequently, the use of these categories may have constrained the participants’ opportunities to accurately express their perceptions of how Puerto Rican culture, as they perceive it, influences the perception of AIDS risk. Also, as previously noted, some of the domains identified here as being potentially pertinent to Latino cultural construction of AIDS risk may have no relevance to how the teens in this sample perceive HIV risk.

Section 8: The Research Setting

Hartford, Connecticut was chosen as a research site for this study for two reasons. First, the city has a large Puerto Rican population. Approximately 30% of the city population is Hispanic (1990 U.S. Census); 75% of whom are Puerto Rican (Hartford Public Schools 1990). It is estimated that there are 40,000 Puerto Ricans living in Hartford today (Singer 1996). Secondly, there was already an existing agency in Hartford with the capacity to facilitate and support research in the Puerto Rican
community. The Hispanic Health Council (HHC) is a community-based organization, devoted to addressing gaps in health care provision for Puerto Ricans and other underserved populations in Hartford through research, training, advocacy and preventive educational efforts. This agency served as an initial entree into the Puerto Rican population. Participant observation was conducted within the HHC, the nearby community, Frog Hollow, which is predominantly Puerto Rican, and a local high school.

In order to situate the Hispanic Health Council, as the locus of this research, in Hartford, I will first briefly describe the city’s Puerto Rican community. Next the epidemiology of AIDS in Hartford will be presented. Against this backdrop, the HHC itself will be described.

**Puerto Ricans in Hartford**

Puerto Ricans have long been a marginalized population on the U.S. mainland. Some researchers argue that they have suffered more social discrimination and prejudice than any other ethnic group in the U.S. (Aguirre-Molina and Caetano 1994), evidenced by the fact that they have the lowest median income among all Latino groups on the mainland (Singer 1995). For example, in 1993, 33% of all Puerto Rican families in the U.S. lived below the federal poverty level (Singer 1995). In fact, out of all Latino groups in the U.S., economically, Puerto Ricans fare the worst: the
estimated 38% of Puerto Rican women employed on a full-time, year-round basis earn an average of $9,390 annually, while the 11.4% of full-time year-round employed Puerto Rican men earn an average of $12,108 annually (Ortiz 1995). Although Puerto Rican women working in the Northeast tend to earn higher wages than U.S. Cubans or Mexicans, the current premium on skilled labor in this area results in fewer Puerto Ricans finding employment here (Ortiz 1995). Puerto Ricans living on the mainland also suffer the negative effects of racism, further intensified by their lack of political organization, and thus, political power (Dinnerstein and Reimers 1975).

The Puerto Rican migration movement to the Northeastern U.S. began in the 1940s and increased during the 1950s and 1960s (Ortiz 1995), largely driven by a federal campaign to recruit Puerto Rican laborers (Aguirre-Molina and Caetano 1994), and a lack of viable employment in Puerto Rico (Singer 1995). The once plentiful factory jobs in the Northeast have now declined due to shifts in predominant U.S. industries (Tienda 1989). As a result, Puerto Ricans in the Northeast, and in the U.S. in general have suffered financially.

The Latino population in Hartford has been growing steadily for the last quarter of this century (Singer 1996). In the 1950s, Shade Tobacco Growers Association hired numerous migrant Puerto Rican labors displaced by U.S. pharmaceutical corporations (Perez-Escamilla et al. 1997). Eighty-five percent of the Latino population in
Connecticut originally came to the state to work as low-paid tobacco workers (Gonzalez et al. 1982).

Today, although Puerto Ricans moving to Connecticut are more likely to move to Hartford in search of work than any other area of the state (Mendez, 1996), they are often either unemployed or underpaid in Hartford (Singer 1996) and across the U.S. (Marin and Marin 1991). The capital of the nation’s wealthiest state, Hartford is the eighth poorest city of over 100,000 people in the country (The Child Council Inc., 1995). Considering the above statistics, and the fact that seventy percent of Hartford’s population is either African-American or Latino, (1990 U.S. Census Data), it is not surprising that many of them are poor. Seventy-one percent of Latino families in Hartford fall below the city household median income (1990 U.S. Census Data). In addition, almost half of Latino families in Hartford are female headed households, and almost all (97%) are on public assistance (Singer 1996). These figures suggest that Puerto Rican women in Hartford fare worse than Puerto Rican women in other parts of the U.S. of whom 33% are female headed households, and 60% rely on public assistance (Singer 1995).

Clearly, the majority of Puerto Ricans in Hartford are living in poverty. The predominantly Puerto Rican neighborhoods in Hartford are: Frog Hollow, Sheldon Charter Oak, and South Green. These neighborhoods are among the four lowest in terms of median family income in Hartford, with annual median incomes of $12,000.
$12,000, and $19,000, respectively (The Child Council Inc., 1995).

Most of the participants in this study live in the Frog Hollow neighborhood. In Frog Hollow, approximately 46% of the families live below the poverty line (Perez-Escamilla et al. 1997). Also, over 50% of children under the age of eighteen in Frog Hollow live in poverty (The Child Council, Inc. 1995). Further, the low status accorded to Puerto Ricans in the city means that they are often relegated to inadequate and crowded housing (Backstrand and Schensul 1982).

Together, the concomitant stresses associated with living in poverty, being an ethnic minority, and experiencing language barriers and discrimination, manifest physiologically in this population. Puerto Ricans in Hartford have high rates of malnutrition (Perez-Escamilla et al. 1997) and possible compromised immune function (Singer et al. 1990a, Singer 1994). This compromised immunity, coupled with the high rate of injection drug use among Puerto Ricans (Alonso and Koreck 1989), make this population particularly vulnerable to HIV infection (De La Cancela 1989). Puerto Rican women in Hartford are especially at risk, with HIV prevalence rates eight times than that of Anglo women (Connecticut Department of Health 1995).

The health status of Puerto Rican children and teens is of particular concern because of the overall youth of this population. Proportionally, Puerto Ricans in the U.S. are a young group (Singer 1996). The median age in 1988 for Latinos in the U.S. was 25.5.
approximately seven years younger than the median age for the entire country (Marin and Marin 1991). In Hartford, 41% of the Latino population is under the age of eighteen (The Child Council, Inc. 1995). The health status of Puerto Rican children now is likely to have ramifications on adolescent and young adult health in the near future. The impact the numerous Puerto Rican young adults living with HIV now will have on such issues as family structure, reproduction, employment opportunities and health care needs among Puerto Ricans in the future remains uncertain.

Compounding difficulties of being HIV infected, and living with HIV, Latinos are the most medically uninsured group in the U.S. (Portillo 1987; Carrillo and Uranga-McKane 1994). Limited access to health care has undoubtedly intensified the course of the epidemic among Latinos (Carrillo and Uranga-McKane 1994). Although new retroviral therapies are increasing the life expectancies of people living with HIV, the long-term success of this therapy is unknown. Many Latinos lack access to newer, experimental drug protocols (Carrillo and Uranga-McKane 1994). Moreover, it is difficult for people without health insurance, as is the case with some Puerto Ricans, to afford retroviral therapies.

Currently in Hartford, Puerto Rican children and adolescents are exposed to the same economic and social conditions faced by Puerto Rican adults. Fifty-five percent of Hartford’s Latino children and teens are living below the federal poverty line (1990 Census Data). In addition, Singer (1995, 1996) notes that Puerto Rican adolescents.
are particularly vulnerable to HIV infection because of several simultaneous stressors. First, Puerto Ricans in general are a highly mobile population, and often relocate because of unemployment and poor housing conditions. Adolescents in these families continually have to form new social networks. Second, there is a high dropout rate, estimated to be approximately 70%, among Puerto Rican adolescents, as well as a high rate of homelessness. Third, Singer (1995) suggests that Puerto Rican teens in the U.S. are apt to suffer identity conflicts and low self-esteem largely because of the absence of attention and respect afforded Puerto Rican history and culture by other ethnic groups in the U.S. Motivated by internal feelings of worthlessness, and external poverty, some Puerto Rican teens become involved in gang activities and the sex trade (Singer 1995).

Taken together, these factors often isolate Puerto Rican adolescents in a seemingly impenetrable cycle of poverty (Singer 1995, 1996). The conditions of poverty are then exacerbated by the high rates of pregnancy among Puerto Rican teens. Estimates indicate that teen births account for one-fifth of the Puerto Rican population (Solis 1995). Lacking viable employment options, and suffering the negative effects of racism, Puerto Rican teens may start using drugs in an attempt to mitigate feelings of worthlessness (Singer 1995), and selling them, especially cocaine and heroin, in order to make money (Wilson 1996). As yet, few adolescent AIDS cases have been reported in Hartford (see next sub-section). Unfortunately, due to under reporting of cases and the sometimes decade long incubation period of HIV (Bowler et al. 1992).
it is likely there are likely many more adolescents in Hartford who are infected.

**Epidemiology of AIDS in Hartford**

Hartford has the highest HIV rate in the state, with an increase of cases from 73.7 per hundred thousand in 1990 to 199.2 per hundred thousand in 1993 (The Child Council, Inc. 1995). AIDS is currently the leading cause of death among 25-44 year olds in Hartford (The Child Council, Inc. 1995). As of September 30, 1996, a total of 2,820 cumulative AIDS cases in the greater Hartford area, including Hartford, Middlesex, and Tolland counties, have been reported to the Center for Disease Control (CDC).

Latinos and African Americans are both over-represented in the number of AIDS cases: Reflecting only 16% of the three-county area population, they comprise 67% of the AIDS cases (Connecticut Department of Health 1995). Latinos account for 31% of the cumulative cases of AIDS (Connecticut Department of Health 1995) in this area. Thirty-nine pediatric cases, and nine cases of adolescents between the ages of 13 and 19 have been reported to date. Slightly less than half (N=4) of the pediatric cases were reported between 1994 and 1996.

**The Hispanic Health Council**

The Hispanic Council was the end result of a mobilization of Hartford’s Puerto Rican community to respond to a medical incident that has since come to represent the
numerous language and cultural barriers between this community and medical establishments in Hartford. In 1972, a Puerto Rican infant died from dehydration after his Spanish-speaking mother had brought him to two different emergency rooms and attempted to communicate with the English-speaking personnel there. Both times, staff failed to recognize the severity of the baby’s condition, or communicate adequately with the mother, and the mother was sent home with instructions to give aspirin and liquids to her baby (Schensul and Borrero 1982). The baby died on the way to the third emergency room (Schensul and Borrero 1982).

A Puerto Rican Health Task Force was formed as a direct result of this incident. Between 1972 and 1978, data were collected documenting the critical need for information about Puerto Rican health in Hartford. Finally, in 1978, funding from the National Institute of Mental Health provided the start-up money for the Hispanic Health Council (HHC), which became an independent incorporated organization (Schensul and Borrero 1982), staffed by Puerto Ricans involved in community issues and several anthropologists.

The Organizational Structure of the Hispanic Health Council

In 1995, at the outset of this study, the Hispanic Health Council was staffed by approximately sixty people. It was divided into several different units: 1) AIDS Prevention and Support Programs; 2) Community Health Research; 3) Family Health
Promotion; 4) Women and Chemical Dependency; and 5) Youth Development and Prevention Programs. I worked as a research intern in the Community Health Research Unit, and recruited staff and teen participants from the Youth Unit. The two programs from which I recruited most of the focus group participants were the Youth Alliance, a communication and problem solving program for Puerto Rican teens, and Jovenes II, a prevocational training program for teens.

The HHC is located one block from Park Street, a large Puerto Rican merchant and residential neighborhood. I became familiar with this area by accompanying HHC outreach workers on their daily condom and bleach distribution routes, by administering door-to-door surveys for HHC's Needle Exchange Project, and by frequenting several of the Puerto Rican restaurants and stores on the street. The other densely populated Puerto Rican area of the city is the Charter-Oak Rice Heights Housing Projects. Here, I conducted several interviews and administered more door-to-door surveys. Becoming familiar with the Puerto Rican neighborhood allowed me to do community ethnography. It also provided a common reference point between the participants and myself during the interviews.

In summary, Hartford was an appropriate place for a study of Puerto Rican teenagers because of: 1) its large Puerto Rican population; 2) the existence of the Hispanic Health Council, which served as an entree to the Puerto Rican community; 3) ongoing research investigating the impact of AIDS and assessing health in the Puerto Rican
community; and 4) the opportunities for further participatory ethnography in
Hartford’s Puerto Rican community through numerous research projects at the
Hispanic Health Council. This study was initially launched within the HHC in April
of 1995. Participants were recruited from the HHC, other community organizations,
and a local high school. Data were collected from April of 1995 until November of
1996.
CHAPTER III: METHODOLOGY

Introduction

To more fully understand the cultural and social structural context informing Puerto Rican teens’ perceptions of AIDS as a risk, and their ranking of AIDS as a risk among several health concerns, this study relied primarily on qualitative methods and ethnographic observation. Participant observation was conducted throughout the course of the study to more fully explore the cultural and environmental context of the research. Specifically, key informant, focus group and intensive interviews were conducted to identify themes and patterns about the cultural context of the teens’ AIDS perceptions. Key informant and focus group interviews were conducted during Phase I of the study. Thematic analysis of these interviews yielded data used to structure the design of the intensive interviews, which were completed during Phase II. In the final portion of Phase II, two interviews were developed based on the analysis of the completed intensive interviews, to examine two of the prominent themes arising about 1) teens’ fear of violence, and 2) the likelihood of knowing someone living with HIV.

The data collection period extended from April 1995 - October 1996. Participants were recruited from the Hispanic Health Council, three other local organizations with

67
programs for Puerto Rican adolescents, and a local high school.

General Procedures

Throughout this study, background data was gathered through participatory ethnography both while I was conducting research for the study and while working as an intern for HHC. Employment as a graduate intern at HHC provided my initial entree both into Hartford’s Puerto Rican community, and into similar community-based organizations with specific programs for Puerto Rican adolescents. At the same time that I was completing the research, various projects I worked on as an intern, and later as an Evaluator of Ryan White Title I programs, gave me numerous opportunities to observe how teen programs functioned, what AIDS-related resources were available to both Puerto Rican teens and adults, and to discuss aspects of Puerto Rican culture with staff and clients at HHC, staff at other community organizations, people in community gathering places, and with individuals in their homes.

For example, in the summer of 1995, as an employed intern at HHC, I conducted interviews and focus groups in Hartford, Tolland and Middlesex counties as part of a Ryan White Needs Assessment. Puerto Rican women living with HIV raised many concerns about their teens and children, some of whom were HIV infected. Also as part of my internship, I conducted interviews about Hartford’s Needle Exchange Program in Frog Hollow, a predominantly Puerto Rican neighborhood. Many of the
participants invited me into their homes to socialize before and after the interview, permitting me to ask about their ideas regarding crucial health concerns in the community. Similarly, I conducted interviews in 1996 to evaluate a sub-section of this same neighborhood’s reception to a proposed community clinic. Both of these projects gave me a broader understanding of what health issues Hartford’s Puerto Rican community deem as risks, thus illustrating how community perceptions largely determine which health risks are attributed importance (Douglas and Wildavsky 1982), and informing my own research in the process.

Further, HHC itself represents a microcosm of Hartford’s Puerto Rican community. Employees there are aware of and well informed about community issues both in Hartford and in Puerto Rico. While working and socializing with these people for one and a half years, I developed a much fuller awareness of what it means to be Puerto Rican in Hartford. Extensive field notes were taken recording conversations with staff and events at the agency. To situate the organizational and cultural context of this study, I attended Youth Group meetings, Youth Unit staff meetings, focus groups, and plays organized by the teen youth program participants themselves.

Ethnographic observation was also done in participants’ homes or apartments, when possible. Twenty-five of the participants preferred to be interviewed at their home rather than at the high school, HHC, or any other location. Conducting interviews in participants’ homes allowed me to collect ethnographic data about the neighborhood.
the house or apartment, and the teen’s family situation.

Confidentiality

Each participant in every phase of the study was given a code number, prefaced by the initials of the interview in which they had participated. Efforts were made to maintain confidentiality by omitting all proper names from the interview. In the findings chapters, participants are referred to by pseudonyms. Further, the three research assistants were asked to maintain the confidentiality of the participants.

Consent Forms

In both phases of the study, each participant was given an information sheet and asked to sign a consent form (see Appendices 1 and 2). Because the majority of the participants were minors, parental consent was obtained during each phase of the study for each underage participant. An information sheet about the study was attached to the parental consent form to be sent home to parents or guardians (see Appendix 3). Both forms were translated to Spanish for parents who were not bilingual, or were more comfortable with Spanish (see Appendix 4). For the focus groups, teens were asked to bring home an information sheet and consent form to the parents, which they returned before the focus group was held. The facilitators of the teen groups at each organization where the focus groups took place were instrumental.
in the completion of this process. After I explained the importance of the consent forms and distributed them, they reinforced this idea, intercepted phone calls, and directed parents with questions to call me. Intensive interview participants were also given consent forms, which they either rought with them to the interview (if it was held somewhere other than their home), or asked their parent or guardian to complete once I arrived at their home, (if the interview was held there). The process of obtaining consent became considerably easier and expedient when the three research assistants were hired to manage the recruitment process, because they were usually able to bring the completed consent forms to me prior to each interview.

Criteria for Eligibility

In total, one hundred twenty-five adolescents, and six adult staff were interviewed during Phase I and Phase II of this study. Criteria for eligibility of the adolescents included the following: 1) both parents of Puerto Rican descent; 2) having lived on the mainland for three years or more; 3) not having a life threatening disease; and 4) having lived the majority of his or her life in urban areas of Puerto Rico, or the mainland U.S. Recruiting participants who had lived only in urban areas was done to reduce potential experiential differences in urban and rural lifestyles. The original research design called for recruitment of teens between the ages of thirteen and seventeen, but this was expanded to include eighteen and nineteen-year old individuals, to match the age range of teens attending programs at HHC. Table 4
shows how many adolescents completed each interview, and how many of those completing, also each interview completed an AIDS knowledge questionnaire. Each interview will be described in greater detail later in the Phase I and Phase II sections of this chapter.

Table 4: Type of Interview and Number of Participants

<table>
<thead>
<tr>
<th>Type of Interview</th>
<th>Number of Adolescent Participants (N=125)</th>
<th>Number of Adolescent Interview Participants Completing the AIDS Knowledge Questionnaire (N=69)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus Group Interview</td>
<td>N=19</td>
<td>N=19</td>
</tr>
<tr>
<td>Intensive Interview</td>
<td>N=42</td>
<td>N=36</td>
</tr>
<tr>
<td>AIDS/Violence Survey</td>
<td>N=50</td>
<td>N=0</td>
</tr>
<tr>
<td>AIDS Acquaintance Interview</td>
<td>N=14</td>
<td>N=14</td>
</tr>
</tbody>
</table>

**Phase I**

The goal of Phase I was the exploration of the major themes of the teens' perceptions of HIV/AIDS in relation to other health risks. Staff Key Informant Interviews and teen Focus Groups were conducted during this phase. The following is a detailed description of what Phase I of the study entailed.

Staff Key Informant Interviews (N=6)

Staff Key Informant Interviews were conducted during the first month of Phase I in...
April of 1995. A total of six interviews were completed. All of the staff who worked with adolescents at the Hispanic Health Council were asked to participate, in addition to two staff who worked with Puerto Rican adolescents at two other community organizations. Four Staff Key Informant Interviews were conducted at the Hispanic Health Council, and one each at *Mi Casa*, and *Latinos Contra Sida*, respectively.

At the Hispanic Health Council, the AIDS Unit Coordinator, the Youth Unit Coordinator, the Youth Project Coordinator, and a Youth and Adult Trainer all served as key informants. At *Mi Casa*, a Hartford program specifically targeted toward adolescents at risk for criminal offense and substance abuse, the Youth Program Coordinator was interviewed. Finally, the Child Youth Program Coordinator at *Latinos Contra SIDA* (LCS), who organizes support groups for infected and affected children, was interviewed. LCS is a Hartford organization formed in an effort to alleviate some of the devastation of AIDS in the Latino community.

These interviews were used to guide the data collection for the Client Key Focus Groups. Staff perceptions about the teens' concerns were compared with the teens' actual concerns. Further, the Staff Key Informant Interviews were used to flag possible themes for exploration in Phase II.
Focus Groups (N=19)

The purpose of the Focus Groups was to elicit cultural themes about AIDS which were pertinent to the teens (see Appendix 6), and to create a directive framework for the Intensive Interviews. Focus groups are regarded as an appropriate tool for rapidly compiling exploratory data (Pelto and Pelto 1990). Krueger (1988) promotes focus groups as a permissive "non-threatening" forum for participants to voice various perspectives and viewpoints without necessarily reaching consensus. However, as a research method, focus groups are only effective for groups of people who are comfortable expressing themselves, and comfortable with the topics being discussed (Basch 1987). As such, they may not always be an appropriate research method for the exploration of sensitive topics like AIDS and sexuality. To prevent these potential problems, I used Singer's (1992) training guide for focus group research at the Hispanic Health Council. This manual describes how to more effectively facilitate focus groups for AIDS research. Also of note, focus group findings may sometimes inadvertently confirm researcher preconceptions, since the findings are based largely on interpretation (Basch 1987).

Focus Group Recruitment

The first Focus Group recruitment strategy was to generate a list of adolescent youth group participants at the Hispanic Health Council and randomly select seventy
eligible participants from this pool. However, there were not enough teens between the ages of thirteen to nineteen involved in programs at the Hispanic Health Council at the outset of the study in April 1995 to proceed with this plan. At this point, the recruitment strategy was changed from random to convenience sampling. All of the five eligible teens attending a program at the Hispanic Health Council were recruited into one Focus Group. The fact that these teens recruited from the Hispanic Health Council had already participated in a Youth Training Program undoubtedly influenced their awareness of AIDS and other community issues.

Teens for additional focus groups were then recruited from two other Hartford community organizations: *Latinos Contra Sida*, and *The Hartford Street Youth Project*. In total there were three teen Focus Groups and nineteen focus group participants. After the first Focus Group interview was conducted at the Hispanic Health Council, nine teens from the Hartford Street Youth Project, an after school program implemented as a violence intervention, participated in the second group. Five teens from *Latinos Contra Sida's* support group for affected and infected teens participated in the third Focus Group. Each Focus Group was scheduled at a time when the teens were normally attending youth groups at each organization.

Prior to each Focus Group, participants completed a Pre-focus Group Questionnaire, which contained questions about demographics, sexual behavior, condom use, drug and alcohol use, and the teens’ perceptions of several health risks (see Appendix 7).
At the same time, they completed an AIDS Knowledge Survey. This survey was adapted from the National Center for Health Statistics Survey of Hispanic American AIDS Knowledge (1990), and administered to assess participant knowledge about AIDS and HIV prior to the focus group (see Appendix 8).

Including the distribution and completion of the Pre-focus Group Questionnaires and AIDS Knowledge Surveys, each Focus Group lasted approximately one hour. At the beginning of each Focus Group, I explained the purpose of the group, collected consent forms, and distributed the questionnaires. Refreshments were provided. After the teens completed the questionnaires, I reviewed them to find prominent or repetitive themes to be used as probes to start the Focus Groups. From this initial discussion, I moved to the remainder of the focus group probes. Each Focus Group was tape recorded, and extensive notes were taken.

**Focus Group Analysis**

After all three Focus Groups were completed, an initial content analysis of the Focus Group data was conducted. Responses to the Pre-focus Group Questionnaire, and the content of each focus group were analyzed to identify prominent themes to be included in the Intensive Interview Instrument in Phase II. Content analysis is the attribution of explicit and inferential meaning to text (Bernard 1988; Luborsky 1994). I used Luborsky’s (1994) procedure for identifying prominent and repetitive themes.
topics, and patterns in the Focus Group data. Luborsky distinguishes between themes, topics, and patterns in his work. According to his scheme, themes are revealed in metaphorical statements participants make about their beliefs, attitudes, or values. Topics refer to summaries of replies made by several people to the same question. Patterns, in contrast, are observations about participants' responses or experiences imposed upon the data by the researcher. Ultimately, these identified patterns reflect the researcher's own biases toward the data. Using this framework, I identified main topics across all the focus groups, and looked for themes arising in individual responses.

These topics and themes were then used to inform the more detailed development of the Intensive Interview instrument. Not only did the Focus Group themes and topics generate the addition of formal questions for the instrument, but they provided a basis for spontaneous probes during the interviews themselves. In addition to using Focus Group data to enhance the Intensive Interview instrument, I asked an ethnographer at HHC, and an employee at another organization who had done extensive work with Puerto Rican adolescents in the past, to provide feedback on how to restructure the instrument. Later, the three research assistants also gave valuable criticism on what additional questions to add to this instrument.
Phase II

To some extent, Phases I and II overlapped because I began recruiting participants for the Intensive Interviews while still analyzing the focus group data. Phase I was completed in July 1996. Phase II began in June 1996, and was completed in November of 1997. The goal of Phase II was to do an in-depth exploration of the teens' perceptions of AIDS by building on the themes elucidated in Phase I. During Phase II, Intensive Interviews were conducted. Two additional instuments were later developed to examine major themes raised in the Intensive Interviews.

Intensive Interviews (N=42)

The purpose of the Intensive Interviews was to thoroughly explore the themes and topics raised in the Focus Groups about the cultural basis of AIDS perceptions, the ways in which the teens' determined their ranking of AIDS as a risk among several other health concerns, and what other competing health concerns existed in their lives. The instrument is semi-structured: the first section contains demographic and behavioral questions, and the second half, open-ended questions exploring the cultural domains of gender roles and dynamics, family, ethnicity, sexuality, and religion. The open-ended questions also explore perceptions of AIDS relative to other health risks (see Appendix 9). Thirty-six of forty-two Intensive Interview participants also completed an AIDS Knowledge Survey prior to the Intensive Interview, again to
assess their knowledge and understanding of AIDS before this issue was raised in the interview.

**Intensive Interview Recruitment**

Teens were recruited for the Intensive Interviews at local high school after I obtained permission from the Hartford School Board. The first recruitment strategy for the Intensive Interviews was to post descriptions of the study around a local high school, announce the study over the public service address system, and leave a sign-up sheet in an envelope behind the desk in the main office, where interested teens could sign up, or call me to state their interest. This strategy was not successful, probably because the teens had no idea who I was, and were uncertain about, and possibly suspicious of the nature of the research.

The second strategy involved recruitment directly from study halls and classes where teachers had pre-approved my coming into the classroom to recruit. In both the study halls and classes, I explained to students that I was doing research about health and community issues faced by Puerto Rican teens, with a particular focus on AIDS. In the study halls, study hall monitors directed me to individuals they knew to be Puerto Rican. If these individuals were interested in participating after I had explained the research to them, I screened them to determine their eligibility. The process used to recruit teens from classrooms was similar, except that I relied on Puerto Rican teens
to identify themselves after I described the purpose of the research.

In total, forty-two Intensive Interviews were completed between June of 1995 and August of 1996. I recruited thirty potential Intensive Interview participants from a local high school in June of 1995. By September of 1995, thirteen Intensive Interview had been completed. After describing the purpose and content of the interview to these potential participants, I asked their permission to call them at home within the next month to set up the interview. Participants were then given an information sheet and a consent form, in English or Spanish according to their preference. I explained that all their responses would be kept confidential, their real names would not be used, and if they preferred the interview could be conducted in a location other than their home. From these thirty potential recruits, thirteen teens were eventually interviewed. The other seventeen were either unavailable or unwilling to do the actual interview.

These thirteen interviews were held in either of two locations: the high school cafeteria, or the participant’s home. One interview was held in the back of a store owned by the uncle of a participant. The majority of the teens preferred to have the interview conducted in their home, where it was more comfortable and convenient for them. Usually, the participant or his or her family member greeted me at the door, and pointed out an area where the interview could be conducted privately, whether it was in the living room, kitchen, or participant’s bedroom. Sometimes, however, the
situation became awkward when the participant chose not to be interviewed in a private area of the house, or if there was no private space available, and the interview was conducted in the thick of family activity. This was not only distracting, but also undoubtedly influenced what the participant felt free to talk about. In these instances, I tried to encourage the participant to find an area of his or her home where the interview could be conducted at least semi-privately. Nonetheless, many distractions were unavoidable. At times, participants had to leap up from the interview to stir a pot of food, or break up a fight between siblings in the next room. These moments when the participants' home life overwhelmed the interview allowed me to briefly experience what home life was like for him or her.

Interviews in the home lasted approximately forty-five minutes to one hour. I talked informally with the participant and his or her parent or sibling while setting up and testing the tape recorder. In addition to being taped, notes were taken during each interview as a guide to important themes arising, and to mark significant passages on the tape. After a parent signed the consent form, I began the interview. At the end of each interview I compensated the participant five dollars.

At this point, two teen girls who had been Intensive Interview participants were hired as research assistants to recruit additional participants. The purpose of hiring these research assistants was to broaden the scope of recruitment, and improve the efficiency of the recruitment process. Together, these two girls recruited seven
additional participants between September and December of 1995. In January 1996, a third girl was hired to replace the first two. After participating in the Intensive Interview herself, she recruited twenty-two participants between January 1996 and August 1996. In total, forty-two Intensive Interview participants were recruited.

Hiring teen participants to recruit for the study made the recruitment process more efficient, but at the same time, it created several biases in the study. The primary bias was that by recruiting participants they knew, the research assistants drew upon networks of teens whose socio-economic and familial backgrounds were similar to their own, thus reducing variation within the sample. As a result, the representativeness of the sample for all Puerto Rican teens in Hartford is limited. For example, the first two research assistants had never had sex, and the majority of the females they recruited for the study were also sexually inexperienced.

It is worth noting the socio-economic background of the third research assistant, because she recruited the majority of the Intensive Interview participants. Carmen², fifteen, was Catholic and attended church regularly. She reported never using drugs or alcohol. Although she had one sex partner in the year before the study, at the time of recruitment, she was not sexually active.

Carmen also appeared to be academically successful, although she talked about being

² The name used here, and those used throughout, are pseudonyms.
too busy to spend enough time on her schoolwork because of her after-school commitments, such as her participation in the HHC program, Jovenes II, a teen advocacy program, her work for me, and several other community teen programs. In addition, she often babysat her four year-old brother after school, while her mother worked. Her future plan was to go to college, followed by medical school, in order to become a pediatrician.

Except for two teens, all of the study participants were in school. Further, the fact that many also regularly attended after-school programs involving work with the Puerto Rican and Anglo communities on a regular basis, suggests that on the whole, this group was generally comfortable about and interested in expressing their opinions to individuals relatively unknown to them. Through the after-school programs, some had also been made aware of issues facing the Puerto Rican community, and as a result had a heightened awareness of racism and discrimination toward Puerto Ricans. Populations of Puerto Rican teens either not accessed or well represented by these recruitment strategies, include: gay teens, the homeless, those who had left school, teen mothers, criminal offenders, teens using drugs, and gang members. The sample did include two former gang members, one criminal offender, and one teen mother. Despite its limitations, the sample does permit understanding about AIDS risk perceptions among an interactive social network of previously AIDS educated teens, the majority of whom were still in school at the time of the interview, and who were from working-class, or impoverished Puerto Rican families.
After the three research assistants were hired to recruit, the majority of the interviews took place at HHC since the recruiters, who attended after-school programs at HHC, brought participants with them in the afternoon. I conducted these interviews in one of HHC's conference rooms. These interviews took less time that those at participants' homes because the consent forms were already signed.

Seven of the participants preferred to have the interview conducted in Spanish. Two translators assisted me in conducting these interviews. One was a research assistant for the study, and the other, an employee of HHC.

Each interview was transcribed. The Spanish interviews were simultaneously translated and transcribed by three individuals. One of the research assistants translated one interview. A consultant translated another, and a bilingual intern at HHC translated the remaining five.

_Preliminary Analysis of Intensive Interview Data_

Before conducting a formal qualitative analysis, each interview text was reviewed for the identification of major themes, topics, and patterns. Two significant themes were noted during this cursory review of the data. The first was the teens' overwhelming preoccupation with violence, a concern which often overrode, and influenced their concern about AIDS. The second important theme occurring across many of the
interviews was the participants’ numerous acquaintances, close and distant, who were living with HIV, or had died of AIDS related illness. Two instruments were developed to explore these themes more fully. Each is described below.

The AIDS/Violence Survey (N=50)

This short-answer survey was designed to compare the teens’ perceptions of the impact of violence, on an individual and community level, to their perceptions of the impact of AIDS, in order to assess which issue was of greater concern, and why (see Appendix 10). However, because key terms on the survey such as “violence,” “fear,” and “concern” were not defined in the survey; participants’ individual interpretations of these concepts are likely reflected in the survey results. I administered ten surveys to Intensive Interview participants to pilot this instrument. These pilot data and feedback from two researchers at HHC provided information about how to refine the instrument to elicit more informative responses from the participants.

AIDS/Violence Survey Recruitment

A research assistant recruited fifty respondents for this survey during the summer of 1996. She was also trained to administer the survey. She did several practice surveys in front of me, and then tape-recorded herself administering the survey to a respondent. After she was comfortable with the instrument, she recruited respondents
from among her acquaintances from the local high school where the Intensive Interview respondents were recruited, and from her neighborhood. Although she agreed to maintain the confidentiality of the survey participants, the confidentiality maintained for the other portions of the study was not possible for this survey since the research assistant was administering it. Further, her interviewing technique may have biased some of the participant responses. A positive aspect of her administering the surveys was that many participants reported feeling more comfortable sharing information with someone of their age and ethnic group. The research assistant obtained parental consent for each respondent under the age of eighteen. In total, fifty teens completed the AIDS/Violence Survey. The data collection period extended from June to August 1996.

**AIDS Acquaintance Interview (N=14)**

This open-ended, semi-structured instrument was developed to explore how knowing someone with HIV or AIDS influences perception of AIDS risk. Similar to the Intensive Interview, the first part of this instrument contains demographic and behavioral questions; the second part poses open-ended questions about beliefs (see Appendix 11). The AIDS Knowledge Questionnaire was also administered in conjunction with this interview.
AIDS Acquaintance Interview Recruitment

Although many of the Intensive Interview participants had discussed knowing several people with HIV or AIDS, and been willing to be interviewed about this topic, it was difficult to track them to participate in the AIDS Acquaintance interview. Some teens had graduated, moved, or changed their mind about being interviewed. Because of these recruitment problems, I looked for a different pool of participants. An outreach worker from HHC recruited four participants from among HIV infected parents she knew, and I recruited ten additional teens, who were the children of parents participating in another study at HHC. For this interview, the age range of participants was lowered from thirteen to twelve because: 1) a number of pre-pubescent teens expressed interest in being interviewed; and 2) older teens were more reluctant to participate.

A total of fourteen AIDS Acquaintance Interviews were conducted. All but two were done at participants’ homes. After arriving at the participant’s home, I asked the mother (no fathers were present) or guardian to sign a consent form. Each interview was tape recorded, and participants were compensated five dollars for their time.

Prior to the interview, I assumed that all the potential participants who lived with an HIV positive mother had been informed of her serostatus, since the teens had agreed to do the interview. Yet one of the mothers pulled me aside when I arrived at her
home, and asked me not to tell her two older sons, whom I was about to interview, that she was HIV positive. Not being able to talk freely about what it was like to have a parent with HIV changed the nature of these two interviews. This same woman decided to disclose her HIV status to her sons three days later, and asked that another HHC intern and I be present. Although painful to witness, this experience offered me a first-hand perspective of how a parent's seropositivity affects teens.

Section 3: Analysis

Intensive Interview Data: Demographic information for each interview and each AIDS Knowledge Survey was coded and analyzed using SPSS software. The open-ended questions on the Intensive Interview were coded and analyzed with the software program AFTER (Analysis of Free Text for Ethnographic Research). AFTER was originally developed in 1992 for the National Institute of Drug Abuse, but recently was reprogrammed to be used for general ethnographic coding (Nova Research 1996). Codes were created for each question on the Intensive Interview (see Appendix 12 for a list of codes created). These codes were clustered around the cultural domains of gender roles, religion, sexuality, ethnicity, and familism. Also, codes were created about topics pertaining to perceptions of AIDS relative to individual and community concerns, such as unemployment, teen pregnancy, gangs, and violence. After the codes were created, each file was coded. Responses to topics were then compared across interviews, and significant themes and patterns were
AIDS/Violence Survey Data: Each survey was coded and analyzed with SPSS. Frequencies were calculated to examine demographic data on the participants, as well as their experiences with violence. Chi-squares were done to explore possible relationships between having been a victim of violence in the past and 1) fear of contracting HIV, or 2) being a victim of AIDS or violence in the present and, 3) being a victim of AIDS or violence in the future.

AIDS Acquaintance Interview Data: Frequencies for the sample as a whole were calculated on the demographic portion of this interview, which was similar to the demographic questions on the Intensive Interview. The sample was then divided into three sub-samples based on participant proximity of relationship to someone with HIV. The first set was those who lived with, or had a close relationship with someone with HIV (N=8), the second set those who didn’t know anyone with HIV (N=2), and the third group, those with a more distant relationship to someone living with HIV (N=4). The open-ended portion of the interview was transcribed. Significant themes were identified through content analysis, and with the program AFTER. This analysis focused primarily on similarities and differences in perception of HIV among the three sub-samples.
Section 4: Summary

In summary, there were a total of one hundred and twenty-five interviews conducted with adolescents during the two phases of this study. In addition, six staff who work with adolescents participated in staff key informant interviews. During Phase I, the Staff Key Informant Interviews were completed, and three Focus Groups were held with a total of nineteen teens. In Phase II of the study, forty-two Intensive Interviews were conducted building upon themes arising from the Key Informant and Focus Group interviews in Phase I. Next, two other instruments were developed to explore prominent themes from the Intensive Interviews. The first of these was the AIDS/Violence Survey, designed to examine the teens' perceptions of the risk of HIV/AIDS as it contrasted with their perceptions of the risk of violence. Fifty adolescents completed this survey. The second instrument, the AIDS Acquaintance Interview, contained questions looking at how proximity of relationship to someone living with HIV influences perceptions of HIV/AIDS. Fourteen teens participated in this interview. Finally, statistical analysis was done to determine frequencies and examine potential relationships with the demographic data in each interview. The software program AFTER was used to do a qualitative analysis of the open-ended questions which largely comprised the Key Informant, Focus Group, Intensive, and AIDS Acquaintance Interviews.
CHAPTER IV: PHASE I FINDINGS

Section 1: Staff Key Informant Interviews

The purpose of the Phase I key informant and focus group interviews was to identify major themes, topics and patterns about the teens' perceptions of AIDS risk.

Initially, staff key informant interviews (N=6) were conducted. The staff who were interviewed worked directly with teens. All were Puerto Rican. Four of the staff worked at the Hispanic Health Council, one worked at Latinos Contra SIDA, and one was the leader of a youth group at Mi Casa.

Several themes arose in the staff key informant interviews. All of the staff key informants agreed that violence was the primary concern of their teen clients. They suggested that AIDS was not an "everyday" concern to the teens, although it was an issue. One staff informant from the Hispanic Health Council said that many of the teens she knew had recently started talking about having a family member, especially back in Puerto Rico, who was living with HIV.

Another theme was the idea that ethnicity, manifesting through religious values, influenced teens' perceptions about AIDS. Because so many Puerto Ricans are Catholic, Pentecostal, or Baptist, another informant stated, Puerto Rican girls try to
resist having sex until they’re married, whereas boys are more likely to have sex.

Three of the staff informants believed that girls were more worried about contracting HIV than boys. One thought teen girls’ concern was heightened by the fact that it was more embarrassing for them to raise the topic of condoms. She thought that girls were now more likely to stay virgins because of their fear of AIDS. In contrast, this same informant said that because boys attending her group would take a lot of the free condoms available at the Hispanic Health Council in order to demonstrate how “macho” they are, she couldn’t be sure how many of the condoms were actually used.

Some of the staff informants thought that the teens they worked with believed themselves invulnerable to risks and danger. They proposed that their teen clients thought they “would live forever,” and that AIDS would not affect them. One of the informants said some of the teens in her group expressed a “fatalism” about AIDS, saying things like, “you’re gonna die anyway, you might as well have fun.” An alternative theory another informant put forth about the teens’ seeming lack of concern about AIDS was that it was too frightening for them to talk about it openly, without joking or framing their statements about AIDS by talking about relatives they knew who were infected.

A fifth theme raised was the financial and environmental constraints which shaped the teens’ perspectives about health risks, including AIDS. Estimating that
approximately 60% of the teens who attended youth programs at the Hispanic Health Council were on welfare, one staff informant stated that teens were concerned about money and finding adequate jobs. This, she believed, created an uncertainty for the teens about their ability to pay for college educations and to find adequate jobs in the future. This same informant stated that the top three serious problems for Hartford’s Puerto Rican community are: 1) lack of resources; 2) drug use; and 3) inadequate housing. Similarly, another informant from the Hispanic Health Council proposed that economic problems were at the root of all the problems in the Puerto Rican Community, such as violence, AIDS, and gangs. She didn’t fully explain this connection, but stated that families who survived on a month-to-month basis became pessimistic about the future.

The sixth theme arising in the staff key informant interviews was the staff’s perception that intolerance of and embarrassment about homosexuality among both teens and adults in Hartford’s Puerto Rican community was a strongly influential component of the teens’ perceptions of AIDS. Some of the staff felt that their teen clients saw AIDS as a problem solely for the gay community, and thus did not think it necessary to protect themselves from it. Because of this misconception of AIDS as exclusively a disease among homosexuals, staff informants also speculated that teens were embarrassed to talk about AIDS.
Section 2: Focus Groups

The following describes the general findings from all three focus groups (N=19), by presenting responses to the AIDS knowledge and pre-focus group questionnaires, and then exploring in greater detail the findings from each specific focus group. The first and third focus group had five participants, and the second had nine.

Demographics: Demographic data for the focus group participants are summarized below in Table 5.

<table>
<thead>
<tr>
<th>Demographic data for focus group participants (N=19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Birthplace**</td>
</tr>
<tr>
<td>Marital status</td>
</tr>
<tr>
<td>Children*</td>
</tr>
<tr>
<td>Place most likely to speak Spanish*</td>
</tr>
</tbody>
</table>

* One response missing
** Two responses missing

Thirty-two percent (N=6) of the participants were male; 68% (N=13) were female.

The age of the participants ranged from fourteen to nineteen, with a mean age of fifteen. Seventy-one percent (N=12) of the focus group participants were born in Hartford, 29% were born in Puerto Rico, and two participants did not answer this
question. One person reported being separated or divorced. None had any children.
The majority of the participants (78%, N=14) said they were more likely to speak
Spanish at home with their families than anywhere else.

**Sexual Behavior and Beliefs:** Although only seven participants stated that they were
sexually active at the time of the focus group, eight participants stated that they were
heterosexual, and one reported being homosexual. The remaining nine participants
did not report their sexual orientation. All seven sexually active participants reported
“always” using condoms. Forty-two percent (N=8) of the participants believed that
both males and females should share the responsibility of using condoms. Eleven
participants expressed no opinion about this matter.

**AIDS:** The majority of the participants (58%, N=11) believed that Puerto Ricans in
Hartford were worried about AIDS. Twenty-six percent (N=5) of the focus group
participants stated that they believed many people in the Puerto Rican community
were living with HIV. Seventy-two percent (N=13) did not have an opinion about
this issue. Another 53% (N=10) of the focus group participants reported knowing
someone living with HIV.
AIDS Knowledge Questionnaires

The majority of the focus group participants (53%, N=10) reported that they knew “some” about AIDS, and five (26%) believed their own chances of contracting HIV were high. Overall, the participants were well informed about AIDS (see Table 6).

TABLE 6: Focus Group Responses to the AIDS Knowledge Survey (N=19)

<table>
<thead>
<tr>
<th>(Q1) Do you know anyone with HIV/AIDS?</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>10</td>
<td>53%</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>16%</td>
</tr>
<tr>
<td>Don't Know</td>
<td>5</td>
<td>26%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(Q2) AIDS is an infectious disease caused by a virus</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely True</td>
<td>13</td>
<td>68%</td>
</tr>
<tr>
<td>Probably True</td>
<td>4</td>
<td>21%</td>
</tr>
<tr>
<td>Probably False</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Definitely False</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Don't Know</td>
<td>1</td>
<td>6%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(Q3) What are your chances of having AIDS?</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>5</td>
<td>26%</td>
</tr>
<tr>
<td>Medium</td>
<td>1</td>
<td>5%</td>
</tr>
</tbody>
</table>

Due to a typographical error the phrase “somewhat unlikely” was used on the survey instead of “somewhat likely.”
<table>
<thead>
<tr>
<th>Question</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>4</td>
<td>21%</td>
</tr>
<tr>
<td>None</td>
<td>5</td>
<td>26%</td>
</tr>
<tr>
<td>Am HIV+</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Don't Know</td>
<td>2</td>
<td>11%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>(Q4) How effective are condoms?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Effective</td>
<td>5</td>
<td>26%</td>
</tr>
<tr>
<td>Somewhat Effective</td>
<td>10</td>
<td>53%</td>
</tr>
<tr>
<td>Not at All Effective</td>
<td>2</td>
<td>11%</td>
</tr>
<tr>
<td>Don't Know How Effective</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Don’t Know What a Condom is</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>(Q5) There is no cure for AIDS now.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definitely True</td>
<td>12</td>
<td>63%</td>
</tr>
<tr>
<td>Probably True</td>
<td>2</td>
<td>11%</td>
</tr>
<tr>
<td>Probably False</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Definitely False</td>
<td>2</td>
<td>11%</td>
</tr>
<tr>
<td>Don't Know</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>(Q6) There are drugs available to treat AIDS.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definitely True</td>
<td>6</td>
<td>32%</td>
</tr>
<tr>
<td>Probably True</td>
<td>3</td>
<td>16%</td>
</tr>
<tr>
<td>Probably False</td>
<td>3</td>
<td>16%</td>
</tr>
<tr>
<td>Definitely False</td>
<td>2</td>
<td>11%</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>4</td>
<td>21%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Question</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------</td>
<td>------------</td>
</tr>
<tr>
<td>(Q7) Have you heard of the AIDS virus?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>18</td>
<td>95%</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>(Q8) You can be infected with HIV, but not have AIDS.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definitely True</td>
<td>3</td>
<td>16%</td>
</tr>
<tr>
<td>Probably True</td>
<td>5</td>
<td>26%</td>
</tr>
<tr>
<td>Probably False</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Definitely False</td>
<td>5</td>
<td>26%</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>4</td>
<td>21%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>(Q9) How likely are people to get HIV from mosquitos?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Likely</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Somewhat Unlikely</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Very Unlikely</td>
<td>5</td>
<td>26%</td>
</tr>
<tr>
<td>Definitely Not Possible</td>
<td>6</td>
<td>32%</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>5</td>
<td>26%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>(Q10) How much do you know about AIDS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A lot</td>
<td>4</td>
<td>21%</td>
</tr>
<tr>
<td>Some</td>
<td>10</td>
<td>53%</td>
</tr>
<tr>
<td>A little</td>
<td>4</td>
<td>21%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Question</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------</td>
<td>------------</td>
</tr>
<tr>
<td>(Q11) How likely are people to get HIV from sharing needles?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very likely</td>
<td>15</td>
<td>79%</td>
</tr>
<tr>
<td>Somewhat likely</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Very unlikely</td>
<td>2</td>
<td>11%</td>
</tr>
<tr>
<td>Definitely not possible</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Don't know</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>(Q12) HIV is passed through sexual intercourse.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definitely true</td>
<td>17</td>
<td>89%</td>
</tr>
<tr>
<td>Probably true</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Probably false</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Definitely false</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Don't know</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>(Q13) A pregnant woman can pass the HIV virus to her baby.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definitely true</td>
<td>16</td>
<td>84%</td>
</tr>
<tr>
<td>Probably true</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Probably false</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Definitely false</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Don't know</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>(Q14) How likely are people to get HIV from sharing silverware?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very likely</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Somewhat unlikely</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Very unlikely</td>
<td>8</td>
<td>42%</td>
</tr>
<tr>
<td>Question</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>--------</td>
<td>------------</td>
</tr>
<tr>
<td>Definitely not possible</td>
<td>9</td>
<td>47%</td>
</tr>
<tr>
<td>Don't know</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>(Q15) Have you heard of the blood test for HIV?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12</td>
<td>63%</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>26%</td>
</tr>
<tr>
<td>Don't know</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>(Q16) Have you been tested for HIV?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5</td>
<td>26%</td>
</tr>
<tr>
<td>No</td>
<td>11</td>
<td>58%</td>
</tr>
<tr>
<td>Don't Know</td>
<td>2</td>
<td>11%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>5%</td>
</tr>
</tbody>
</table>

However, there were several topics about which the participants were uncertain. As shown in Table 6, the first of these was the existence of the HIV blood test. Five of the participants had not heard of the blood test. Second, 42% (N=8) of the participants were not entirely convinced that HIV could not be passed through sharing silverware. The third topic of uncertainty was the availability of drugs to treat HIV: A total of nine participants (48%) thought these drugs either “definitely” or “probably” (32%, and 16%, respectively) did not exist. Four participants (21%) did not know the answer to this question. The range of answers for this question reflects the teens’ confusion about the existence and efficacy of treatment options for HIV/AIDS. A
fourth issue of confusion for the teens was the likelihood of transmitting HIV through needles. Two participants (11%) thought this very unlikely; one (5%) considered it definitely not possible. There were other incorrectly answered questions. One participant thought it "probably false" that a pregnant woman could pass HIV to her baby. Another participant stated that it was "probably false" that no cure for AIDS existed, while two participants (11%) thought that it was "definitely false" that there was no cure for AIDS.

The next three topics of confusion predicted questions that some of the intensive and AIDS Acquaintance interviews participants later answered incorrectly. Again, as presented in Table 6, five (26%) of the participants did not know whether HIV can be transmitted by mosquitoes, although the responses to this question may be skewed by a typographical error in the survey (see Table 6 footnote). In addition, five of the participants (26%) did not think that it was possible that a person can be infected with HIV without having AIDS. Four (21%) of the participants did not know the answer to this question. Finally, ten (53%) of the participants pronounced condoms only "somewhat effective" as a barrier against HIV, two participants (11%) said that condoms were "not at all effective," and one individual (5%) did not know what condoms were. Discussing their concern about the ineffectiveness of condoms in greater detail, these participants stated their belief that condoms leak.
Pre-focus Group Questionnaire Responses

**Competing Health Concerns:** Asked what they perceived to be the biggest concerns in their community, six (32%) participants reported violence. Three participants (16%) thought the largest concern in the Puerto Rican community was violence, one (5%) thought drug use, and one (5%) thought AIDS and violence were equal concerns. Eight participants did not answer this question.

Participants were also asked to rank their concern about seven health and well-being issues: 1) alcoholism; 2) poverty; 3) AIDS; 4) violence; 5) drug use; 6) discrimination; and 7) unemployment. Of these seven issues, only eleven participants selected a number one concern. The majority of these eleven participants rated AIDS as their number one concern (see Table 7). This ranking of AIDS as the number one concern contradicts the prevailing opinion among the staff key informants that the problem of violence overshadowed that of AIDS for the teens. The reasons for this discrepancy are unclear. One potential explanation is that the teens fear the possibility of AIDS and the suffering they associate with it, more than they do violence, although they think that realistically they are more apt to be affected by violence. This theory will be discussed in greater detail in Chapter VII. A second possible factor influencing the majority response of AIDS as a number one concern is that the participants knew the study was about AIDS, and so thought this was the issue they should be most concerned about.
Table 7: Issues Ranked as Number One Concerns

<table>
<thead>
<tr>
<th>Issues Ranked as Number One Concerns (N=11)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
</tr>
<tr>
<td>Violence</td>
</tr>
<tr>
<td>Poverty</td>
</tr>
<tr>
<td>Discrimination</td>
</tr>
</tbody>
</table>

* Eight participants did not state a “number one” concern

In addition, three participants rated AIDS as their second concern, four rated drug use as their second concern, and one participant each rated unemployment, and violence, respectively, as secondary concerns.

When questioned about perceived concerns to health and safety they faced on a daily basis, two participants reported violence, one reported drug use, and another suggested that unprotected sex, in general, was a concern. Fifteen responses were missing.

However, when asked which of seven health and well-being issues (alcoholism, poverty, AIDS, violence, drug use, discrimination, and unemployment) was the greatest worry to them personally, the majority of the participants who answered the question listed discrimination. Thirty-seven percent (N=7) were worried about discrimination; three participants were worried about alcoholism; one participant regarded poverty as the greatest worry; another viewed violence as the greatest worry.
and one reported AIDS and violence as equal worries. Six responses were missing. Responses to this question contradict the previous set of responses to the question about what worried participants on a daily basis. Again, it is possible that the teens conceptualized these two questions differently.

**Focus Group Questions**

Questions for each focus group were based in part on the pre-focus group questionnaires; topics the teens gave most attention to, such as violence, racism, religion, and sexuality, were used to determine the issues covered in addition to the focus group probes. The focus group probes examined the teens' perceptions about AIDS and what cultural domains shaped these perceptions.

**Focus Group #1**

The first focus group was held at the Hispanic Health Council. Five teenage girls, ages fourteen to seventeen participated. One girl later told me she was Costa Rican, and not Puerto Rican. In the pre-focus group questionnaires, three of the girls stated that violence was the greatest problem in the Puerto Rican community. One of the girls thought that AIDS was the greatest problem. The fifth girl said she believed that drug use was the greatest problem, but that she was personally afraid of being shot or raped.
In the focus group discussion, the participants reported that they thought AIDS, violence, and drug use were all of equal concern in the Puerto Rican community. Yet they thought that violence was the largest concern to them personally, because they “lived around it.” Some of the participants said that they knew people who had been killed, and one girl related an incident about gang members surrounding a boy walking with her and her brother to the store.

The three focus group participants who reported that they were sexually active, stated that they always used condoms. The number of sex partners they reported having ranged from one to three. However, each girl spoke about knowing friends who did not use condoms consistently. One participant stated:

Most of my friends at one time like they have sex, they didn’t use a condom.

Other participants agreed, and said that they thought these friends had not used condoms because “they forgot,” or because they “were stupid.” One girl remembered a boy telling her that sex with condoms would not “feel right,” and another said she knew of a boy who had refused to use condoms because of his “ignorance.”

As to how their religious beliefs influenced the way they felt about sex, the participants generally agreed that religion was not that “big a deal to them,” but in some cases it was to their parents. One girl explained how having a religious family affected her feelings about having sex:
If you're family is really religious, it's something while you're doing it, sometimes while you're doing it, you may think, "Oh God, what does God think, what do my parents think if they knew what I was doing or something like that" and then after you do it, it's like I have to go to confession and all this stuff.

Another girl spoke about how her father's negative reaction when he suspected her of having sex:

My father brings it up because one day he picked me up from my boyfriend's house and he was like cussing me out because he was like, you have that bad look. It looked bad. And he's like, that's why all you're friends are getting pregnant. I was like, I wasn't even doing anything.

The participants had a range of beliefs about homosexuality. One said she thought it was "weird," another mentioned that her parents had told her not to date anyone who was homosexual, and a third participant had this to say:

If they're happy, hey God made everybody. People were born like that. Who are we to say? We're not nobody to judge. We can't judge anybody.

Finally, the participants talked about the importance of Puerto Rican culture to them. These discussions suggested that ethnic identity was an issue the teens' considered, although at this point, it was still unclear how beliefs about ethnicity might affect perceptions of HIV. One participant said she went to Puerto Rican festivals to "know her culture." Another articulated the tension between becoming "Americanized" while remaining true to her Puerto Rican background:

I think in parts like you stay Americanized because there are Americans and of course you're going to be Americanized. But I think I don't want to forget about my culture just because I live in America. My culture is my image.

In sum, participants in this focus group perceived AIDS, violence, and drug use as being of equal concern in the Puerto Rican community. These participants did not
regard themselves as highly religious, but thought their parents were. The group had mixed opinions about homosexuality.

Focus Group #2

The second focus group was held at Hartford Street Youth Project. Nine teens participated in this focus group: four males, and five females, aged thirteen to eighteen. This group talked about unemployment and discrimination as large problems, eclipsing AIDS in the Puerto Rican community. Some also were frustrated with stereotypes about Puerto Ricans, especially those voiced by their teachers.

One teen specifically said that jobs were a problem for Puerto Ricans. This participant speculated that Puerto Ricans had trouble getting jobs because they weren’t sufficiently educated. Other participants noted that many of their peers dropped out of school, thus contributing to the problem of completing education. One participant stated that teens dropped out of school:

Because they want the North End (a mixed African American and Puerto Rican neighborhood in Hartford) to be down, you know what I’m saying, down with the wrong crowd, you know what I’m saying.

Another participant drew a connection between unemployment, drug use, and violence:

If you have jobs there won’t be so much violence, there wouldn’t be so much drugs. But then again if you’re not getting paid on the job, you’re going to sell drugs, definitely.
Considering whether they felt more threat from AIDS or violence, these focus group participants said they felt violence was a larger problem in the Puerto Rican community, although one participant believed that “Violence cooled down around here.” Participants attributed the violence to drug use, and to people “wanting money.” One participant said that AIDS and violence were essentially the same thing, because they both kill people. Only one teen stated feeling more concerned about AIDS because of the protracted suffering it involved:

I worry about AIDS number one. I don’t care about violence. You can be outside and get shot right there. AIDS takes time for you to die.

Also in response to the comparison between AIDS and violence a participant said:

Nobody think about (AIDS) when there’s violence.

Another participant said:


In response to this, a participant added:

When Puerto Ricans get mad, they get violent.

This comment sparked the topic of stereotyping. One teen questioned:

Why do they say everything is Puerto Rican this, Puerto Rican that? They say Puerto Ricans do this, Puerto Ricans do that, but they don’t know.

Another teen stated:

In school, a teacher be telling us all Puerto Ricans, you Puerto Rican, you do something, you know what I’m saying?
In response to this comment, participants brought up the topic of racism, talking about the racism they felt toward Puerto Ricans in Hartford. They thought their high school teachers were particularly racist. One participant explained:

There's a lot of racism, but it's not like they come in your face and say spic this, spic that, the way they say it in words, we understand it. In my class there's Romanian people and they'll be talking their language, and they think that we don't know what they're trying to say, you know talking about us, and when we talk our language the teachers started getting an attitude with us, and when they talk their little Romanian, they always get their own way. And I'm not prejudiced.

Another participant then said:

They (the teachers) keep saying Puerto Ricans can't get nowhere.

Like the participants in the first focus group, these participants reported believing in God, but not going to church often. Some of the participants thought that religious attitudes influenced perceptions of AIDS. One said:

Some people that don't believe in God, they're like, oh, we can't get AIDS.

Although it is not clear exactly what is being conveyed in this quote, the participant seems to suggest that people who are not religious think they are not susceptible to HIV.

Of all three focus groups, this group expressed the most discomfort with homosexuality. The following is an excerpt from the group discussion at the point when homosexuality was raised, which illustrates a homophobia not evident in either
the first or third groups:

I respect faggots, but only when they act stupid man, they try to-

When they be touching you and you be like-

When they rubbing up on you-

They want to buy you too.

My mother don't like them. They look at you like they like you.

Nasty.

You're talking about gay men and women; if you're talking about the women, I wouldn't mind.

Of note, all of the participants quoted above were male. The first focus group was all female, and only two males participated in the third focus group. It is possible that adolescent males are less comfortable with homosexuality than females.

Focus Group #3

The third focus group was conducted at Latinos Contra SIDA (LCS). Two males and three females between the ages of fourteen and seventeen participated. The participants were members of an LCS group for teens infected with or affected by HIV/AIDS.

Comparing the risks of AIDS and violence, these teens thought that they were more at risk from violence. Violence, one participant noted, was “hard to control,” while people can “protect themselves” from HIV/AIDS. Some of the teens also suggested
that their friends were not as worried about AIDS because “they think it’s just for homosexuals.” Another teen voiced agreement saying that people who were “not open-minded” were more likely to think they could never be affected by AIDS:

They won’t listen, they say, like, no, this is a homosexual thing. They don’t think that if it could happen to somebody, it could happen to me.

Regarding violence, the participants in this group thought that violence in the Puerto Rican community fueled stereotypes that people held about Puerto Ricans. One teen said that people thought of Puerto Ricans only as “criminals and gang members.”

This group addressed the changes in some of the traditional beliefs held about Puerto Rican culture. Referring to the idea that Puerto Rican girls should wait until marriage to have sex, and raise children, one participant said this idea was “dying out,” while another thought it had disappeared completely. Participants in this group also felt that attitudes toward homosexuality in the Hartford Puerto Rican community were changing, and people were becoming more tolerant.

### Section 3: Summary

The consistent theme across all three focus groups was that other concerns, both individual and community-wide, were overshadowing the teens’ concern about AIDS. Despite the six participants who stated that AIDS was a number one concern.

Specifically, participants in all three focus groups believed that violence presented a
greater problem to them personally than AIDS did. Several focus group participants also believed that some people thought AIDS was only a disease that affected homosexuals. One participant referred to people who somehow thought themselves invulnerable to HIV because they did not believe in God.

However, as for the major points of discussion, there was considerable variation between focus groups. For example, the participants in focus group #1 were the only ones to talk about the consistency of their condom use, and their perceived reasons why some boys refused to use condoms. Because this group was also the only entirely female focus group, the participants may have been more at ease talking about sex than participants in the mixed gender groups. Focus group #2 was the only group in which the issues of discrimination and racism were discussed. Participants in this group expressed a sense of frustration with stereotypes about Puerto Ricans in Hartford, and talked specifically about how racism had affected them on a personal level. In focus group #3, participants spoke more about how attitudes toward homosexuality and premarital sex in Hartford’s Puerto Rican community had grown more tolerant.

Gender differences among the three groups may have influenced responses. Among all three focus groups, participants in focus group #2 vocalized the most discomfort with homosexuality. The opinions in this group may have reflected the fact that this focus group had the most male participants, who may have been more self-conscious
about expressing any positive opinions about homosexuality in front of the other males in the group. In the third focus group, the males rarely spoke at all, so it is unclear from the data if their opinions are accurately represented.

It should be noted that diverse opinions were also expressed about topics within focus groups. Participants in focus group #1 expressed a range of opinions about homosexuality; those in focus group #2 debated the extent of the problem presented by violence in the Puerto Rican community.

The Development of the Phase II Instrument

Themes from the staff key informant and focus group interviews were used to more accurately develop the intensive interview instrument used in Phase II. Questions were added to the instrument examining: 1) the influence of ethnicity on perceptions of AIDS; 2) the teens’ perceptions of racism and discrimination in their lives; 3) stereotypes about Puerto Ricans; and 4) the teens’ perceptions about the magnitude of the problem of violence in contrast to AIDS.

Besides the specific questions added, themes from the Phase I data served as a framework for topics to be explored in the intensive interviews. Homosexuality was a particularly charged issue in both the staff key informant and focus group interviews, although the staff and teens expressed some ambiguity about the importance of
homosexuality in the teens’ attitudes toward AIDS. Religion was not an overt influence in the teens’ lives, but it was not clear if this would also be the case in the intensive interviews. In addition, some of the staff key informants had directly attributed problems in the Puerto Rican community to political economic factors. Focus group #2 participants had alluded to the connection between poverty, racism, and the condition of Puerto Rican neighborhoods, but none of the other focus group participants mentioned this. Further, statements about the overall tolerance toward homosexuality and premarital sex made by participants in the third focus group supported the idea raised in some of the literature that depictions of “traditional” Puerto Ricans may be stereotyped and outdated. Each of these themes was explored in the intensive interviews.
CHAPTER V: INTENSIVE INTERVIEW PARTICIPANTS' SEX BEHAVIORS, KNOWLEDGE, AND ATTITUDES ABOUT AIDS

The intent of this chapter is to provide a framework of the Phase II participants’ general knowledge and attitudes about AIDS in order to better understand findings about their perceptions of AIDS. This chapter examines the teens’ basic knowledge about HIV transmission, prevention, and treatment. Areas of confusion and uncertainty about these topics, and the teens’ sources of AIDS information are identified. Also presented are the teens’ attitudes about discussing AIDS with their friends, their perceptions of their peers’ risk of HIV infection, and their attitudes about condom use.

In the intensive interview data, frequencies were calculated for the following variables: 1) age; 2) gender; 3) birth place; 4) years lived in Hartford; 5) year in school; 6) marital status; 7) number of children; 8) whether participant was employed; 9) place of employment; 10) religious background; 11) whether participant attended church; 12) language preference; 13) whether participant was sexually active; 14) how many sex partners the participant had at the time of the interview; 15) how many sexual partners the participant had a year prior to the interview; 16) how often the participant had sex; 17) what type of sex the participant had; 18) condom use; 19) alcohol use; and 20) drug use.
Chi-square analysis was used to examine bivariate relationships between the following sets of variables. The first set tested the relationship between gender and: a) condom use; b) alcohol use; c) drug use; d) sexual activity; e) current number of sexual partners; and f) number of partners in the last year. The second set examined condom use and: a) number of partners; b) number of partners in the last year; c) sexual activity; d) alcohol use; and e) drug use. The third set tested age and: a) alcohol use; b) drug use; and c) types of drugs used. The fourth and fifth sets tested alcohol use, and drug use, respectively, and: a) substance use; b) number of current sex partners; and c) number of sex partners in the last year.

Frequencies of the Likert-Scale responses for the AIDS Knowledge Questionnaire were also determined. Chi-square analysis was done to discover potential bivariate relationships between gender and response.

Section 1: Intensive Interview Participant Demographics and Reported Sex Behaviors

Before presenting the findings about AIDS knowledge and attitudes, demographic data from the Intensive Interview participants’ backgrounds, as well as their reported sex behavior, alcohol, and drug use is briefly examined here. Aside from condom use, participants’ HIV risk behaviors were not formally measured in this study. Thus, the purpose of this section is to provide a descriptive basis of the teens’ sex behaviors and alcohol use as a frame for the discussion of their AIDS knowledge and attitudes.
There were forty-two Intensive Interview participants between the ages of fourteen and nineteen, with a mean age of sixteen, and a standard deviation of 1.31 years. Appendix 13 presents basic demographic data for both the male and female participants, identified by a code number from 1 to 42. As shown in Appendix 13, twenty-six of the participants were female (62%), and sixteen were male (38%). All of the participants reported having completed "some high school." Two had graduated high school, and none had dropped out of school at the time of the interviews. The majority of the participants were born in Puerto Rico (N=22), and all of these twenty-two had been living on the mainland for most of their lives, an average of twelve years. Fifteen were born in Hartford, three were born in Springfield, Massachusetts, and two in New York City. According to Rogler and Cooney's (1984) theoretical model of factors influencing ethnic identity, these participants would not be likely to have maintained as strong a sense of ethnic identity as Puerto Rican teens who had been living on the mainland for less time, and who were less educated.

Ten of the participants have jobs. Only one of the participants, a sixteen-year old girl, has a child. None of the participants were, or had ever been married. Participants were not asked specifically about their family's income. However, the majority of the teens were from single female-headed households. This and the fact that most of the teens also resided in Frog Hollow, where the average annual family income is $12,000, both suggest that the majority of the teens were likely from working-class. if
not impoverished, families. According to the Social Security Administration, the “poverty threshold” in 1990 was $12,674 (The Child Council, Inc. 1995).

Although most of the teens reported being less religious than their parents, the majority of the teens were still strongly religious. Thirty-four (81%) of the participants stated that they were Catholic. The remaining eight were Pentecostal. Eighty-four percent (N=17) of the teens who answered a question about whether they went to church regularly responded yes. Nineteen percent (N=4) said no. Twenty-one of the teens didn’t have an opportunity to answer the question about church attendance because it was added onto the initial questionnaire after half of the interviews were completed.

Twenty-two (52%) of the teens stated that they were sexually active, although two of these did not consider themselves currently sexually active since they had broken up with their partners at the time of the interview. All of the twenty-two sexually active teens stated that they were heterosexual. The majority of those teens who were sexually active had one partner at the time of the interview (N=12, 55%), and in the year before the interview (N=13, 59%), although some participants may have been referring to the same partner for both questions. One male participant reported having five partners at the time of the interview. Another male reported having eight partners in the year before the interview. Thirty-six percent of the sexually active participants (N=8) stated that they had sex once a week or more. Two reported having sex less
than once a week, but more than once a month; five reported having sex a few times a month, and seven reported having sex a few times a year. Of the sexually active participants, ten (45%) stated that they always used condoms; one (5%) reported using them frequently; five (23%) reported using condoms sometimes; and six (27%) reported never using them.

As previously discussed, 62% (N=26) of the intensive interview participants were female, and 38% (N=16) were male. There were two notable trends in the data in relation to sex behavior and alcohol consumption when examined by gender. First, these data point to a trend between gender and the likelihood of being sexually active. Although eleven of the male participants and eleven of the female participants reported being sexually active, proportionally, more of the males are sexually active than the females. Sixty-nine of the male participants (11/16) are sexually active and 31% (5/16) report not being sexually active. Forty-two percent (11/26) of the female participants reported being sexually active, and 58% (15/26) are not sexually active. This appears to reflect a general trend for males to be more likely to be sexually active, a phenomenon reported by participants in the open-ended questions of the intensive interview, and described in greater detail in Chapter VI. However, these figures may suggest a selection bias in the sample. The sample size is too small to make any definitive statement about this trend. There was no significant relationship between gender and condom use. Nonetheless, among the sexually active teens, girls were more likely than boys to report never using condoms: five (45%) girls of the
eleven sexually active girls, in contrast to one (9%) of the sexually active boys stated that they never used condoms.

The other important trend in the data when analyzed by gender is that of alcohol and drug use. Only two of the participants, both male, reported ever drinking alcohol or using drugs. Both said they drank beer on weekends and had used marijuana in the past. It is possible that these data reflect under reporting. For example when compared with similar data from the YOUTH survey discussed in Chapter II, the number of intensive interview participants reporting drug and alcohol use seems unusually small. In the YOUTH sample, 50% of Latinos and 31% of Latinas said they drank; eighteen percent of males and 3% of females said they used drugs.

However, the YOUTH surveys were self-administered so that respondents retained some anonymity. The fact that the interviews in this study were face-to-face may have resulted in some participants being reluctant to reveal aspects of their life they perceived as private, or socially undesirable. Marin and Marin (1991) note that Latinos may be more likely than other ethnic groups to give socially desirable responses when participating in a survey or interview. They attribute this potential both to the Latino cultural value *simpatico*, emphasizing politeness, respect, and a non-confrontational style of interacting with others, as well as a social deference they suggest is often linked with having less prestige or social power than the culturally dominant group (Marin and Marin 1991). Also, the female research assistants, who themselves reported no drug or alcohol use, recruited from among their social
networks, were likely composed of teens who were also unlikely to use drugs or alcohol.

Section 2: AIDS Knowledge and Attitudes

Based on the responses to the forty-two Intensive Interviews conducted during Phase II, the majority of teens in this sample were very knowledgeable about AIDS. All intensive interview participants were asked basic questions about AIDS knowledge. They appear to have fewer misconceptions about AIDS information than the focus group participants did. Although many participants had heard about AIDS earlier in their lives, most of them had been formally taught about AIDS as part of a high school health class. Twenty-three of the teens (54.7%) stated that they had first learned about AIDS in this class. Additionally, thirty-six of the forty-two participants completed AIDS Knowledge Surveys with the intensive interviews. (Six intensive interview participants did not complete AIDS Knowledge Surveys.) These surveys suggest that the teens' overall knowledge about AIDS is very high. Only one participant reported that he had never heard of AIDS. The remaining thirty-five participants accurately assessed themselves as well-informed about AIDS (see Table 8).
TABLE 8 Intensive Interview Participants’ Responses to the AIDS Knowledge Survey (N=36)¹

<table>
<thead>
<tr>
<th>Question</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Q1) Do you know anyone with HIV/AIDS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>24</td>
<td>67%</td>
</tr>
<tr>
<td>No</td>
<td>12</td>
<td>33%</td>
</tr>
<tr>
<td>Don't Know</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>(Q2) AIDS is an infectious disease caused by a virus.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definitely True</td>
<td>27</td>
<td>75%</td>
</tr>
<tr>
<td>Probably True</td>
<td>7</td>
<td>19%</td>
</tr>
<tr>
<td>Probably False</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Definitely False</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>(Q3) What are your chances of having AIDS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>7</td>
<td>19%</td>
</tr>
<tr>
<td>Medium</td>
<td>3</td>
<td>8%</td>
</tr>
<tr>
<td>Low</td>
<td>3</td>
<td>8%</td>
</tr>
<tr>
<td>None</td>
<td>17</td>
<td>47%</td>
</tr>
<tr>
<td>Am HIV+</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>6</td>
<td>17%</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>(Q4) How effective are condoms?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Due to a typographical error the phrase “somewhat unlikely” was used on the survey instead of “somewhat likely.”

¹ Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
<table>
<thead>
<tr>
<th>Question</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Effective</td>
<td>12</td>
<td>33%</td>
</tr>
<tr>
<td>Somewhat Effective</td>
<td>15</td>
<td>42%</td>
</tr>
<tr>
<td>Not at All Effective</td>
<td>6</td>
<td>17%</td>
</tr>
<tr>
<td>Don't Know How Effective</td>
<td>3</td>
<td>8%</td>
</tr>
<tr>
<td>Don't Know What a Condom is</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>(Q5) There is no cure for AIDS now.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definitely True</td>
<td>30</td>
<td>83%</td>
</tr>
<tr>
<td>Probably True</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Probably False</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Definitely False</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Don't Know</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>(Q6) There are drugs available to treat AIDS.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definitely True</td>
<td>13</td>
<td>36%</td>
</tr>
<tr>
<td>Probably True</td>
<td>14</td>
<td>39%</td>
</tr>
<tr>
<td>Probably False</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Definitely False</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Don't Know</td>
<td>5</td>
<td>14%</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>(Q7) Have you heard of the AIDS virus?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>35</td>
<td>97%</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Don't Know</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Question</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>----------</td>
<td>--------</td>
<td>------------</td>
</tr>
<tr>
<td>(Q8) You can be infected with HIV, but not have AIDS.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definitely True</td>
<td>10</td>
<td>28%</td>
</tr>
<tr>
<td>Probably True</td>
<td>9</td>
<td>25%</td>
</tr>
<tr>
<td>Probably False</td>
<td>4</td>
<td>11%</td>
</tr>
<tr>
<td>Definitely False</td>
<td>7</td>
<td>19%</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>5</td>
<td>14%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>(Q9) How likely are people to get HIV from mosquitos?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Likely</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Somewhat Unlikely</td>
<td>4</td>
<td>11%</td>
</tr>
<tr>
<td>Very Unlikely</td>
<td>10</td>
<td>28%</td>
</tr>
<tr>
<td>Definitely Not Possible</td>
<td>17</td>
<td>47%</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>3</td>
<td>8%</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>(Q10) How much do you know about AIDS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A lot</td>
<td>11</td>
<td>31%</td>
</tr>
<tr>
<td>Some</td>
<td>17</td>
<td>47%</td>
</tr>
<tr>
<td>A little</td>
<td>6</td>
<td>17%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>(Q11) How likely are people to get HIV from sharing needles?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very likely</td>
<td>35</td>
<td>97%</td>
</tr>
<tr>
<td>Somewhat unlikely</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Very unlikely</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Definitely not possible</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Question</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>--------</td>
<td>------------</td>
</tr>
<tr>
<td>Don’t know</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><em>(Q12)</em> HIV is passed through sexual intercourse.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definitely true</td>
<td>34</td>
<td>94%</td>
</tr>
<tr>
<td>Probably true</td>
<td>2</td>
<td>6%</td>
</tr>
<tr>
<td>Probably false</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Definitely false</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><em>(Q13)</em> A pregnant woman can pass the HIV virus to her baby.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definitely true</td>
<td>22</td>
<td>61%</td>
</tr>
<tr>
<td>Probably true</td>
<td>13</td>
<td>36%</td>
</tr>
<tr>
<td>Probably false</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Definitely false</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><em>(Q14)</em> How likely are people to get HIV from sharing silverware?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very likely</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Somewhat unlikely</td>
<td>3</td>
<td>8%</td>
</tr>
<tr>
<td>Very unlikely</td>
<td>5</td>
<td>14%</td>
</tr>
<tr>
<td>Definitely not possible</td>
<td>27</td>
<td>75%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><em>(Q15)</em> Have you heard of the blood test for HIV?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>31</td>
<td>86%</td>
</tr>
</tbody>
</table>
There were however, four main topics about which some teens remain uninformed. One of these was the difference between HIV and AIDS. Nineteen percent of the teens (N=7) thought that being infected with HIV and not having AIDS was not possible, and 14% (N=5) did not know the correct answer to this. Confusion about the difference between being HIV infected and having AIDS were also shown in the responses to the AIDS Knowledge Questionnaires administered during the focus groups and AIDS Acquaintance interviews. Some intensive interview participants recognized a difference between HIV and AIDS, but were not entirely clear about the specifics of this difference. One sixteen year-old participant in particular perceived the difference between HIV and AIDS as the difference between a treatable and non-treatable illness. He raised this issue to explain why he felt his friends were not that concerned about HIV/AIDS:

I think it's like (they) go to a hospital, get treated so it don't become AIDS, because HIV is the virus and AIDS is the real one. So they think when they have HIV they just go and treat themselves before it becomes AIDS.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
The overlapping definitions that some participants have about HIV and AIDS may create confusion about HIV treatment like that expressed above. It can also contribute to an unnecessary sense of dread of immediate death that some younger teens have upon learning that family members are HIV-infected. For example, some AIDS Acquaintance Interview participants referred to both HIV and AIDS as the "sickness." when talking with friends and family members, further blurring the distinction between AIDS and HIV. When the mother of two of the participants told them she had AIDS, although she had only been diagnosed with HIV, they mistakenly thought her death was imminent.

The second issue the teens were uncertain about is the probability of mosquitoes transmitting HIV. Earlier in the epidemic, several studies found that Latinos, in general, and Hartford Puerto Ricans, in particular, were more likely than Anglos and African-Americans to be misinformed about this issue (Flaskerud and Cavullo 1989; Singer et al. 1990a). Eleven percent (N=4) of the teens thought this was only somewhat unlikely, suggesting that some of this confusion still exists, although the majority of participants correctly answered the question. However, it should be noted that the responses to this particular question may have been skewed due to the typographical error in the AIDS Knowledge Survey, described in Chapter IV. Yet the uncertainty about HIV transmission through mosquitoes, and concerns about casual transmission were also raised in the intensive interviews:
Some of my friends think that you can get AIDS by a mosquito bite and we just be arguing stuff like that. M, 15

We wonder if you can get it from a mosquito bite or just eating off of things, you know, spoons like not washed, or something, or like it you were to kiss one of your relatives who has it, or somebody's clothes that has it. We always used to wonder. We never did figure out if it was true or not. F, 16

There are several possible reasons why the teens in this sample express uncertainty about these topics. One possibility is that the AIDS education these teens receive is simply not adequate in all areas, despite the overall high level of AIDS knowledge reflected in the survey. Another possibility is that there are some issues, such as HIV transmission through casual contact, or mosquitoes, about which the teens trust their own perceptions over that of an instructor or course materials.

The third topic of uncertainty for the teens is the efficacy of condoms as a measure of protection against HIV infection. Forty-two percent (N=15), and 17% (N=6) of the participants respectively, thought condoms were only “somewhat effective” and “not at all effective,” (see Table 8). During the intensive interviews, some teens expressed concern about the fragility of condoms. For example, one boy said he regularly used two condoms during sex to increase his protection. Other teens said things like, “Condoms aren’t 100%,” and talked about the likelihood of condoms breaking. In fact, some participants, such as this eighteen year-old male, viewed the perceived fragility of condoms as another reason to avoid using them at all. He argues that condoms do not protect against HIV because they break:
Even if you use protection, you could still get it, just touching a break (in the condom). So really I think about it and I say if I'm going to have it no matter what kind of protection, I'm going to have it.

Finally, similar to the focus group participants, the intensive interview participants also seemed confused about the state of AIDS treatment options available. Thirteen (36%) participants thought drugs to treat HIV existed; two (6%) thought there were no such drugs, and five (14%) participants did not know the answer to this question.

Sources of Information About AIDS

Junior-high health class was not the first exposure to AIDS for the majority of intensive interview participants. Most remembered first hearing about AIDS when they were seven or eight years old, in the late 1980s. Six had talked about AIDS with a family member, most commonly their mother, usually in reference to another family member living with HIV.

Knowing one or several people living with HIV was shockingly common for this group of teens. Twenty-four (67%) of the participants knew at least one person either living with HIV, or dead from AIDS-related complications. Some teens knew several people living with HIV: one sixteen year-old girl told me she had learned about HIV from her grandmother, both parents, her father's friends, and two uncles, all of whom were HIV infected. Fiona, another sixteen year-old, said that she was sad about her friends who were HIV infected, and angry about an infant who was infected by HIV.
in utero and later died:

They're not really my family but, you know, I know a lot of girls who have AIDS and it makes me sad. And he wasn't my nephew, but like my nephew; he wasn't really my nephew, but you know, for my part I find him as a nephew, and he died because of that. It makes me angry, you know.

Daisha, a seventeen year-old girl, reported a similar experience with a friend:

I had this friend and she was pregnant and her boyfriend was using drugs, so he was sharing his needle with his friends, and he got AIDS but he didn't tell her nothing until the last minute as she went, you know when you're pregnant they do blood test and everything. So she went to do it, and it came back like she got the HIV virus. When her baby was born, it died because the baby had AIDS.

Participant Discussions About AIDS

The teens may be less comfortable talking about AIDS with friends than with family members. Girls were more comfortable talking about AIDS than boys, who talked about AIDS rarely, and usually only in the context of sex. One boy said:

It doesn't even come up. All guys talk about when they get together is about girls. They don't even talk about, you know AIDS....

A nineteen year-old boy echoed:

Like a guy, you don't talk to nobody (about AIDS).

Yet boys did talk about AIDS, as revealed by one sixteen year-old male participant who first told me that his friends don't talk about AIDS, only about sex. Then he added:
We sometimes talk about it. I just come up with the question what you going to do if you got AIDS, they just come up with an answer—just, like I won't kill myself. I'll just got to rehab and have something done or whatever.

Girls, on the other hand, can talk about AIDS by grouping it in a category of risks that girls are confronted with as part of having sex. The predominant risk in this category was pregnancy—not so much the state of being pregnant, but of being abandoned by the father of the child, and being forced to cope with the economic and social repercussions of single parenthood. Girls usually included infection with HIV, or an unnamed sexually transmitted disease, as something that a boy might "give" to a girl, and then leave her to cope with on her own. Accustomed to being responsible for avoiding pregnancy when they had sex, girls perceived HIV as one other issue they needed to worry about in relation to sex. Boys, possibly less apt to worry about impregnating their sex partners, or of discussing this possibility with their sex partners or male friends, were less comfortable expressing concern when discussing sex.

Perceptions of Peer Risk of HIV Infection

Although 66% of the teens knew someone living with HIV, only 53% (N=22) perceived their friends or acquaintances to be at risk for HIV infection. Participants thought their friends were at risk because of having either sex with multiple partners, not using condoms, or both. Two participants said they knew people at risk for HIV infection through drug use. Other reasons teens gave for their friends’ risky behaviors
can be described as related to a sense of fatalism. This will be discussed in greater detail in Chapter VII.

Beliefs About Condom Use

For the teens, the term “safer sex” was synonymous with condom use, or getting “strapped,” or “hung up.” Yet condom use is itself representative of the troubling gap between knowledge and behavior change: despite knowing that condom use could prevent HIV infection, this group of teens did not report consistent condom use.

Table 9 shows the reported frequency of condom use by frequency of sexual activity.

Table 9: Frequency of Sexual Activity and Condom Use Among Sexually Active Participants (N=22)

<table>
<thead>
<tr>
<th>Sexual Activity</th>
<th>Condom Use</th>
<th>Once a week or more (N=8)</th>
<th>Less than once a week (N=2)</th>
<th>A few times a month (N=5)</th>
<th>A few times a year (N=7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>50% (N=4)</td>
<td>N=0</td>
<td>20% (N=1)</td>
<td>57% (N=4)</td>
<td></td>
</tr>
<tr>
<td>Frequently</td>
<td>13% (N=1)</td>
<td>50% (N=1)</td>
<td>N=0</td>
<td>N=0</td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>13% (N=1)</td>
<td>50% (N=1)</td>
<td>60% (N=3)</td>
<td>14% (N=1)</td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>25% (N=2)</td>
<td>N=0</td>
<td>20% (N=1)</td>
<td>29% (N=2)</td>
<td></td>
</tr>
</tbody>
</table>

Teens who did not report using condoms consistently could not explain why this was so for themselves, often saying they just “didn’t know” why they did not use condoms. These teens were, however, able to generate theories about their friends’
erratic condom use. Problems raised with using condoms were: 1) they were not always effective, and might break; and 2) they caused a loss of sensation during sex. Most of the participants stated that loss of sensation was a problem for males only, but one boy insisted that his girlfriends had been the ones to refuse condom use:

Some of them say, “If you want to use condoms then forget it, I don’t want to have sex.” They say almost the same thing as some men, that they don’t feel the same thing in sex, and it’s slippery.

Another girl corroborated this viewpoint, describing her friends who also agree that sex with condoms doesn’t feel the same:

Some of my friends they say that sometimes they don’t use a condom because it doesn’t feel like the same. I don’t know how to say that, like, passion and that. And if the males think that they (the males) are all that, they do not use condoms.

This girl uses the term “passion” to refer to an emotional connection between partners that her friends have complained is disrupted by using condoms. Other researchers have talked about the impact condom use has on women’s perceptions of the emotional bonds they might have with a partner (Sibthorpe 1992; Singer et al. 1990a; Sobo 1996). This teen also makes the important point that the boys she knows sometimes don’t use condoms if they “think they’re all that,” implying that they may fear condom use compromises their image of being masculine, macho, or skilled and desirable lovers.
In summary, this sample of teens is well informed about AIDS. Despite their overall knowledge, they are uncertain about several topics. Some teens have misconceptions and uncertainty about the differences between HIV and AIDS, the transmission of HIV through mosquitos, the state of treatment of HIV/AIDS, and the efficacy of condoms for protection from HIV. The majority of the participants had learned formally about AIDS in health class, but many had been exposed to HIV/AIDS informally by knowing friends and relatives living with HIV. Some teens talked about discussing AIDS with their family members, but were less likely to talk about AIDS with their friends. Girls, however, were more comfortable talking about AIDS with their friends than boys. As to condom use, both males and females spoke about the loss of sensation, unpredictable efficacy, and loss of emotional intimacy as three problems associated with using condoms.
CHAPTER VI: THE CULTURAL CONTEXT OF AIDS RISK PERCEPTIONS

This chapter presents findings on potential ways five cultural domains shape perceptions about HIV/AIDS. The domains discussed here are: 1) religion; 2) conceptualizations of gender roles; 3) sexuality; 4) familism, and 5) ethnic identity.

Section 1: Religious Beliefs and HIV Perceptions

Participants' religious beliefs were not strongly linked to HIV/AIDS perceptions overtly, but their inferences about the relationship between religious values and other cultural domains, as these relate to HIV/AIDS, are identified. As for religious attitudes, none of the teens recalled AIDS, in any dimension, ever being discussed during church sermons. Few of the teens directly described any relationship between their religious values and how they perceived AIDS. Only one sixteen year-old male, a practicing Pentecostalist, voiced the opinion that AIDS was the consequence of excessive “sins of the people.”

Yet noting that religious beliefs, in combination with parental expectations, had influenced their attitudes about premarital sex, many participants made indirect statements about how religious ideals influenced their thinking about sex. Even participants who did not perceive themselves to be religious invoked religious values
to express feelings about having sex before marriage. This fourteen year-old girl is a prime example:

I felt bad when I had sex; I felt bad. I know you're not supposed to feel like that but I thought about it and the Bible came into my mind and God, and I should have never done, I should have waited until I was married.

Reflecting how an individual who is not religious articulates her ambivalence about having had sex through concepts such as God and the Bible, this quote shows how closely religious values are interwoven with the teens' ideas about sex. Further, since the teens' perceptions of AIDS encompass, to a large extent, cultural values about gender and sexuality, it is also possible that religious values, by way of influencing thinking about sexuality, also indirectly influence thinking about AIDS.

Section 2: Perceptions of Gender Roles and the Division of Labor

In this section, the purpose of examining how the teens in this sample conceptualize gender roles is to establish a framework for the division and distribution of power between genders, upon which gender interaction, and the negotiations of intimacy and sexuality are made (Weeks et al. 1996). Household decision making, and economic responsibility ultimately reflect the distribution of power between the genders (Hurtado 1995). In turn, household distribution of power may have implications for the division of power in sexual domains, although it has not yet been established how much Latina decision-making power in the household extends to sex (Weeks et al. 1996).
Importantly, in the last twenty-five years, researchers studying Latino familial dynamics and gender roles have made a concerted effort to avoid the reduction of these roles to stereotypes (Vega 1995). The stated patriarchal ideal in Latino culture often differs from the actual distribution of power (Singer 1995). Further, the process of acculturation for Puerto Ricans on the U.S. mainland undoubtedly impacts the manifestation of gender roles (Lewis Fernandez 1992). Findings here demonstrate the complexity of the teens' conceptualizations, and highlight the differences between the teens' perceptions and "traditional" gender role ideals and values. This section serves as a contextual background for examining the teens' perceptions about gender roles and sex.

**Household Gender Roles and Responsibilities**

In response to questions about who should be the family breadwinner if the participants were to have families of their own in the future, fifteen (36%) of teens answered that they expected the man to be the breadwinner, two (5%) of the teens thought the woman should be the breadwinner, and the majority of the teens (N=25, 60%) thought both male and females should be breadwinners.

Seven of the fifteen participants who thought males should be the sole breadwinner were male. These boys appeared to draw upon culturally shaped notions of Puerto Rican male gender roles of the man as a source of strength and protection for his
family in formulating this opinion. Pedro, sixteen, explained that he thought working women were potential targets on the “street,” a euphemism many teens used to refer to the nexus of public drug use, prostitution, criminal, and gang violence. In contrast, Pedro thought men were safer on the street, and working outside the house, because of their physique and “street smarts”:

Because he’s stronger; not stronger, but like he should be going out there. It’s less risk than a woman going out in the street, and go get a job. The woman, it’s like she more at risk if anything happens, a guy might stop her and take the car, and jewelry, and everything.

In the past, the “street” has traditionally been viewed as an exclusively male domain, while the home is centered around women (Klor de Alva 1988). Clearly, Pedro’s opinions represent more traditional views about gender roles. His own family, he proudly told me, “kept the Puerto Rican tradition,” making rice and beans every day. He spoke Spanish with his mother at home, and most of his friends were Puerto Rican. In addition, Pedro had traditional beliefs about sex, and, although he had a girlfriend, had decided to wait until marriage before having sex.

Girls who thought men should be the sole breadwinners viewed the division of labor between the sexes as clear and unambiguously defined. One fifteen year-old stated that this division of labor is simply Puerto Rican tradition:

Because the Puerto Ricans say that the woman’s for the house, the man’s for work.

This fourteen year-old girl, who had cerebral palsy, lived in Puerto Rico until she was
nine years old. She lived with her conservative family noting that her mother would “kill her,” if she ever used alcohol or had sex before marriage. She had not had sex at the time of the interview.

Other girls who thought men should be the sole breadwinners implied that this division of labor was something they had learned in their families while children. Daisha, who is sixteen and has a baby of her own, describes how she believes both men and women should divide labor toward the shared goal of caring for the children:

> The mother got to be taking care of the kid, and it’s like in my family they told me that the man always should be taking care of the kids. The woman, too, in a way, you know, when the men come home from work or whatever she should have the house clean, the kids clean, and food on the table for him; she should be there for him and in a way a man should be there for a woman, too. For me, the man should support his family.

While she mentions that both father and mother should be “taking care of the kids.” Daisha distinguishes between the monetary form the father’s contribution toward child-care should take, and the housework and child care she believes comprise the mother’s role. In her own family, the father of her baby worked to support her and the baby while she stayed at home to take care of the child.

Two participants (5%) thought the woman should be the prime breadwinner. One of these two was a boy, and the other a girl, who said she did not want to be dependent on her future partner. The majority of the participants thought that both people in a relationship or marriage should be breadwinners.
Some participants voiced an awareness that the culturally constructed boundaries of gender roles were in a state of flux. For example one girl, aged fifteen, said in response to the question of whom the primary breadwinner is:

It's usually the man but in this day it could be both.

Another girl, 16, said:

Both; more the man, but both.

When I asked her why she thought the man should be the breadwinner, she responded:

Tradition: it's supposed to be like that, but it's not like that, but it supposed to be like that.

These responses underscore the complexity of the shift from perceived traditional to less traditional gender roles, experienced by second, and some first generation Puerto Rican teens. However, it is not clear how much the notion of "traditional" Puerto Rican women working exclusively within the home during this century, is based on cultural ideal versus actual practice. Puerto Rican women’s participation in the workforce is not a new phenomenon. Island and mainland Puerto Rican women working outside their homes to support their families has become increasingly common during this century (Vega 1995). In general, Puerto Rican women have more success in finding employment on the mainland than men. In the Northeastern U.S. however, Puerto Rican women’s participation in the work force declined briefly during the 1960s because of the decrease in manufacturing jobs at this time (Ortiz 1995). By nature of the fact that it has often been easier for Puerto Rican women to
find employment than it is for Puerto Rican men, previous research has suggested that some women are at greater risk for both domestic violence and HIV infection, as their male partners attempt to cope with loss of their status as breadwinner by drinking excessively, or having unprotected extramarital sex (Singer et al. 1990; Weeks et al. 1996). It is unclear whether the Latina teens in this sample will be at similar risk through their partners; the boys in the sample who spoke of wanting both spouses earning income seemed pleased with the idea of having their girlfriends and wives share responsibility for expenses. A most common response for both boys and girls was that responsibility for earning money should be shared evenly. Girls also raised the issue of establishing financial independence apart from their partners, in case their husbands tried to control them financially, or later turned out to be unsuitable mates.

Ironically, the participants' ideas of equal distribution of work did not extend to childcare. In New York City, Rogler and Cooney (1984) also found that while gender egalitarianism among Puerto Ricans appeared to increase incrementally by generation, this has resulted in women taking on more traditional male tasks, without male reciprocity. With the exception of a few participants who said they would opt to hire a babysitter to care for their children, most of the teens, males and females alike, said that they believed child-care responsibilities in their future families should be shouldered by the mother, whether or not she was working outside the house. All of the scenarios suggested by the teens were biased toward the woman doing most of the work, and premised on the idea that the man would be unlikely to help, although he
could possibly be persuaded. Some male participants alluded to the idea of assisting with household responsibilities, as reflected in the following statements, but they clearly saw their role as secondary:

He (the father) could help. He can't do everything, but he could help her with something. M, 19

If she want to, I'll help a little bit. M, 17

Only four (24%) of the boys said that they would be willing to share housework with their future partners.

Female participants’ perceptions about who should be responsible for child care in a two-household income matched the males’. Josie, fifteen, suggested a seemingly unrealistic, or at the very least, exhausting, scenario for the mother in her description of household division of labor:

When the man is good to the woman and they talk about it or discuss it, they both work, one for the day, one for the night, like that, to support the house. One works days, one works nights. The woman works in the day in the house with the children and when the husband comes in after working, he stays in for the night and the woman works at night.

When I asked her what she meant by the man being good enough, Josie replied:

The situation, and they are not like, on no, you cannot do that, because I’m the man I should bring stuff to the table.

This quote illustrates how notions of gender equality have influenced these teens’ values. The idea of shared economic responsibility has been widely accepted, although according to Josie it still largely depends on the man’s consent. However, changing concepts about employment equality have not been matched by shifts in
thinking about equality for child care and housework, meaning that the woman’s work has simply increased (Rogler and Cooney 1984). This is especially so in Puerto Rican families headed by single women who are responsible for both child care, housework, and financial support of the family (Vega 1995).

**Women’s Locus of Control in the Household**

While the traditional notion of the man as the financial provider for his family is still a culturally salient theme for these teens, most of them stated that their mother had considerable decision-making power in the house. This is not surprising: Puerto Rican men and women commonly share decision making for their families on the island and mainland (Vega 1995; Weeks et al. 1996). A third of the teens stated that their mothers made most of the decisions for the family, including some who lived in single family households headed by their mothers. Yet even teens living in two parent households talked about how much authority their mother had in the household. Billy, 14, provides one example:

It’s like my father isn’t the type of man that thinks he should be like king, do you know what I mean? My pop thinks that—my pop will let my mom be in charge. He just pays attention, I guess. He just be like I don’t have to make no choices around here, I just pay taxes, I do this, pay the rent or whatever, but if you want to make any—you know, he’s not the type of man because most guys do that, they want to rule over, end up fighting and everything, he just don’t pay attention to that kind of stuff, he let her do whatever she wants, he don’t want no problems or fighting or whatever because that’s the way it ends up most of the time; they end up both want to be leaders. My mom’s really like in charge.

Though Billy claims that most guys “want to rule over,” their wives and families in
the home, this perception was not mirrored in what the rest of the teens’ described happening in their families. Billy’s attitudes were “traditional” in comparison to some other participants. In two parent households, while it was generally expected that the fathers provide financially for their families, it was also acceptable for women to work outside the home. These findings are consistent with current trends among all U.S. Latino groups, in which even more traditional males expect their wives to work outside the home to sustain current standards of living and increase future economic and occupational opportunity (Hurtado 1995). Within the home, the mothers of the teens in this sample appeared to have considerable decision-making clout.

Section 3: Perceptions of Sexuality

Beliefs About the Relationship Between Gender and Sexuality

Nearly every participant articulated a sense that boys have more freedom sexually, while girls, to remain respected members of the community, have to adhere to a far stricter set of standards. Both girls and boys in the sample agreed that girls have much more at stake than boys when they decide to have sex, by running the risk of getting pregnant, or damaging their “reputations.”

Descriptions of traditional Latino cultural values invariably describe the expectation that Latinas should remain virgins until they get married (Espin 1986). These values
are encompassed in the broader concept of “marianismo,” discussed in the Chapter II. The female participants in this study had a range of beliefs about the importance of virginity. They discussed the Quince, or “Sweet 15” party, a specific ritual observed regarding virginity. The Sweet 15 party is a coming of age party for girls celebrated by several different Latino groups: its anglicized counterpart being the “Sweet 16” party (The Boston Globe 1/5/97, pC1). The following is one 16 year-old girl’s description of a Sweet 15 party:

That’s like people go to church and you wear a white dress, a white crown, everything white and that’s like you’re pure, and it’s just like a wedding. You have girls come out and then guys. You have like a little bonder, a girl bonder, she wears a dress, and they put a ring on you—this one—and that’s like you stay a virgin until the day you get married. Then you wear flowers in here, and you take them out for a crown, and then you take off your little sandals and put on high heels and then you have a big party after that, like a wedding.

For the girls in this sample, the Sweet 15 party, traditionally celebrated to mark a girl’s initiation into womanhood, and her ability to bear children, has now taken on an added significance. Female participants in this study described it as a public vow to God to maintain their virginity until they are married. Realistically though, not all the female participants who had a Sweet 15 party or planned to have one in the future, expected to honor these vows literally. One girl, for example, said she simply wanted to maintain her virginity one more year so that she would not be deceitful in the eyes of God by wearing the Sweet 15 white dress:

Like I won’t want someone to think that I’m 15, and I got to wear a white dress. So if I’m not a virgin, I can’t wear a white dress, so I think I’m going to wait (to have sex) until I’m 15.

Male interviewees also expressed ambivalent opinions about whether or not girls
should have sex before marriage. Seventeen year-old Jorge first stated that he thought it acceptable for girls to have premarital sex, but then added that he does not want to marry a “wrong girl”—one sexually experienced—and would prefer to wed a virgin. Jorge was uncertain about how he had acquired this value; he suggested it may have religious roots, or may instead have the prevention of sexually transmitted diseases as a practical basis. Ultimately he noted:

My father never teach me to do that (want to marry a virgin), I picked that up myself like in school. Puerto Rican girls be talking about that and I picked it up by myself and I think they’ll (other teens) pick it up by themselves too. A lot of people be talking like that.

Jorge’s uncertainty about the origins of this value is significant. His speculation about the various influences he recognizes in his life as contributing to his belief about the importance of marrying a virgin captures the intersection and overlapping of multiple cultural domains influencing a particular belief. It also illustrates the difficulty of trying to separate the influence of one cultural domain over another. Jorge’s hypothesis about the origin of this value reflects his awareness of the differences between the values of his parents, and those of his peers, and mirrors the changes AIDS has had on social norms among this group of Puerto Rican teens.

Arturo, 19, has a more succinct understanding of how sexually active Puerto Rican adolescent girls violate the tradition of marianismo:

They always put them (sexually active girls) down.

Why do they put them down?

They expect them to be virgins until they get married. They teach them they got
What about guys who are sexually active? Is that OK?

It's like a normal thing.

Do you think it's OK for a girl to be sexually active?

I don't think so.

In accordance with Arturo’s statement about the expectation that Puerto Rican teen males be sexually active, the majority of the sixteen male intensive interview participants (N=11, 69%) did report having sex.

Girls in the sample were sexually active despite Arturo and other male and female participants' opinions that having sex is not acceptable for teen girls, unless they are known as “tramps,” or “sluts.” However, among the twenty-six girls in the sample, proportionally, the number having sex (N=9, 35%) was much smaller than the number of males. The teens’ perceptions of whom among their friends were sexually active matched these proportions. Most thought that males were more sexually active than females, except a few participants who believed that girls must be having sex more often, because so many of them “came up” pregnant.

Participants consistently noted that beyond cultural standards deeming it acceptable for male adolescents to be sexually active, boys are in fact bestowed with status because of having sex. Participants had only positive associations linked with sexually active teen boys. Recurring themes about sexually active girls were more
negative and revolved around two specific ideas: 1) the risk of the girl becoming pregnant through a sexual encounter; and 2) the likelihood of the girl acquiring a reputation of being sexually promiscuous, resulting in a loss of her respectability:

The guy is gonna be oh, you cool or you're bad or whatever (about other sexually active males), but the girl's not going to be like, oh, you did it with him, that's cool. They're going to be like oh, you've got to be careful, you're going to get pregnant you know. F, 16

I guess it's because that they expect them not to do it. The boys, they know that they won't follow the rules, but they expect the girls to. F, 14

The same thing for the boys they don't gossip a lot. The girls get a lot because the girls had the possibility to get pregnant. F, 15

If a girl has sex, she's considered that she's a tramp or whatever. If a guy sleeps around, you know, he's a good guy or whatever. F, 15

I know this girl she have like many sexual partners and she does not have respect; the guys don't have respect for her. F, 18

I don't know, they supposed to stay virgins and if you got a lot of partners they call you a bitch and whatever. F, 16

Well, I know people they blame it on the girls because sometimes they let the boys do it, you know, that's all I can say. F, 14

They think they're sluts. Probably because they want to be like be part of the church and wear a white dress and be part of being a virgin. They still believe in that. M, 16

They say that they're stupid for letting boys do that to them; that they should have thought better; that now they got to be stuck with that kid and you know, now he's not going to be there, so. F, 16

If the girl is having sex with different guys, she's a hooker. M, 16

I mean like if they get pregnant, the guys, it's like they put it all on her. Like you have the baby, like, I'm going my way, you go yours, and they leave the girl. F, 14

Some male participants, such as Billy, voiced a sexual double standard. Billy told me how he had cautioned his sister about being seduced by boys who want her for sex and nothing more. He held up his own behavior for scrutiny by his sister, as an

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
example of how sexually shallow other boys can be:

These day, you know girls, you know what I mean, they just like having sex and me. I talk to my sister and I tell my sister the things that I do and I tell her, you know, I do this with a girl, you know what I mean, and this and that, and this is to show you that things I do to a girl, this is the same thing a guy could do to you, you know. Most girls they just be skeezing around, you know, they just be creeping around with the guys. I don’t like that. There are some girls that, I’m going to be honest with you, I probably just wanted them for sex, and that’s what I tell my sister—I probably just wanted her for this and that’s it. I told her you should wait until you’re like older, eighteen or nineteen, and you know then if you find a man who’s truthful—a guy that you want, you love, whatever, that’s the person you should—if you’re going to get married, that’s when you should lose your virginity, whatever, but for now, you know, that’s why I watch over her. I’m not the type of person that if a guy comes up to her, I’m not going to bully him or anything, but if he starts talking crap like I want to hit her, I want to bone her or whatever, that’s when I get into a confrontation with any guy if he disrespects my sister like that. That’s the way I watch over her. But if she wants to talk to a guy in school, that does not bother me as long as things don’t get out of hand and they disrespect my sister, or touch her, but I’m not going to be on her. Most girls, fathers and brothers be on them so much that they’ll end up doing it, that’s why I don’t want to do it.

There are several striking features in Billy’s quote. He believes that seeking sexual experiences is acceptable for him, but he loses respect for whatever girls agree to have sex with him. Another 17 year-old boy, who like Billy had more conservative views about sex, voiced a different perspective about this dynamic. He agrees with Billy that it’s unacceptable for his female partners to be sexually active in the first place, but fears refusing their advances will have repercussions on his reputation among his male peers:

I think it’s wrong, but I’m not going to tell her it’s wrong, because if she wants it, no problem. When they tell me they want it, I don’t want to tell her I don’t want it. She might tell other boys.

Billy also reports his own behavior as a way of cautioning his sister not to let herself be used or “disrespected,” and encourages her to find a “truthful” man before she marries and has sex. Yet because of his implication that most boys, including him
himself, are not truthful, it may be difficult for his sister to envision exactly what kind of boy is worthy of sex and marriage.

Billy’s main intent is to defend the honor of his sister, and therefore the honor of his family, especially because she is younger than he. The importance of defending the honor of one’s younger sister is better illustrated by a nineteen year-old boy who while talking about his unwedded older sister’s pregnancy, remarked that he would have been “mad as hell,” if his younger sister had been the one to get pregnant instead. Latino cultural values supposedly dictate that male Puerto Ricans defend the honor and respect of their sisters and mothers (Espin 1986). Billy, however, has practical reasons for wanting to prevent his sister from having sex, besides simply guarding her virginity. He described how he believes his father ruined his mother’s opportunities by “getting her pregnant” before she could use her four scholarships:

My mom went to college for like one year; she graduated from Buckley, she had four scholarships; she could have had it all and then my father messed it all up for her. Got her pregnant. Back then he was like in the wrong stuff, like in gangs, back in the days and stuff like that. He was really overprotective, you know. Didn’t let her do the things that she wants to do with her life and it’s like he really messed it up for her and she lost her scholarships or whatever.

Billy then explains that his sister has inherited his mother’s intelligence, and he wants to safeguard her future by sabotaging any relationship that would derail his sister’s academic progress.

This aspect of Billy’s protectiveness is included to show that Billy has
multidimensional perceptions of gender roles, and numerous and sometimes contradictory motives for attempting to uphold them. Indisputably guided by a sense of machismo in his evaluations of gender-specific behavior, Billy also conveys his pride in his sister's intelligence and accomplishments, clearly wanting more for her than the traditional roles of mother and wife. Billy's determination that his sister succeed also underscores his own uncertainty about his future, and the future of the Puerto Rican community.

In terms of AIDS risk, the main point of detailing the viewpoints of Billy and the other male participants discussed here is to convey the atmosphere within which both male and female teens negotiate sexual activity. Beliefs and attitudes about sexuality directly impact perceptions about HIV.

Perceptions of Fidelity

To understand the extent to which participants in this sample perceived themselves at potential risk for infection through sex with partners who have multiple sexual contacts, I asked questions about fidelity and monogamy, if these topics hadn't already been raised during an interview. All but six participants had an opinion about which gender was more likely to be faithful in a sexual relationship. Of the thirty-six teens who answered this question, five teens (13.8%) thought both males and females were equally apt to be faithful to a partner. The other thirty-one teens (86.1%)
believed girls were more likely to be faithful. No one suggested that boys were more likely the faithful partners, although one sixteen year-old girl theorized that boys might occasionally be more faithful than girls when boys are “strung out” on heroin.

Girls were perceived to be inherently more faithful than boys because of qualities associated with female gender roles. According to the quotes below, participants thought girls more likely to be faithful because they are more emotional, fall in love more easily, and are more honest than boys.

When they (girls) think they are in love or whatever, they don’t even look at nobody. I been there. They think that’s the perfect guy, I’m going to be with that guy forever and they have kids or whatever and they have sex. Guys, they’re not going to think about marrying the girl or whatever. Sometimes, I’m afraid my boyfriend is going to whatever, I think about that, too. I don’t want him to get tired of me and break up with me about something. I know guys are always flirting and whatever. F, 17

I think they (girls) get more serious about the relationship. They get in love or something and the boy just keep it as a joke or he don’t tell her; he pretends being serious but he thinks it’s a joke and she don’t see that. I think the girl loves him and takes it serious. F, 15

Guys like a chance to lie a lot, and girls they don’t lie. M, 18

Girls are more sensitive, they got more feelings for a guy or whatever. F, 17

Some participants emphasized the fact that even if girls do have multiple partners, this is not tolerated. Josie, for example, talks about boys’ reactions when they find out that their girlfriend has not been faithful to them. She notes the contradiction in the standard that deems it acceptable for males to have multiple partners, but not females:

Hey, they start fighting and they say stuff that they don’t mean, but they say it.
Sometimes, they hit the girl, they act like crazies because, oh my God, I’m not good enough, you have to get another one? Boys, they can do that to us but we cannot do that to them?

While several boys openly spoke about having multiple partners, none of the girls acknowledged having more than one partner at a time. Boys perceived their having multiple partners as a testament to their manliness, and machismo; girls worried that they will be labeled a “slut” or “tramp” if they are known to have more than one partner. Portraying their current partners as truthful and faithful was also important for the female participants, although most of their peers reported that their friends’ boyfriends were not faithful to them. Sobo (1993, 1996) refers to this as the monogamy script.

Boys who currently had multiple sex partners speculated about whether they would be faithful to their wives if they married in the future. In some cases, their hypothesis about whether or not they would be faithful was predicated on their perception of how well their wives will treat them, as this 17 year-old boy describes:

> It depends. Me, I’m going to get married to the one that I feel that I’m in love with, I mean, if I’m going to have to be deeply in love with this girl, I mean, love, love, love, and I think I could do it, you know what I mean, stay with one girl and especially if I have kids and this girl treats me like I’m number one, like I’m the best thing and everything, then I would make a life with her and everything.”

Some female participants suggested that “canita al aire,” an expression referring to married men having affairs, is more common among Puerto Rican men, than men of other ethnic backgrounds, because of Puerto Rican machismo. Importantly, this attitude was not universally held by all the females in this study; one girl actually
pointed to the notion of married Puerto Rican men's tendency toward infidelity as a misconceived stereotype about Puerto Ricans, citing her aunt and uncle's monogamous marriage as evidence of this. The fact that this perception of male infidelity was so widespread is striking, however, because it serves as an indicator of the level of concern the girls in this sample have about their current and future partner's fidelity.

**Homosexuality**

Because none of the teens in this sample reported being homosexual, and very few of the teens spoke about homosexuality at all, it is difficult to assess how perceptions or experiences of homosexuality among these teens shapes perceptions of AIDS. The very fact that this topic was raised so infrequently can either be taken as an indication of the strength of the stigma surrounding homosexuality among Puerto Ricans (Cunningham 1989), or alternatively, as evidence that homosexuality is not a taboo issue among the teens in this sample. It is also possible that participants did not associate homosexuality with their perceptions of AIDS, and therefore saw no reason to discuss it.

The few male teens who talked about homosexuality in relation to AIDS voiced their discomfort with the idea:

I'd feel kind of funny (if a male friend got HIV through sex with another man).
If he's gay or something, I don't have anything against gays because my uncle is
gay, but I’m really like homophobic. I don’t want nothing to do with them. I don’t like hugging them. I don’t like nothing, you know, you be on your side, I be on my side. I don’t want nothing to do with that. M, 14

Well, it’s like if they want it like that; you don’t know which way you could take it. If you want a woman; if you’re a woman and you want another woman, that’s your problem. That’s their own personal problems. I don’t care what they do. M, 16

Interestingly, girls may be more comfortable with homosexuality than boys in the sample. One fifteen year-old spoke about having gay and bisexual friends. Another female participant mentioned finding out a friend was gay when he told her that he had AIDS, and he had gotten infected through sex with another man.

In sum, intensive interview participants expressed a range of views about sexuality. Some female participants stated that it was important to them to maintain their virginity until marriage, some were less committed to this idea, and others had already had sex at the time of the interview. Overall, it appeared that male participants perceived themselves as more able to be sexually active, and have more sexual partners, than female participants did. Nearly all the female participants stated that community norms toward adolescent girls’ having sex were less positive than norms toward sexually active boys. Religious beliefs and values appeared to influence the participants’ ideas about gender and sexuality, although none of the participants overtly discussed religion as being influential in their HIV perceptions. Also, many participants also theorized that men were more likely than women to be sexually unfaithful. Importantly, some participants classified characterizations of Puerto Rican men as being more prone to infidelity than any other men as stereotypes. Finally, very

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
few of the participants raised the topic of homosexuality, although among those who did discuss it, girls appeared more comfortable with the topic.

**Section 4: Perceptions of the Influence of Gender Roles on Condom Use**

Participants' beliefs about gender roles were particularly manifest in their attitudes about who in a sexual relationship should be responsible for condom use. Male and female participants distinguished between the categories of: 1) discussing condom use; 2) buying condoms; and 3) actually using them during sex. The fact that different parts of this process were deemed appropriate for either males, or females, for various reasons, has broader implications for the teens' perceptions of gender roles. For example, even some participants who thought both partners had a responsibility to raise the issue of condoms differentiated responsibilities between the discussion about condoms versus their actual use. Boys and girls alike concurred that males should carry condoms with them at all times because they believed that males, in general, have more sexual partners.

In response to being asked about who should raise the idea of using condoms, the majority (N=26, 62%) of the intensive interview participants thought condom discussions should be a shared endeavor, and were comfortable with the idea that both partners in a relationship should bring up condom use before sex. Six participants (14%) thought girls should initiate condom discussions; and nine (21%) thought these
discussions should be boys' responsibility. One response was missing.

Participants who thought both males and females should discuss condom use perceived these shared discussions as an ideal, however, and at various other points in the interview, the sexually active teens described differences in their own approach to condom use and experience using condoms, and that of their friends. As one male participant noted:

Every friend I got, they just say different things than what they usually do.

Aside from thinking of shared discussions about condoms between sex partners as an ideal, an additional possibility is that, although I asked them to base their answers on their own opinions and experiences, the participants treated the question as if I were asking for the correct "protocol" in raising condoms with one's partner.

Participants who thought that males should raise the idea of condom use, stated this was so because: 1) men have sex more often; 2) men have more partners; 3) men are more likely to be unfaithful; and more abstractly, 4) because of "tradition." The participants who thought men should be responsible for condom use were more apt than other participants to view condom negotiation as a polarized issue between the sexes, with men depicted as perpetually reluctant to use condoms, and women viewed as always being proponents of condom use, to counter this reluctance. One male participant underscored his point about the stasis and predictability of gender roles in relation to condom use by tracing this dynamic back to the Bible, saying:
From the beginning in God's book the woman is still always suggesting using them.

Although he did not literally believe that there was reference to condoms in the Bible, this participant's comment reflects his belief in the integral influence religious values have on perceptions of gender, and demonstrates the importance of religion to this participant, who discussed religion throughout his interview. Framing this connection within the context of AIDS, this participant suggested that it is women's responsibility to insist upon condom use, since men probably will not. Although he believed that the enforcement of condom use falls within women's domain, this participant also proposed that men should always have a supply of condoms, so women can choose to use them or not. The ideas that men would never choose to use condoms themselves, and that women have considerable decision-making power about condom use, are both implicit in his statement:

Like we make sure we have the condoms and stuff. It's up to the woman if the girl wants to use it or not. The guy is supposed to have the condom.

Several girls who had not yet had sex also thought that men should supply condoms in heterosexual relationships, because this was part of male responsibility. Yet concern about AIDS had altered this belief in some cases. According to Josie:

It's supposed to be the man, but these days the AIDS is running away, like party time, and you're supposed to protect yourself too.

This comment conveys the full impact AIDS has had on social norms among this
small sample of Puerto Rican teens. Speaking from her sense of what the pattern of gender behavior has been, this girl voices her understanding of how gender roles shape sexual behavior. Then she suggests that in “these days” of the second decade of the AIDS epidemic, it has become necessary for women to become more assertive about protecting themselves from HIV. As to why she feels that men should traditionally be in charge of condom use, Josie made inferences about male promiscuity:

He should because he’s the one who goes here and has a relationship, goes there and has a relationship. The woman’s like more shy.

In contrast, the six girls and one boy who believed women should take responsibility for initiating discussions about condom use tended to believe that women had more control over sex. Rosa, for instance, said:

I think she should care more about condoms than men, because they don’t, they don’t like to use condoms. A woman should know how to tell the man to respect her ‘cause we like the ones who like control. We say no, we don’t want to bed with them. But if we tell them, and if you want to have a sexual relationship with a woman, I think the woman is going to tell them you better use condoms.

Revealing the complexity of the teens’ conceptualizations of gender roles and their impact on condom-related behaviors, Rosa, who believes that girls should initiate discussions about condom use, nonetheless agrees with Josie’s statement that men should be responsible for using condoms, again, because of her expectation of their greater likelihood of having several sex partners at once:

They (the men) should be responsible. Sometimes the wife is at her house doing whatever she’s doing like cleaning and they do take care of the child, the husband he’s off with girls in the street and you know, he got another woman. And let’s say that women has AIDS, and then he go to bed with the wife, the
wife's going to have the same thing.

This statement contains several important references that help to clarify how AIDS is situated in a broader cultural context for these teens, encompassing both domains of gender and sexuality. First, Rosa's vignette, hypothesizing how women are at risk for HIV infection from their husbands, reflects traditional connotations of Puerto Rican gender roles: The woman in the scenario is at home doing housework and child care, while the man, true to stereotypical depictions of Latin men, is off with "the girls in the street," and his other mistress as well.

Combining elements of cultural values about gender and sexuality, Rosa's opinion echoes the common refrain among some of female participants that all men, and not just Puerto Rican men, are inherently unreliable and irresponsible. This echoes the idea raised in Chapter V that girls believe that they need to take responsibility for prevention of pregnancy and the protection against HIV. Theresa, sixteen, also spoke about how girls have to be able to talk about condom use with boyfriends, or any sex partner, because boys are able to just "get out of the whole thing," if the girl gets pregnant or becomes infected with HIV:

Well, if you want to protect yourself you're gonna have to talk about it, that's the way I look at it. I mean, I think, you know, like if he's your boyfriend or, you know, if you talk about before (having sex) you don't want to have a baby now, well, I think both of you, you know, talk about how they think about it but for my part if it's like if I don't know a guy but I'm gonna have sex with him, well, I'm the one getting—he won't care because he could just, you know, get out of the whole thing and I stay here where if I get pregnant or if I got this or if I got that, if I got a disease, so I would think about it that way—I would tell the guy that way. I'm the one that, you know, you have to have a condom if you want to do
Similarly, two other girls, ages seventeen, and fifteen, respectively, had this to say about why they believed women should raise the idea of condoms in a sexual relationship:

(1) Well, maybe for me, the woman got more responsibility than the man because the man’s like okay, you could get pregnant, I’m going to leave you, they don’t care, it’s like a one night stand and they don’t care. For me, guys don’t care. Women are more dedicated than men.

(2) I think the woman should bring up the idea, because if she don’t bring it up, he’s not going to care to put it on, or whatever, but both should carry a condom. In case he don’t have it, she has it. Because my opinion, guys don’t really care. If you let them have the chance like if he told you he don’t have it and you go okay, okay, he ain’t going to care to bring a condom, so you say no, I have them.

Here again, concepts of gender roles clearly guide these girls’ perceptions of appropriate actions relating to condom use and negotiation. Both contribute to the consistent theme among this group of girls, declaring that when it comes to sex, men’s irresponsibility, and apathy, especially manifest in male attitudes toward pregnancy, compel women to look out for themselves. Beyond the realm of condom use, the first quote also reflects the idea that women are more inclined to be invested and committed to a relationship.

Seventeen year-old Ricardo, the only male participant who believed that girls should initiate discussions about condoms, had sharply defined views of gender role appropriateness for different condom related behaviors. He explains in the two consecutive quotes below why women should raise the idea of condom use, but men
should “carry” condoms with them:

For me, the woman should bring it up. They is the one that gets done, but if the man is bringing them, that’s OK too.

For me, the guy is banging girls of course he should carry condoms.

Ricardo’s first quote, similar to that voiced by the five girls who also thought women should initiate discussions about condoms, implies that women are inherently more responsible about condom use. In another part of the interview, he stated that he believes women, because they have more at stake in a sexual encounter than men, in terms of pregnancy and the possibility of contracting a sexually transmitted disease from a man who may have had multiple sex partners, are more committed to the idea of condom use than men, and more likely to be conscientious about condom use. Importantly, though, Ricardo also states that it’s “OK” for men to bring up condom use also.

About the issue of who should bring the condoms to a sexual encounter, or have condoms conveniently on hand, Ricardo notes what he perceives as the obvious, explaining that men are the ones who always want to be “banging” girls, so subsequently, they should provide the condoms. To derive this conclusion, Ricardo draws upon culturally constructed notions about sexuality and gender. Men, he implies, always want sex; the fact that he does not mention girls except for their role in initiating the condom discussion, indicates that he believes either girls don’t want
sex, or at least, should be the more passive participants in the process. Ricardo also suggested that boys preferred not using condoms, because they felt more mature having unprotected sex, and entertaining the possibility of getting their girlfriend pregnant. The topic of males attitudes toward impregnating their girlfriends was not explored in depth in the interviews. Highlighting the complexity of individual beliefs, and the discrepancy between beliefs and behavior, Ricardo says that in his own relationship he initiated the discussion about condom use, contrary to his beliefs about females being the more appropriate gender to raise this issue.

Excerpts from an interview with Manuel provide another example of the disjunction between belief and behavior. In his statement of why men should always raise the idea of condom use, and buy condoms Manuel, eighteen, revealed his perception that the behavior surrounding condom use is largely culturally determined:

The man always got to ask the woman, that's the way us Puerto Ricans do it.

Here, Manuel suggests that male initiation of any sexual activity is a Puerto Rican tradition, supporting the traditional profiles of Puerto Rican male gender roles put forth in previous research (Alonso and Koreck 1989). But in the next breath, he suggests that before beginning a heterosexual relationship, both partners should talk things over first. Similarly, a 19 year old-male who hypothesized that he would be grateful if a girl supplied her own condoms, also emphatically stated that condoms are ultimately the man’s responsibility because he “couldn’t see a girl carrying a condom.”
Statements from the girls in the sample also reflect multiple, and at times, contradictory beliefs about condom-related behavior. They fluctuate to some extent between the idea of being sexually passive, on the one hand, and actively participating in their protection against HIV, on the other. For example, one sixteen year old girl said that although she thought the responsibility of discussing and buying condoms should be equally shared, she “didn’t dare” bring up condoms with her own boyfriend.

The contradictory beliefs voiced by several participants can be interpreted, reflecting the fluidity of this group of teens’ perceptions of gender roles in relation to HIV/AIDS. While recognizing that individuals do not always maintain a consistent sets of beliefs, in some cases, discrepancies in beliefs suggest that participants are struggling to incorporate their knowledge of AIDS risk reduction behaviors with beliefs about acceptable and appropriate gender roles. Ultimately, the different beliefs expressed reflect the diversity of attitudes within this sample of teens.

Although the teens in the sample are from similar socio-economic backgrounds, in general, each had different familial and religious backgrounds. Also, the teens had been living on the mainland for varying amounts of time so that acculturation levels were likely different among individuals.
The teens in this sample and in other studies are not using condoms consistently (Boyer and Kegeles 1991; Horowitz et al. 1996; Oswalt and Matsen 1993). It is necessary to explore the teens' alternative strategies for reducing their risk of HIV infection, apart from condom use, to be able to better understand their reasons for not using condoms. Examining the teens' strategies also elucidates the cultural context from within which they develop beliefs to protect themselves based on standards of morality and behavior. This will allow the elucidations of "cultural logical systems" (Swanson et al. 1992) these teens have developed about AIDS. These logical systems reveal the cultural matrix through which the teens identify risk behaviors among their peers, and why they distinguish particular actions and behaviors as markers of risk behavior. Logical systems are lay models of HIV risk. Within these systems, public health information is interpreted so that individuals can locate sources of risk, but still not necessarily perceive the need to change their own behaviors (Swanson et al. 1992). In fact, these beliefs sometimes serve to reassure the individual that standard precautions of safer sex, such as condom use, are unnecessary because another strategy for risk reduction has been developed (Nicoll et al. 1993).

In the instances when a participant told me that he or she did not use condoms because they knew their partner was not infected with HIV, their responses about why they thought condoms were unnecessary fell in one of three groups. One comprised
boys who believed condom were unnecessary when they had sex with girls who were virgins at the time of their sexual encounters with these male participants. In this situation, the boys assumed that their prospective partners were honest about their sexual inexperience. They also assumed that sexual inexperience eliminated the possibility of their partner having HIV. In fact, one male participant, age fourteen, equated youth with sexual inexperience, and then interpreted both qualities as signs of a girl being uninfected with HIV:

Mostly like, I don't mess with girls from my school, you know what I mean? You have like girls like 18, 17, 16, you know, and I know that they ain't, I know these girls can't have AIDS or probably...be messing with older people. Some girls do mess with older guys, so probably, but you know they're clean and you know what I mean, 17. I probably think they don't get AIDS.

The possibility of an otherwise virginal girlfriend having contracted HIV through external agents, such as needles, or from an infected blood supply, was never raised.

In the second group were participants who referred to HIV testing as the basis for their decisions not to use condoms. Only two of the participants stated that they and their partner had both been tested together. It was far more common for the participant to say that the partner had reported he or she had tested HIV-free in the past.

**Clean and Quiet Sex Partners**

The other set of determinants the teens raised in regard to their decisions not to use condoms were based on concepts that incorporated values about appearance and
behavioral characteristics. The terms the teens used are of particular interest for two reasons. They are not specific to Puerto Rican teens, and are used by teens and adults alike, across ethnic groups. Yet in this case, the concept behind the terms resonates with Puerto Rican cultural values, rooted in religious tradition. The terms also have a much broader historical and symbolic context, which will be discussed shortly.

Secondly, the teens' reliance on both superficial and behavioral characteristics to determine level of probable HIV risk raises important questions about the feasibility of designing AIDS intervention programs nuanced enough to reflect the culturally shaped decisions many people, and not just Puerto Rican teens, make in regard to sexual risk behaviors.

The two concepts the teens most frequently relied upon to voice their assessments of a partner's potential risk were: "clean" and "quiet." The classification of a disease-free sex partner as "clean" has historical roots in public health campaigns against gonorrhea and syphilis (Brandt 1987). Symbolically, such attributions of risk also echo culturally embedded notions of cleanliness, representing an adherence to social order and morality (Douglas 1966), on the one hand, and uncleanliness, associated with sexually transmitted diseases, on the other (Brandt 1987). Based on the teens' usage, whether or not a partner is determined to be "clean" is primarily contingent on two factors: a person's outward appearance, and his or her sexual reputation. For the male participants, their perceptions about their partner's cleanliness may be integrally tied to the girl's level of sexual experience, with virgins representing a completely
disease-free partner, literally and symbolically. The combination of the clear link between virgins’ lack of penetrative sexual experience and the low probability of them having HIV, and the traditional high esteem placed on virginity among Puerto Ricans resulted in many male participants’ strongly emphasizing the state of virginity, as an ideal both culturally and practically. Fourteen year-old Billy connects what he perceives to be the two important attributes of virgins in the following quote:

Because they’re cleaner; they’re special. To me they’re special. I’ll be honest with you, I haven’t even had a virgin yet, but if I ever have, I’ll respect her with all I’ve got. I think a girl who’s a virgin deserves to be respected. That’s the way I see it.

Although he has not had sex with a virgin yet, Billy imbues the state of being a virgin with an importance doubly compounded by merit of the girl also being “clean.” In addition, he clearly believes that a virgin is someone to be revered and respected. He later elaborates his perceptions about what exactly sexual “cleanliness” refers to when he talks about how he raises the topic of condom use with his partners:

Nowadays to tell you the truth, it’s like me, I always like have to bring it up sometimes because if I see the girl is kind of like--some girls are sloppy, some girls are really like, you could tell, you know--like my sister. To me, that’s a clean, you know, gorgeous girl that I know she probably don’t have nothing but you know, some sloppy girl, I strap it on.

So, you say if a girl is sloppy-- how can tell if they’re sloppy? What do you mean by that?

Some girls, to tell you the truth there be like girls they talk about things, you know, penises--there’s a lot of dirty girls, you know what I mean? Those are the kind of girls you’ve got to watch out for.

You mean dirty when they talk about a guy’s penis?

They talk about having sex with them, they like this, they like that, and you know those are kind of like sloppy girls.
Billy defines cleanliness by describing the state of “sloppiness” he sees in stark opposition to it. According to Billy, sloppy girls are assertive, or even aggressive sexually, as manifested in their willingness to talk graphically about sex and genitals. In contrast then, a “clean” partner would be much more reticent about initiating an open sexual discussion. Billy’s description of sexual “sloppiness,” and presumably the potential sexual risk that would convince him to “strap” a condom on, underscores the dilemma faced by his Latina counterparts attempting to negotiate a safe sex discussion. To the extent that Billy’s perceptions of sexual frankness as being integrally connected to HIV or other sexually transmitted diseases are shared by his male peers, such a discussion may well result in the male partner agreeing to use condoms, assuming this was the end result the girl hoped for from such a discussion. However, this assurance of safer sex would come at the price of her esteem as a valued and respected sexual partner.

The voices of Billy and some other teen male participants suggest that despite having lived in an urban area on the U.S. mainland for most of their lives, and being exposed to and influenced by changes in the definitions and boundaries of traditional gender roles, most of the boys in this study are still strongly influenced by traditional cultural values in their estimations of morally ordered sexual conduct. Traditionally, it is expected that Latinas defer to men and be sexually passive (McGoldrick et al. 1989). Although such a sweeping characterization ignores intra-ethnic diversity and individuality, and has been called into question by participants in this study and by
other researchers (Acosta-Belen 1988; Andrade 1982; Cardosa 1987; Cromwell and Ruiz 1970; Weeks et al. 1996), it is raised here because it does portray aspects of traditional cultural ideals about women. Billy’s response to the perceived social transgression of the girl who so openly discusses sex, in violation of his perceptions of the traditional female gender role, is to label her as an unclean partner.

Yet Billy’s perceptions are complex, and not solely shaped by traditional values about gender roles. At the same time that he regards girls who openly discuss sex as culturally immoral, he is disturbed by how helpless and passive the girls in his high school appear to be about pregnancy:

They don’t know how to say to a guy, I guess they don’t have the heart to say to tell the guy, you know, get a condom or you ain’t getting nothing, you know what I mean? They just stand there and do what they have to do, and you look now and you look around school and all you see is bellies all around.

Although this comment initially seems counter to his previous declaration that girls should not initiate discussions about condom use, Billy clarifies his beliefs about when it is acceptable for a girl to reveal that she anticipates sex, and wants to prepare herself for it when he reveals his attitudes about girls initiating condom use:

I understand where she coming from, you know, because she probably think she don’t want to catch nothing. Mainly, they just tell me to wear it because they don’t want to get pregnant, so that’s why I really do it. I think mostly girls that I know, it doesn’t bother me, to tell you the truth. I respect it, I’m not going to get mad over something like that. Most guys don’t like wearing condoms because they say it feels better.

Based on what Billy says here about condom use in the context of pregnancy, he feels it is appropriate for girls to talk about sex if they restrict themselves to two topics:
condom use and the prevention of pregnancy. In fact, in terms of negotiating condom use, many female participants reported that it was easier to request their partners to use condoms to prevent pregnancy rather than to imply that they feared contracting HIV through their partners, because they believed boys were more receptive to using condoms for this reason.

The use of the concept of "clean" to allude to adherence to traditional gender roles is used by another male participant, age eighteen. When asked what qualities he sought in a potential marriage partner, he responded:

Someone clean, definitely.

*What does that mean to you, clean?*

Not being dirty, you know, someone polite.

Here again, the hypothetical female partner’s cleanliness is inextricably tied to cultural values about female politeness, and suggesting submissiveness.

Billy also raises the idea of a partner’s outward appearance as part of his discussion of cleanliness. He holds up his “gorgeous” sister as an ideal to be sought when seeking a clean partner. Later in the interview he again refers to his sister’s beauty, which he describes as being a reflection of all that is good about her—especially her virginity and her deferential nature-- as well as an ideal standard to which he measures potential girlfriends. The idea of using appearance to judge a potential partner’s likelihood of being HIV infected is not unique to the teens in this sample, or reflecting a greater tendency of boys or men to rely on appearance to make decisions about a
partner's health or morality. It is raised here to demonstrate the gender power
differential that occurs because of attempts to determine risk through appearance.

For example, Arturo, eighteen, tells me that he decided to start using condoms:

"Because it's not a safe world no more, you know, you could get it by anyone;
they could look pretty on the outside, you never know what they got."

In reference to conversations he has with his friends about AIDS, seventeen year-old
Miguel mentions something similar:

You could get it by having sex with girls, you could have sex with a beautiful
girl but you don't know what she might have, understand. That's what we be
telling each other that you got to use a condom. You got to carry a condom at all
times.

In general, male participants' suspicions toward their potential female partners were
focused around appearance and perceived adherence to culturally proscribed
behavioral standards. In contrast, female teens attempted to extrapolate potential
exposure to HIV circumstantially, from a male partner's behavior in specific social
settings, and not surprisingly, though his interactions with girls believed to have
multiple sexual partners. Some girls used the term "quiet," connoting sexual
inexperience, to refer to boys they had assessed to be safe. Fiona, sixteen, describes
how she perceives male "quietness" to be an apt measure of sexual risk:

If in school they, like a boy ask you or something, it's like you know how his
reputation is because people like, oh, you know, he used to be with this girl, and
if you the girl you're gonna be like oh my god, she's a slut or whatever, so you if
you find a guy's who's real quiet--maybe he didn't even have sex.

Fiona's strategy to protect herself from HIV is to avoid partners who have had sex
with girls known to have multiple partners, "sluts," as she puts it. Here again, the
gauge utilized for monitoring sexual risk is the sexual behavior of girls, and not boys. In attempting to determine her partner's potential risk to her, Fiona focuses her examination on the reputations of the girls her potential partner has had sex with in the past, and not on his own sexual reputation, in terms of sleeping with multiple partners, or of being deceitful to his partners. Later in the interview, she tells me she is particularly wary of "sluts," and discusses how she determines whether a girl is a slut or not:

She be acting like, you know — she be acting like, oh, I been with this guy, you know, I mean, you couldn't know if it's true or not by the way you act, so, you know, if they have a lot of guys this way—different boyfriends the whole year you know her, well, you don't know. It's like a circle. If you know the guys she being with, you're like, oh my God, he been with this, all the girls, he be with that other girl.

Beyond Fiona's definition of a slut as a girl who has many sexual partners, her statement reveals her understanding of the nature of HIV transmission, and the importance of having a means of evaluating a potential partner's network of former sex partners. As to Fiona's implication that female "sluts" are the central potential disease bearers in "circles" of relationship networks, her assessment is consistent with other teens in the sample who regularly cast sexually active girls, specifically those with multiple partners, as behaviorally deviant.

The second part of Fiona's strategy, to seek out a "quiet" boy as a partner, possibly one who is sexually inexperienced, is particularly notable when contrasted to her male counterparts' preoccupation with finding girls who conform to traditional values as a
means of avoiding exposure to HIV. Billy and Arturo’s perceptions about “clean” female partners suggested that they believed this quality was synonymous with being behaviorally traditional. In contrast, Fiona’s assessment of a quiet boy as being a potentially safer sexually partner is not predicated on traditional cultural values of appropriate male gender behavior. The traditional profile of a Puerto Rican male is of the “machista,” as some female interviewees derisively put it: macho, aggressive, and sexually promiscuous (Comas-Días 1982). Again, while this reductionist portrait of traditional male Puerto Rican attributes is flawed for its generalizations, it represents part of a supposed ideal for traditional Puerto Rican male behavior (Alonso and Koreck 1989). In addition, although several female participants corroborated this image of male flirtatiousness and the tendency to have multiple sex partners with statements such as those below, they also spoke about these actions as being typical of any man, not just Puerto Rican men in particular:

I’m not a tom-boy or anything, but I hang with guys and I know how guys react and guys see a certain girl, they’re like oh my god, I want to hit that and I want to be with her, and I know because I have four brothers and luckily two of them— one was married and now he’s not and he’s going the same way he was going before, he’s sleeping around, too. All of their friends are the same. They’re all the same; they like to sleep around; they like to be with girls and do whatever. F, 16

It’s like they always flirt around with other girls and they should say, oh, look at that girl she looks fine or whatever and he wouldn’t care what his girl, you know, they just wouldn’t care about their girl at that moment. F, 16

Bearing the image of the traditional Puerto Rican male in mind, Fiona’s comment is significant because she is purposefully looking for a non-traditional male as a strategy of reducing her contact with potentially infected partners. Aware that traditional cultural role models for men emphasize having multiple sex partners, Fiona
intentionally looks for boys who don't conform to this cultural concept: quiet; shy; and subsequently, she assumes, sexually inexperienced, in an attempt to reduce her risk of exposure to HIV. It is unclear how effective this strategy would be as an actual means of risk reduction since being quiet is not necessarily predictive of sexual inexperience.

Fiona’s strategy of looking for “quiet” boyfriends is also noteworthy because of how it compares with the male teens’ primary reliance on the concept of “clean” as a way of assessing a sex partner’s potential risk of being infected with HIV. Whereas the males invoked traditional female gender roles as a yardstick from which to elucidate the deviant behavior they equated with “uncleanliness,” and potential HIV risk, Fiona regarded traditional male gender role behavior as inherently risky because of the emphasis placed on having multiple partners. Although it could be argued that teen girls who talk about sex possibly have sex more often, or with more partners, the boys’ strategy also selects against girls who attempt to have conversations about sexual history and safer sex. Both strategies are based on cultural beliefs that have been incorporated into the teens’ logical models of how they believe they can protect themselves from HIV.

Section 6: The Influence of Familial Bonds on AIDS Risk Perception

This section explores how the cultural domain of family relationships shapes the teens’ perceptions of AIDS risk, with a specific focus on familism. Familism, the
importance of familial bonds, is widely regarded as a key cultural value for Latinos, including Puerto Ricans (Hurtado 1995; Marin 1989; Ortiz 1995; Vega 1995). Although a previous survey found two-thirds of Hartford Puerto Ricans believed that Puerto Rican families are less likely to care for relatives living with HIV than relatives with other sicknesses (Mendez 1996), the views of the teens in this sample suggest otherwise, paralleling previous research proposing Puerto Ricans to be willing to provide emotional and financial support to family members living with HIV (Bok and Morales 1991; Cunningham 1989). Teens and pre-teens who had family members with HIV were or had been in many cases, caretakers of these family members themselves. They were protective of this person, and saddened by negative reactions toward AIDS that they perceived from others.

For this section, two sources of data are used: 1) the AIDS Acquaintance interviews with 14 teens; and 2) a sub-sample from the YOUTH Project Survey (Horowitz et al. 1996) discussed in Chapter II. In terms of how acquaintanceship with people living with HIV or AIDS influences perceptions of HIV, findings here indicate that the most crucial factors shaping these perceptions is to have lived directly with and cared for a person living with HIV or AIDS (PLHA). Most often, teens living with a PLHA were living with HIV positive family members.

Because the YOUTH data (as presented in Horowitz et al. 1996) described in Chapter II also identified respondents’ relationships to people living with HIV, data from a
sub-set of this sample was analyzed and used in conjunction with the AIDS
Acquaintance Interview data. Although the YOUTH survey participants were not
specifically questioned about whether they lived with anyone with HIV/AIDS, the
assumption was made that Puerto Rican teens with HIV positive relatives had closer
ties to these relatives than to their HIV positive friends, because of the strong familial
bonds between Latinos in general (Harwood 1981; Singer et al. 1990a). Puerto Rican
YOUTH survey respondents were divided into three categories: those with a close
relationship to someone living with HIV; those with a distant relationship to someone
living with HIV; and those who did not know anyone with HIV. The frequencies of
the following variables were compared between sub-sets: 1) sexual activity; 2)
number of sexual partners; 3) frequency of sex; 4) condom use; and 5) alcohol and/or
drug use. Chi-square analysis was done to identify bivariate relationships between
knowing someone with HIV/AIDS and: a) concern with HIV infection; b) number of
sex partners; c) condom use; d) the assessment of chance of contracting HIV; e)
concern about HIV; and f) precautions taken against contracting HIV.

Among teens who completed interviews, those who had lived with someone with
HIV/AIDS were on the whole better informed about HIV, less apprehensive about
casual transmission, and in some cases, were wary about doing anything that as one
girl described it, would take them, “down the wrong road toward HIV.” They were
also less likely to moralize about the probable means of infection. Yet, it can’t be
concluded that these factors exist solely because of living with a PLHA. One teenage
boy, for example, sexually inexperienced at the age of fourteen, had lived most of his life with a Baptist foster family, and adopted some of their conservative ideas about sex. Because of his religious beliefs, he reported that he was committed to not have sex until he married. Also, because the AIDS Acquaintance Interview participants included two twelve year-olds, the younger age of this sample may also have affected responses. For example, the two twelve year-olds were not sexually active, and had not received formal AIDS education.

The YOUTH surveys reinforce the idea that proximity of the teen relationship to the PLHA exerts a strong influence on beliefs. Among the sub-set of Puerto Rican teens, those closest to someone with HIV/AIDS were less frightened of casual contact with this person. Surprisingly, however, among these respondents, close proximity to a PLHA is also linked with an increased likelihood of sexual risk behavior, as discussed in Chapter II. These findings suggest Fisher’s hypothesis (1988) that Caucasian teens who know someone with HIV are less likely to take HIV-related risks, is not applicable to this group of Puerto Rican teens.

**Proximity**

Relationship to PLHAs is conceptualized here on a continuum of proximity, from having a casual acquaintance to the PLHA at one end of the spectrum, to living with or caring for a PLHA at the other. This sample was selected to most heavily represent
teens who had the most proximate relationship to PLHAs. Eight of the AIDS Acquaintance Interview participants had lived with, or were currently living with a PLHA. Not surprisingly, these teens discussed HIV/AIDS in the most concrete terms, and were the most disturbed by the suffering, especially accompanying end-stage AIDS. They spoke of AIDS from an experiential standpoint, describing their interpretations of this person's thoughts and feelings.

Interview participants who were more distantly acquainted with a PLHA were more apt to talk about the person in terms of their physical condition. When asked about visiting her HIV-infected aunt in the hospital, all one twelve year-old girl remembered was:

I went to see her, she was real skinny, purple--she thought I was someone else.

Teens who did not know anyone with HIV were more likely than those with more proximate relationships with PLHAs to believe they would be embarrassed or ashamed if a family member contracted HIV. This 15 year-old girl explains why she would feel this discomfort about a family member with HIV:

I would be a little embarrassed...because if other people know, then they're gonna think that the rest of the family has AIDS.

This indicates that teens living with PLHAs have a slightly higher degree of comfort with AIDS than those with more distant associations. Statements from intensive interview participants who had lived with PLHAs further affirmed this. One fifteen year-old girl, who lived with her HIV positive uncle for a year before he died,
regretted having once listened to her neighbors’ warning that she avoid getting near him so she wouldn’t be infected. Anticipating that others in her position may be similarly biased by outsiders, she advised the following:

Don’t be scared of them, give your heart to them. That’s what they mostly need: love and affection.

Teens closely associated with a PLHA were not necessarily free of misconceptions about AIDS, however. For example, they frequently did not distinguish between HIV and AIDS. Six out of fifteen (40%) of the AIDS Acquaintance interview participants incorrectly answered a question on the AIDS Knowledge Survey asking if one could be infected with HIV, yet not have AIDS. This parallels the finding among both the focus group and intensive interview participants who were uncertain about the same issue.

Teens with close associations with PLHAs were decidedly more cynical about the possibility that people who knew about HIV/AIDS would reduce their high risk sexual and drug-injection behavior. A fourteen year-old interviewee who had cared for her five year-old cousin before her death from an AIDS-related infection, asserted that knowing someone with HIV or AIDS made absolutely no difference in reduction of risk behaviors. She said:

All of my friends know someone who has AIDS, and none of them take precautions.

In contrast, Hector, a fourteen year-old AIDS educator with several distant PLHA
acquaintances, was more optimistic about people with a close relationship to a PLHA being motivated to protect themselves from infection. He suggested that having a close bond with a PLHA made the possibility of infection more concrete:

It makes it real in one way, in sex. If the person got AIDS from sex, or unprotected sex, or I think if the person got AIDS whatsoever...that person will talk about how he got AIDS. Not only how he got it, not only to encourage people to get AIDS tested, but to help them to stop the virus (from spreading). If I got AIDS, for example, I would talk to my brother and sister all the time for them not to get it.

It is unclear if Hector's philosophy prevails among the HIV positive relatives of the Puerto Rican sub-set of survey respondents.

As presented in Chapter II, the YOUTH data show a trend for teens who are acquainted with PLHAs, in contrast to those who don't know anyone living with HIV, to be slightly more likely to be sexually active, and have multiple partners. This trend is noteworthy given the parallel trend for more of the teens with proximate relationships to PLHA to "rarely" use condoms during vaginal sex, despite the small sample size.

It is not entirely clear why there appears to be a trend for greater HIV-risk taking proclivity among Puerto Rican teens who are the closest to PLHAs. There are several factors potentially influencing this risk-taking. One theory is that teens living with a family member with HIV are living in homes where there is a greater likelihood for HIV risk-taking behavior within the family. This idea is supported by the fact that two of the participants, both siblings, whose mother had been infected with HIV from
injection drug use, had an older sibling who had recently started using injection drugs. Further, the mother of a participant who had watched her uncle and cousin die of AIDS, was living with relatives at the time of the interview because her mother was serving a prison sentence for selling heroin.

Another theory that has been advanced is that Puerto Rican teens with infected family members are particularly vulnerable to HIV risk behaviors expressly because of the strength of their family bonds. Kribeck (1997) argues that teens living with family members with HIV are more likely to take behavioral risks because they want to support this person in their suffering, even if it means becoming infected themselves.

Finally, it is possible that the bonds between family members living with a PLHA have been stressed by the emotional and financial hardships of AIDS to the point where none of the members have adequate social support. The strain of trying to maintain a family while living with HIV/AIDS is especially manifest among the teen interview participants who had single HIV positive mothers. In these situations, both the teens and their mothers were struggling unsuccessfully to maintain whatever familial equilibrium had existed before the mothers tested positive: the teens by acting as caretakers for their mothers, and the mothers, by reminding their children of their vulnerability, in order to sanction cooperation and care-taking. These teens may then become overwhelmed by their increased responsibilities, and the knowledge that despite their efforts, the HIV positive family member will eventually die. In such
circumstances, they may become increasingly likely to take risks with their health.

**Section 7: Ethnicity and Perceptions of AIDS**

Teens' beliefs about Puerto Rican ethnic identity, and its significance in their lives, were explored as a basis for examining the research question of how ethnic identity influences perceptions of HIV/AIDS. Ethnic identity does not appear to be overtly influential in the teens’ perceptions of AIDS. However, participants did directly address this issue in their responses to a question asking whether ethnic identity influences beliefs about AIDS. Prior to the presentation of these findings, participants’ more general beliefs about ethnic identity are explored in order to provide a broader context for understanding the relevance of the findings.

**Puerto Rican Values and Beliefs**

Concretely, ethnicity was examined by looking at “cultural awareness,” and “ethnic loyalty” as defined by Keefe and Padilla (1987). To explore the teens’ sense of cultural awareness, questions were asked about what values, beliefs and behaviors characterize the state of being Puerto Rican. Aside from a few responses, participants were unable to think of many specific values or beliefs that were Puerto Rican. One 15 year-old girl, for example, mentioned respect for elders as a distinctly Puerto Rican value:

> Older people should be respected because they’re old, they know, they’ve got more experience, they teach you, you know. And if you respect and be caring
and everything like that, they love you.

Similarly, an eighteen year-old male refers to familism in this quote:

Just the way the family is, you know? Family values. A family is supposed to be real close, open with each other.

References to other traits and characteristics of being Puerto Rican were made at other points during the interview.

**Holidays**

Many teens mentioned holidays, specifically Three King’s Day, as a holiday specifically celebrated by Puerto Ricans, that was important to them. According to Catholic Tradition, Three King’s Day, January 6, is the day when the wisemen reached Christ, bearing their gifts. Participants and Puerto Ricans working at the Hispanic Health Council said that although Puerto Ricans living on the mainland celebrate this holiday, it is celebrated much more lavishly in Puerto Rico.

My family always celebrate—you know, like in Puerto Rico they celebrate a lot of things, they always do that. Like here they don’t believe like the three kings, I mean, they believe in the three kings here but it’s not like you go, you give gifts on Three Kings Day, so, you know, American families they give you a little gift or something. F, 16

I think mine (family) is a little bit more traditional because we celebrate, even if they don’t celebrate it here, we celebrate it. Three Kings Day. A lot of people don’t like to celebrate that or I guess they don’t remember or something but in my house my mom always talks to us about like what does the Three Kings mean, it’s not only presents. She explains it to us. Some people think Three Kings Day is one more day to get gifts, I guess. It’s like about religion, the kings brought Jesus presents or something and she says like it’s one more day to grant your child with a gift for something good they did. F, 17

Participants spoke about wanting to pass Puerto Rican traditions and values on to...
their children. One boy spoke specifically about teaching his children Puerto Rican holiday traditions:

I'll teach them how we became Puerto Rican. African, Latin, Spanish and Indian. That's how we came as far as Puerto Rican. How we celebrate our customs at Christmas, and Three Kings Day, we celebrate that, too. They give presents to God and stuff.

Ethnic Loyalty

The teens expressed a range of opinions regarding ethnic loyalty. Some identified strongly with being Puerto Rican:

To tell you the truth, I was born over here, you know what I mean, but I love my heritage with all my heart. I'm Puerto Rican from head to toe, I'm full Puerto Rican. And if you go tell me you're Hispanic, I be like, no, you got that wrong. I'm Puerto Rican. That's one thing I stand for. I'm Puerto Rican. That's it. Just because I was born here doesn't mean -- that's why I always end up arguing with teachers and stuff about, oh, you're Hispanic just because you were born over here, but my mom was full Puerto Rican and my father's full Puerto Rican and I'm born. what I am? I'm Puerto Rican. I'm not Hispanic. I'm Latin, that's the way I am. M, 17

Others stated that they aspired to become “Americanized,” yet still maintain contact with their Puerto Rican roots:

I want to be Americanized but I don't want to forget my heritage; I don't want to forget where I came from. I want to know my background. F, 15

A few talked about why they believed Puerto Rican heritage was not important. These participants believed that it was unnecessary to actively draw attention to the fact of being Puerto Rican since it was only important that they themselves knew they were Puerto Rican:
It's not important 'cause since you're born in Puerto Rico, they call you Puerto Rican and when you walk up the street they know you're Puerto Rican and it don't matter what family you're from, you're still Puerto Rican. M, 16

I know I'm Puerto Rican. I don't have to get screammy. People are doing that, like, I'm Puerto Rican. I know I'm Puerto Rican. I don't have to tell everybody. M, 19

This last participant represented the minority opinion, stating that when he had children, they would not be Puerto Rican since they were not born on the island:

I'll teach them they're Hispanic. They aren't born in Puerto Rico so they're not Puerto Rican. They're not teaching them over there. They live over here where we just raise them up like kids. It won't be like they're Puerto Rican.

His comment is surprising since the majority of teens were insistent that they wanted their own children to be able to aware and proud of their Puerto Rican heritage, and at the very least, be able to speak Spanish. The inclination to maintain Puerto Rican culture and language in the teens' hypothetical future families was linked to the importance of being Puerto Rican in the current family:

My mom wants to keep the culture; she doesn't want us to forget where we came from. To her that's real important.

In fact, in some participants' families, like this 15-year old girl, speaking English at home was considered disrespectful, and an affront to one's heritage:

If you be talking English in front of my family, "What you think you're white now? They be like that. Like the accent off the black guy, they're like, "What you think you're black now?"

Only one participant, a seventeen-old boy who lived alone with his father, but rarely
saw him since the father was always at a girlfriend’s house, said that Puerto Rican culture did not matter to him at all:

Because it doesn’t matter if I’m Puerto Rican, I can act like I’m black, I can act like I’m white. All people is the same. For me all of them is the same, all persons are.

As he states, “all people is the same,” and he doesn’t see the point in distinguishing people by cultural heritage.

**Partner Ethnicity**

In terms of potential partners, 19% of the teens (N=8), wanted to be in a relationship with another Latino; forty-three percent (N=18) specifically stated that they would prefer to have a Puerto Rican partner (see Table 10).

<table>
<thead>
<tr>
<th>Preferences for Partners’ Ethnicity (N=42)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Latino</td>
</tr>
<tr>
<td>Puerto Rican</td>
</tr>
<tr>
<td>Mixed</td>
</tr>
<tr>
<td>African American</td>
</tr>
<tr>
<td>Anglo</td>
</tr>
<tr>
<td>No preference</td>
</tr>
<tr>
<td>Missing</td>
</tr>
</tbody>
</table>
One set of reasons for preferring partners of a Latino background, as represented by the quote below, was overtly rooted in both peer and familial pressure to maintain the vitality and identity of the culture:

Most of my friends they're like stick with the race. Because they don't like the other races, they say, that's your race, that's what Puerto Rican parents think, too, most of the Puerto Rican parents think that way, get somebody of your own race. They (her family) distrusting so much about race, stick with your race and all that, it must be important because they don't want me to mess up the race. F, 16

More often, however, participants mentioned seemingly practical reasons for preferring a relationship with someone from the same ethnic background. These articulated rationales were also more deeply rooted in perceptions of concrete cultural and language differences acting as barriers to intimacy:

A Puerto Rican girl, she understands you, she know what you're talking about, she know the language. If you a black girl or a white girl, you talking Spanish, they gonna think you talking about them, and this and that, and they always going to be arguing to you, screaming, this and that. M, 17

My God! They have a different way of thinking, it'd be hard to understand each other. F, 16

It's necessary because the person would understand the other customs. F, 15

Not surprisingly, the last two girls quoted here were primarily comfortable speaking Spanish, and clearly a relationship with a non-Spanish speaking individual would have been impractical.

There was one participant, a seventeen year-old female, who eschewed relationships with Puerto Rican males, after having been raped and beaten by a group of them when
she was fourteen. From this experience, she decided that Puerto Rican males were more inclined to machismo, and to violence, than other males. In light of this decision, she had been dating only African-American males.

**Beliefs About the Influence of Puerto Rican Values on Perceptions of AIDS**

The participants talked specifically about whether or not ethnic identity, in terms of "being Puerto Rican" influenced their perceptions about and attitudes toward AIDS. Most of the participants, such as this eighteen year-old male, believed that ethnicity had no bearing on beliefs about AIDS:

> Everybody, when it comes to AIDS, everybody got the same thoughts and doubts.

Nonetheless, arguing that more Puerto Ricans were affected by AIDS than people of other ethnic backgrounds, several participants linked ethnicity, in a variety of ways, to perceptions of AIDS. These two participants speculate that Puerto Rican families are more aware about AIDS because so many Puerto Ricans are affected by it. The second participant quoted suggests that this heightened awareness results in the likelihood of parents instructing their children to be cautious about AIDS:

> I don't know, I think the Puerto Rican families look out more because they are the ones that mostly have, you know, the most AIDS, the Puerto Ricans. F, 15

> I don't even know about that. I mean, my mom talks to me about AIDS and I think most Puerto Ricans now they talk to their daughters and kids about it because, man, I mean there's a lot of Puerto Ricans out there with AIDS, the
minorities, and you can just see these girls getting knocked up everywhere, you
know, back and forth everywhere, so I think they should. I hope they’re talking
about it because they should. M, 17

One seventeen year old girl expressed her belief that the majority of Puerto Ricans, in
contrast to Anglos and African Americans, are the ones primarily affected by AIDS.
She goes on to explain why she believes Puerto Ricans are more likely to “get a lot of
AIDS”:

Because, for me, almost 90% of the Puerto Ricans right now or 80%, got AIDS.
A lot of white people, black people, they don’t get a lot of AIDS, it’s all Puerto
Ricans. And for me because of that.

Why do you think so many Puerto Ricans have AIDS and not white or black?

Because Puerto Ricans, it’s like a lot of Puerto Ricans using drugs especially
teenagers go out there and have sex without thinking. Because for me, because
black people think before they do stuff. Us Puerto Ricans, we don’t think, we
just go and do it.

This participant explicitly attributes the prevalence of AIDS among Puerto Ricans to
qualities she identifies as being Puerto Rican, such as the tendency to use drugs, or
have sex, without thinking. Because she was the only participant to link ethnic
identity and HIV risk behaviors this way, her beliefs do not represent those of the
entire sample, but instead illustrate the diversity of beliefs within this group of teens.

Despite discussing pride in their Puerto Rican heritage, some teens vocalized
frustration with the conservatism of what they perceived to be traditional Puerto
Rican values:
I want them to learn the lifestyle of now. I don't want them to live the way I live. I'm living the way my father lived when he was younger. I want them to live now. I want them to base their opinion and know that their opinions matter. In my house none of our opinions matter. As long as it's my father and my mother, doesn't matter. F, 15

I don't know, they raise you in a way like going to church and doing, I don't know, they raise you really-- it's good in a way to raise you like that but it's bad too because they raise you so ignorant, too ignorant. They be raising you like you can't go out, you can't do this, you got to be home and this and that, you got to always listen to your mother. I mean, you always listen to your mother, but she's always right. Sometimes it's not what reality is like over here in the United States it's different. You know we got our customs, we got our ways to be but we got to adapt to the way they live over here. You can't live like, oh, you can't go out because you're already sixteen, thirteen years old you can't go out. Why can't you go out? Why can't you have a boyfriend? F, 16

Within this context, a few of the teens linked their perception of traditional Puerto Rican values, representative of their ethnic heritage, to sexuality. Through this filter, inferences can be made about their beliefs about HIV infection. For example, one girl explained why she thought that this conservatism is problematic for teens living on the Island:

Over here, they're more open about things, they talk about sex more. Over there, you don't talk about sex a lot with your parents, you don't got that communication about sex and all those things. Over there they raise you like, I don't know, not to talk about sex because it's wrong and that's it. They don't want to talk about it anymore. I think that's wrong. Then the kids get afraid of talking to them about sex. So, over here, they're more open about these things.

Clearly, if teens are uncomfortable talking about sex, they will be less likely to voice concerns or questions about HIV to family, peers, and sex partners.

This eighteen year-old teen offers another example of how he believes traditional Puerto Rican values put teens at greater risk for infection, in this case through their
perception that HIV testing is unnecessary:

I think if you are in Puerto Rico that (the idea of HIV testing) wouldn’t really got through your mind because I don’t think they really talk about it too much over there. That’s why I’m saying it’s different. It’s different because, I mean, if you have a girlfriend she’s supposed to be yours and nothing is really going to go wrong.

Describing standards of appropriate gender behavior in Puerto Rico, this boy explains why an adolescent male, living on the Island, might not perceive the necessity of his girlfriend being HIV tested. This participant theorizes expectations of appropriate behavior might in this case be an impediment to the perception of the reality of HIV risk.

Section 8: Summary

This chapter has explored the participant’s beliefs about sexuality, gender, family, and ethnic identity, and possible ways in which these beliefs may influence perceptions of HIV/AIDS. In a few cases, participants overtly linked their beliefs to perceptions of AIDS. It was often difficult to separate out which cultural domains were the most prominently influential; often several cultural domains were entwined in a single statement. Therefore, it is possible that these findings reflect the cultural categories imposed by the research design more than they do the most influential cultural domains in the formation of HIV risk perceptions. Still, the use of these cultural domains has permitted the exploration of key cultural ideas in this group of teens’ perceptions of HIV risk.
Despite the considerable variation among the participant beliefs here, reflecting the individuality of the participants, there are several themes reflected in these findings. Of the five cultural domains identified as having potential relevance in the teens’ formations of risk perceptions, the domains of religion and ethnic identity appear to be the least overtly influential. Cultural conceptualizations of gender and sexuality, in addition to beliefs about family bonds, are explicitly reflected in the teens’ perceptions of AIDS.

The teens’ attitudes toward gender roles ranged from being what is commonly denoted as “traditional” in literature on Latino culture to non-traditional. Teens with the most traditional values were more likely to be living with both parents, and to identify more strongly with religious beliefs. Some participants described ways that they thought AIDS had changed traditional values, such as making it more acceptable for girls to insist upon condom use. Most of the teens agreed with the idea that males were more likely to be sexually active, and that this was acceptable by community standards, whereas girls were less likely to be sexually active. Teen girls who did have sex faced more community disapproval.

Teens’ own strategies for avoiding HIV risk were described. The boys who talked about ways of avoiding risk looked for girls who acted more traditional, appeared passive, and did not talk about sex directly. Female virgins were perceived as personifying ideal sex partners both because they were less likely to talk about sex or
exhibit knowledge about sex, and because on a practical level, they had supposedly not yet had sex, and so were considered low-risk. Girls, on the other hand, looked for boys who seemed less traditional: those who appeared quiet and shy. This behavior was viewed as an indication that the boy was not sexually experienced, or at least, had not had many sex partners.

Results from the AIDS Acquaintance Interviews and the YOUTH surveys showed a trend for teens with the most proximate relationships with PLHAs--those who had relatives or family members living with HIV--to be more likely to take HIV-related risks. This trend needs to be explored in greater detail in later research.
CHAPTER VII PERCEPTIONS OF HARTFORD'S PUERTO RICAN NEIGHBORHOODS AND DESCRIPTIONS OF COMMUNITY-DEFINED RISKS

To better comprehend how the teens in this study assess and prioritize risks to their health and well-being, this chapter examines the teens’ perceptions of their environment through descriptions of their experiences living in inner-city Hartford, and their evaluations of the health risks concomitant with living in this area. Since many of the participants’ expressed a sense that their environment constrained their choices and opportunities, detailing the teens’ perceptions of life in Hartford in this way provides a framework for the exploration of how they assess and rank AIDS as a risk in relation to other life concerns.

Section 1: Life in Inner-City Hartford: Themes from Intensive Interviews

Previously, anthropologists writing from a perspective of political economy have posited that minority communities are not only vulnerable to HIV infection, but also apt to progress more quickly from initial infection to full-blown AIDS because of the structural context of their lives (Bourgois 1996; Clatts 1993; Singer et al. 1990a; Farmer 1996). They suggest that poverty, institutionalized racism and discrimination ultimately have a large impact on the trajectory of the AIDS epidemic in inner-city communities (Clatts 1993; Singer et al. 1990).

Intensive Interview participants raised several concerns about their current and future
lives. Describing how Puerto Ricans in Hartford struggle with poverty, unemployment, poor living conditions, lack of community solidarity, and violence, they worried that these circumstances would be obstacles to well-being for both themselves and their peers. Most participants expressed a sense of anger and disgust with Puerto Ricans in general, accusing them of being excessively violent, ruining their neighborhoods, or cheating the welfare system.

Fragmentation in the Puerto Rican Community

Andres Hernandez, the director of Latinos Contras SIDA, a Hartford organization devoted to ameliorating the negative effects of AIDS among Hartford’s Latino communities, has stated that currently these communities lack an internally organized political leadership and cohesiveness. He suggests that this type of cohesiveness is an integral component to efficacious AIDS prevention programs for the Puerto Rican community (Hernandez, personal communication). Although they did not link community apathy and lack of political organization to AIDS, several study participants shared similar perceptions about the apathy of the Hartford Puerto Rican community:

They don’t help each other. It’s like the credit shut down and instead of helping each other they get their backs up, and they don’t help. They don’t care. They’re like, “I don’t care about the rest of my people.” If you like Puerto Rican, you live well and you can help other people. They say, “I don’t care, they can do it themselves.” M, 19

All Puerto Ricans, they’re not together. Like when they have to do things together like meetings to talk about Puerto Ricans...not a lot of people show up. F, 15
The Puerto Rican teenagers most do drugs and are in gangs. And Puerto Ricans. I mean, I'm Puerto Rican and this and that, but they're like, they get, I don't know, they don't care about what goes on in their community. They mess up the community, because I mean, I see white people and they live in nice places and they're all clean and things; when you come to see Puerto Ricans, they're all dirty, they don't care. They don't care about that, I mean, they don't care, they just don't care. F, 16

Like (Puerto Ricans have) no political power. There's no people that try to run for office. There's a couple of them, but people don't back them up. Like, Puerto Ricans don't vote at all. I don't know why. They're just probably lazy. M, 18

The last two quotes in particular, and several others in this chapter, are indicative of how negative stereotypes about Puerto Ricans have permeated the Puerto Rican community, and are articulated by individuals living in the community. For Puerto Rican teens in particular, there are severe repercussions of internalized racism: Singer (1995) has described how some mainland Puerto Rican adolescents turn to drug use to cope with feelings of internalized racism, thus making them vulnerable to HIV infection. Also indicative of internalized racism are the quotes from the sixteen year-old girl speaking in the third quote who attributes drug use, gang activity and deteriorating neighborhoods to Puerto Rican apathy, and the eighteen year-old male in the fourth quote who describes "lazy Puerto Ricans," who imply that Puerto Ricans themselves are directly responsible for the problems in their community.

In contrast, fifteen year-old Jessica speculates that the poor condition of the Puerto Rican community is not attributable to the Puerto Ricans themselves, but exists because the "people in control" have not provided adequate support for it:
I think that the people that are the ones that are in control and if they control it a certain way—if you plant a flower and you take care of it, of course it's going to grow, and of course, it's going to be nice. But if you don't take care of it, of course, it's going to die and whatever and that's what's going on around here. People don't take care of themselves, they don't take care of other people, and that's why we're messed up right now. That's why we're in the situation we're in right now with everybody killing each other because people don't take care of society or whatever.

Jessica implies that people with more money or power in Hartford than the Puerto Ricans, have not “taken care” of this community. Both perspectives reflect the participants’ sense that the neighborhoods in which they live are not conducive to their health or well-being.

**Unemployment and Welfare**

Lack of employment opportunity is especially marked in the Northeast, where the majority of mainland Puerto Ricans are living. Here, the labor market is steadily declining (Ortiz 1995). Some of the participants, such as this eighteen year-old boy, expressed the perception that racism and ethnic stereotypes impede job availability for Puerto Ricans:

> A lot of young kids, you know it's all about stereotype, like, some people judge us by somebody broke a window, we all broke the window, you know? That's not right because they should treat everybody equally like human beings. It's all about helping people out and understanding people, it's not about judging one person or a lot of persons, that's not right. Everybody should have opportunities to work and be treated equally.

One girl spoke explicitly about how she believes she was denied a job because of racism:
Like when I went to get a job they didn’t want to hire me because I was Puerto Rican, she’s like a pig, they all pigs and we’re nasty. They judge people by their color and that’s wrong because not all Puerto Ricans are the same; we all got different feelings. To a person, all of us are the same. When I went to get a job they didn’t want me, me knowing that they were hiring people, because I was Puerto Rican. That’s wrong because one person could go steal, I’m not going to go to a store and steal because I’m not like that, but some people don’t want to understand that. For them all of us are the same and that’s wrong. They should not judge the book by the cover. F, 17

These two girls raise the issue of language as a barrier to job opportunities, and a possible source of discrimination for Puerto Ricans:

I guess because they don’t speak a lot of English, fluent English, so they don’t have equal opportunities or something. F, 18

Puerto Ricans go by I don’t know how to speak English, they don’t try to look for jobs, or they should learn how, you know, try to do something for them to do better, get higher in the level. I don’t think many people are trying. Yes, some Puerto Ricans are trying, but the majority are not and if the majority don’t get together, it’s never going to be. They are afraid to get it because they’re going to think they’re going to discriminate him or her. F, 15

Another eighteen year-old boy eloquently explains how the presence of numerous wealthy insurance companies in Hartford intensifies the difficulties Puerto Ricans living here have in trying to find viable employment:

They are no jobs. All the jobs in Hartford are in downtown in the insurance companies and a lot of people can’t do that. If they try to work in the mall or something, try to go somewhere else, they have no transportation and you need a job to have transportation, so people get stuck, can’t do nothing else.

Unable to find employment, many Puerto Ricans turn to welfare for financial support (Singer 1996). U.S. values about individual responsibility and work ethic then fuel and further perpetuate negative stereotypes about Puerto Ricans who “exploit” the
welfare system (Singer 1995). The teens in this study were extremely sensitized to this characterization of Puerto Ricans. Some accepted it as a valid portrayal of reality, and others denounced it. Maritza, sixteen, describes how she believes Puerto Ricans migrating from the island rapidly become trapped in the welfare cycle:

I think it’s that they come here to like find a better way to live and everything and they don’t. They might look for jobs but then they go to the state and they’re on welfare.

This sixteen year-old teen expresses a more derogatory opinion of Puerto Ricans on welfare, allowing that while some people may truly be in financial need, many simply prefer receiving welfare assistance than working. She states that it is especially inappropriate for teens to have babies, first of all, and to then rely on welfare to support these children:

There’s a lot of people that are young and they could work and everything and they could get themselves their GED or whatever, and they just want to lay back and take welfare because they’re being lazy. I mean, some people do need it because they can’t work or whatever, but lots of people, lots of young girls, you see them on Park Street with their babies and stuff. You see a lot of young girls carrying babies, carriages and that’s not right, I don’t think that looks right.

Interestingly, this eighteen year-old boy has a similar opinion, but an entirely different explanation of why so many pregnant teens end up on welfare:

They (adolescent males) want to prove their machismo, you know. They sleep around with everybody, you know, that’s not right. Some men just impregnate their women and then leave. That’s why so many of them are on welfare, you know. There should be more job opportunities out there for everybody. Everybody should work.

Fifteen year-old Billy’s attitudes toward welfare are based on negative beliefs about Puerto Ricans. His opinions reflect stereotypes about Puerto Ricans, and convey an
extreme frustration with the economic condition of the Puerto Rican community:

This is one of the main things that I hate. They (Puerto Ricans) get on welfare. They don't go out there and get jobs. It pays better, you're still getting paid, don't live off the government. That's the most thing people will laugh at or make jokes about Puerto Ricans being on welfare, but to tell you the truth, it's true. It's kind of true. I don't like hearing that. I would like to see a Puerto Rican, a Latin person, just make it up there for once, you know, make it up there, become a businessman or do something instead of being on checks or whatever.

When I ask him why he thinks people go on welfare, he suggests that laziness and drug use are two primary reasons:

There are some that I think should get help but there are some that do it for drugs, get on Welfare, they want drugs or they want money—just plain lazy. Most of them are lazy. The mother's on drugs. Mostly it's just drugs and they want money because they see the money coming in and they take it.

Later in the interview, Billy again returned to the idea of welfare in his description of what he hoped to be doing in the next five years:

I want to have kids but I want kids when I'll be able to support them, to take care of them, not like now. I don't want to be on Welfare. I want to make my own, get my own little place, do what I have to do, then when I'm ready I'll probably have kids, which is the right way. I hope to be making it, surviving, you know, surviving here in Hartford. You know what I'm saying, the way things are as a teenager, as a Puerto Rican male, I just want to make it out there.

In the above quote, Billy voices his experience of being male and Puerto Rican in Hartford. Survival is made difficult, as he notes, by the fact of being both a teenager, and a male Puerto Rican. Reinforcing this point, another male explicitly states that his primary concern as a Puerto Rican teen is finding a job:

Surviving is the first (priority). I mean you need a job to survive; I don't want to be homeless.
Gang Violence

As a male Puerto Rican teenager, Billy told me he is afraid that having the “face of a gang member,” will put him at increased risk for violence. His concern that he will be mistaken for a gang member is integral to his perception of himself as a Puerto Rican male. Billy’s belief that he has the face of a gang member conveys a sense of being specially marked or targeted because of his ethnicity. When asked what stereotypes non-Puerto Ricans had about Puerto Ricans, participants consistently said that they thought people often equated being Puerto Rican with being a gang member. In fact, some of the teens, like this 17 year-old, implied that Puerto Ricans were intrinsically violent:

If you go out there, you see a Puerto Rican shooting. If you go out there some Puerto Ricans live in the streets. For me, all Puerto Ricans, for me, I’m not trying to put my race down, but it’s the shooting.

The above quote is an example of the link some of the participants established between their perceptions of violence in the Puerto Rican community and Puerto Rican ethnic identity. Stereotypes about Puerto Ricans, in addition to experiences of being affected directly or indirectly by violence, appear to have influenced the teens’ conceptualizations of Puerto Rican ethnicity, and shaped their perceptions of violence in Puerto Rican neighborhoods. For example, this 17 year-old male speculates that Puerto Ricans are by nature of their ethnicity, predisposed to mochicha (gossip), thereby instigating fights:

Yeah, they love to fight. They like to, I don’t know how to say it, like mochicha, gossip. A lot of Puerto Ricans like to gossip, get people in trouble, get one
Another eighteen year-old male drew a similar connection between Puerto Ricans and violence. In comparison to the first two quotes above, however, this boy perceived the link between Puerto Ricans and violence as a stereotype imposed on the community by non-Puerto Ricans, rather than an actual reality:

If a Puerto Rican go out and stab somebody and they hear it in the news they’re going to be like, oh, Puerto Ricans always stabbing everybody, you know, they’re all like, they all dress the same, they got their pants hanging down, they all want to be gangsters. It’s not true. There’s a lot of us out there that want to make it. Those that don’t want to make it and they want to be like that, let them be like that. They don’t want to get help.

This boy’s description of how stereotypes about Puerto Ricans are perpetuated may be attributable, in part, to his participation in several community programs concerning the advancement of Puerto Rican adolescents in Hartford, and the fact that he had a sister who taught a group of Puerto Rican teens about cultural awareness.

Numerous stories about violence in Hartford’s Latino community in The Hartford Courant between 1995 and 1996 document the magnitude of this problem. Some of the study participants believed that the sale of illegal drugs contributes to the problem of violence. Some, like Billy, thought that drug use is the sole cause of violence in the Puerto Rican community. Billy, in fact, proposed that Puerto Ricans are inherently vulnerable to drug use:

Puerto Ricans killing each other (is the number one problem). They get down with the gangs and they’re shooting each other instead of looking out for each other. They get involved in the drugs. One Puerto Rican gets into drugs, call his old friend, you know, another Puerto Rican. this is good, it gets you high, this.
that, gets him all messed up, ruin his life. It's just all the negative stuff going on.

Billy later elaborates on this theme, developing a theory that so many Puerto Ricans are involved in drugs, either using or selling them, because they see that selling drugs is more lucrative than the various minimum wage jobs that are available to Puerto Ricans who are not fully bilingual, or have not completed high school or college degrees. He suggests that those using, rather than selling drugs, hope to one day be able to support themselves by dealing drugs. Wilson (1996) and Bourgois (1996) have both documented how drug trafficking has become one of the few consistent sources of income in poor communities with little job availability.

The unmistakable appeal of having an income, even at the high cost of gang violence entrenched in illegal drug markets, explains some of the fear and helplessness many of the teens expressed about gangs. Even if they believed they themselves could avoid gang involvement directly, most worried that their brothers, sisters or friends would be enticed into gang involvement. Daisha, a sixteen year-old mother, who lived with her baby's father and his mother, expressed her perception of the enormity of the problem of gang violence through her concerns for her son’s future:

> Because how things are right now it's not good out there. I wish my baby would stay little how he is because he don't know nothing about it. I always pray to the Lord every night I fall asleep that my mother-in-law will last until my baby is 18 years old because she told my baby's father a lot of stuff and I'm scared to talk to my baby about everything, but I would pray to the Lord that my mother-in-law lasts at least until my baby is fifteen, sixteen.

Clearly, Daisha does not expect her neighborhood to improve by the year 2010 when
her baby will be 15.

**Limited Educational Opportunities**

Participants in this study did not perceive the educational system available to them in inner-city Hartford as adequate. For example, one eighteen year-old boy who had transferred to high school in a wealthier suburb of Hartford, contrasted the education he received there, with that available to him in Hartford:

Teachers (in the suburb) are more interested in (their students). I'm not saying that any in Hartford High aren't but it's really limited and the way the school is, their parents, they have a lot more books and, you know, they really got a lot more newer books, and they have a lot of school materials.

Another sixteen year-old girl implied that existing teachers and educational materials do not reinforce the Puerto Rican teens’ impressions that their ethnic heritage is a topic significant to the discussion of U.S. history or current affairs:

Today we were talking about (stereotypes) in French class. They (the teacher) would say name me a famous Puerto Rican that is in the history books or whatever, somebody that’s famous in history and we wouldn’t know what to say.

Some of the participants perceived poverty as a further barrier to receiving and pursuing educational advancement. Although college, or other higher education, is traditionally viewed as a means of obtaining greater employment opportunity, many of the teens who said that they would like to go to college, expressed strong uncertainty about being able to afford it. This is not surprising given that annual family income, viewed as a predictor of teens’ successful completion of college
degrees (Solis 1995), is extremely low for Puerto Ricans (Ortiz 1995). In addition, Puerto Ricans’ education level is generally the lowest of all Latinos and other ethnic/racial groups, including African-Americans and Native-Americans (Ortiz 1995). For some of the teens, thinking about the reality of paying for a college education raised doubts and fears equal to their fear of gang violence. Some even declared that they were more afraid of not being able to afford a college education, and the implicit opportunities for escaping poverty that it offers, than of violence itself. Efrain, sixteen, describes why his anticipation of the difficulties, and near impossibility of paying for a college education filled him with a concern equal to the gunfire he hears in his neighborhood:

> Cause sometimes you can escape from guns but you shouldn’t want to escape from college if you want to be somebody. Nowadays you have to go to college but the simple jobs working at Burger King you need at least one year of college to get an advantage (over) somebody else.

**Perceptions of the Neighborhood**

Many of the teens’ aspirations for their future concluded with their goal of being able to move out of their neighborhoods to a safer community. Several teens voiced their dislike, and even disgust with the neighborhoods they live in now. Angelina, who theorized about the roots of fatalistic attitudes among her friends, explained to me why she believed that the atmosphere of her neighborhood actually promoted a sense of fatalism and perpetuated violence:

> Probably they’re used to it already. They’re pretty much used to everything and be like we did it, you know, whatever, and it’s crazy because not every day, but yeah probably every day a person dies; people that I know die and I don’t even
know about it. Like right now somebody could be getting shot and I don’t even know about it. And it’s sad. Even innocent people die because of the stupidest things.

The kind of area they envisioned as healthier for themselves and their children was a community where people were employed, and where there is less apathy, violence, and disruption. Not surprisingly, the areas of Hartford that the teens perceived to be safer, and to hold more promising employment possibilities were the few remaining predominantly white, middle class sections of the city, as well as the outlying suburbs.

When asked where she wanted to be living five years later, one girl without naming a specific area of Hartford, simply said:

I don’t know, someplace where there’s not—like, white people’s place, but I mean they’re quiet, they are quiet neighborhoods.

The phrase “white people’s place,” alludes to wealth and the promise of health and well-being not offered in neighborhoods of the city populated primarily by people of color. Historically, mass migrations of the white, middle class populations from cities to suburbs, has led to the growth of poor inner-city ghettos (Wilson 1996). It is well established that the flight of the middle-class from these neighborhoods, and the subsequent decline in standards of living, has had a devastating economic impact, reflected in these three comments about their neighborhood.

The poorness: You could see Park Street; not just on Park Street, Charter Oak—most Puerto Ricans live there and you could see the building like gangs writing Solids and everything like that. They destroy everything that should be nice because most of it, most of us do not care for people’s things because that’s why American people—like gringos—like they say, do not want us near them because we got something and we destroy it, we don’t take care it, and that hurts because I’m a Puerto Rican and that hurts. F, 15

The community; I mean look at Park Street, a lot of buildings closed, streets are
dirty; that’s on the people too, you know, that they dirty them, but could be a little more, I don’t know, could clean up a little more. A lot of buildings getting closed, especially Charter Oak, they’re going to close it down, there’s a lot of people moving out—where are they going to go? M, 18

Like the people they mess up everything. They don’t take care of nothing. Where there’s Puerto Ricans they’re all messed up, the streets, the houses. F, 16

Again, these comments are disparaging toward Puerto Ricans, and imply that the people inhabiting these areas are at fault for the dilapidation of the buildings. As such, these quotes reflect how the teens have internalized negative cultural stereotypes about Puerto Ricans.

The difficulties of inhabiting the inner-city have also created a dilemma for the teenage Puerto Ricans living in Hartford. They aspire to move to safer and more comfortable neighborhoods, on the one hand, while on the other, recognizing the danger of losing contact with their ethnic communities, their roots, and of being labeled a “sell-out,” on the other. Carlos, eighteen, explains:

I’ve been here all my life, but if I had the chance I would probably move out. That’s another problem, you know, people, you can’t blame them for moving out because they’re looking better for themselves but once they move out they never come back, they just forget about where they’re coming from.

Competing Health Concerns

Participants’ perceptions of what in their lives constitutes a risk to their health or well-being, and their reasons for ranking these various risks, reflect broader community standards of risk. The previous section presented the participants’
experiences of life in inner-city Hartford in order to convey their sense of the Puerto Rican community in which they live. Using their perceptions of the community as a framework for understanding their general thoughts about life as Puerto Rican adolescents in Hartford, it is possible to examine their estimations of risk to their lives within the Puerto Rican community.

The assessment of community standards of risk, as defined by Douglas and Wildavsky (1982), and voiced by the teens, is a particularly important component of evaluating perceived risk of AIDS. For instance, divorced from the context of the participants’ perceptions of life in inner-city Hartford, and the other health concerns they are contending with as part of their daily lives, the following quotes about attitudes toward AIDS might be interpreted as evidence of the manifestation of Elkind’s (1967) “adolescent invulnerability” to health risks among this group of teens:

I think probably teenagers (are more likely to get AIDS). They're not as careful as an adult would be probably. F, 15

A couple of them just do what they do without protection. I guess they think they’re invulnerable to it. M, 18

I asked my friend if she protects herself; she says no, no, whatever happens, I’ll suffer the consequences or whatever. F, 16

First of all, however, these teens are talking not about themselves, but about their friends, and peers. It is unclear whether their statements, such as the first one about teenagers in general, apply to the speakers themselves. It seems unlikely that any of the participants would have described themselves as invulnerable to HIV infection.
Possibly they express this sentiment by talking about teens in general, or about their friends. It also may be true that these teens do perceive their friends as more likely risk takers than they themselves are.

Teens who do actually seem less concerned with HIV risk may view it as a smaller risk relative to numerous other perceived health risks. Many of the participants in this study have either experienced first-hand, or witnessed, the negative ramifications of poverty, unemployment, racism, widespread drug use and violence described in the first section of this chapter. For some of these teens, these issues are viewed as posing more of an immediate threat to their survival than AIDS. Since many of the teens clearly do perceive themselves at risk for violence, as noted in the first section, and covered in greater detail later in this chapter, they do not regards themselves as wholly invulnerable to risks.

A separate but important issue to discuss here is the influence of fatalism on adolescent AIDS perceptions. The notion of fatalism is relevant to the discussion of adolescent invulnerability. The following quotes exemplify participants' statements about fatalism toward HIV/AIDS:

People don’t try to prevent getting AIDS; some people just don’t care, they’re like I’m going to die one day or the other, but they could prevent it. F, 15

Yeah, they don’t care what they do. They’re going to die, they don’t care if they pass it on and on. Instead of caring for somebody, they don’t care. M, 18

Descriptions of Latino culture generally hold that fatalism, arising from Catholicism.
is a predominant attitude among Latinos (Medina 1987). Several problems with the concept of fatalism have been discussed in Chapter II. Researchers have speculated that fatalism, measured as a psychological construct, presents a barrier to AIDS intervention efforts (Magura et al. 1992; Moore and Rosenthal 1991).

Some of the study participants themselves suggested that the circumstances of life in the inner-city cause teens to be more fatalistic toward protecting themselves from HIV. They made overt references to the ways they believed life as a Puerto Rican teen in the inner-city heightened this feeling of not being able to alter life circumstances. However, because fatalistic attitudes were not formally measured in this study, it is not possible to draw any conclusions about the effects of fatalism on these teens’ perceptions of their abilities to protect themselves from HIV and violence.

Participants in this study raised a number of issues, aside from AIDS, that worried them personally and concerned them about their community. Not all of these concerns were directly related to health, but all had a direct bearing on each adolescent’s quality of life. On a strictly individual level, teens expressed fears about their success in school, their ability to pay for higher education, and the health of their parents, friends, and siblings. Concerns, apart from AIDS, that are perceived as impacting both teens’ personal lives, and the Puerto Rican community included: 1) drug use; 2) unemployment; 3) teen pregnancy; 4) poverty; 5) language as a barrier to
employment and educational opportunities; 5) the number of Puerto Ricans subsisting on welfare; and 6) violence. These 16 year old girls’ comments are representative of many of the teens’ perceptions of the seriousness of AIDS as a Puerto Rican health concern in relation to other risks:

I think (AIDS) is a problem, but I don’t think it’s that big of a—well I don’t know a lot of people with AIDS. I know more people that are in gangs and they use drugs and are pregnant than people with AIDS.

I mean there’s many, many people out there using drugs. In schools, kids in schools are always high, violence, there’s a lot of violence in schools, there’s the gang members, and there’s a lot of friends that use, they’re just out there going to school, doing nothing, no job, no activity after school, just in the street. I mean. AIDS is a big problem and I mean it’s a big problem but I mean those are the things I can see mostly happen around me, you know, every day, in school, my neighborhood, everything else.

**Angelina: A Case Study**

At the time of my interview with fifteen year old Angelina, she had just attended the funerals of two friends who had been shot by rival gang members, and she had many ideas about the origins of what she perceived to be fatalism toward both AIDS and violence among her peers:

They (teens) don’t care about anything, because of the atmosphere; because of the surroundings and the way it is around here, the environment that we’re in, people usually die and it’s the same everyday routine.

Her experiences are described here to illustrate how one individual assesses and prioritizes AIDS as one of several risks in her life, within the context of the community. Although aware of safer sex practices, and afraid of the potential of contracting HIV from at least one of her partners, Angelina does not consistently use
condoms. Her beliefs about competing health concerns do not necessarily explain why she does not regularly use condoms, but they provide insight into how she conceptualizes the need for protecting herself from HIV within the context of her fears about violence.

Angelina is worried about AIDS:

The last partner I had sleeps with like every girl that he meets and just not like I'm the only one, because I know him, we were like brother and sister, so that pretty much scares me and I talk to him about it but it's like he wants to have fun now and suffer the consequences later, so I just let him do what he wants. He sleeps pretty much with anybody, anybody that looks good to him, he sleeps with, I guess. Pretty much there's this one particular girl that scares me that he was with and I have found out she was doing cocaine and she used drugs, stuff like that. And I told him and he was, well, I'm not going to go out with her any more. And I told him if it can happen with her, it can happen with anybody, so you ain't never going to be safe the way you are.

On the one occasion Angelina had sex with this partner, it "just happened" and she didn't use condoms. She focused primarily on her former partner's exposure to risk, yet Angelina also talks about her concern that she herself is infected with HIV:

He's been with a certain amount of girls, and I'm one of them. The chance that he has (HIV) could be the chance that I have, the same, because he's been with a lot of girls, and I been with him and, you know, it's a big percentage. The way he is, I guess, I'm scared.

Angelina says she does not necessarily want to be tested for AIDS, because she is not sure how she will "react" to it. Nor does she want to blame her partner if she is infected with HIV, because she believes it was "both of our fault" that they had unprotected sex.
So although Angelina is concerned about the number of partners her friend had prior to having sex with her, and the fact that she knows he does not regularly use condoms, she herself did not use condoms when she had sex with him. Neglecting to use condoms does not mean that Angelina perceives herself as invulnerable to HIV infection, because she acknowledges the fact that her former partner may have put her at risk. I propose the following idea for understanding why Angelina does not consistently protect herself from HIV. It is possible that she may accord less risk to HIV infection within the context of other perceived competing health risks, especially violence. She implies she is less concerned about the possibility of being infected with HIV than she is worried about other issues affecting the community in which she lives—such as gang violence and teen pregnancy. When I ask her if AIDS is a large problem in her neighborhood, she responds affirmatively, but then incorporates her concerns about teen pregnancy, and violence—expressed as a fleeting reference to drive-by shootings—into her response:

Yeah, it's pretty normal around here. Because here that's all you see is gays and girls getting pregnant. I'm telling you there's not one day that passes by and I don't see two or three girls that have a belly like out to here—and they'll be drive-bys here--there's a lot of people who have it here.

Clearly, for Angelina, the impact of AIDS is inextricably tied with issues connected with impoverished life in the inner-city, such as teen pregnancy, and street violence. Violence in particular, preoccupies her attention, and is draining her emotionally. She says:

I've seen people get shot in front of me. I'm tired of crying. Every time a person dies, I'm just tired of crying because it's the same thing.
She then explains why she thinks violence is a more life-threatening problem than AIDS:

You could get AIDS and still live; but with violence, you got to go outside and worry about you going to live the next minute, or you going to die that same minute. There's a lot of people that I've known that have AIDS and they live for years and years and years and years but it's not the same when you—it's a painful death, but when you see a person get shot, you're the one that feels pain because you know the person, and the person doesn't feel pain any more because they just got shot, which is crazy.

Comparing the relative devastation brought about by AIDS on the one hand, and that of violence, on the other, Angelina perceives AIDS as much less of an immediate threat. She perceives AIDS as creating loss only after an extended period, whereas violence often leads to immediate death.

**Perceptions of Violence Versus AIDS Risk**

There is little literature available that examines the dual themes of violence and AIDS, or the interrelationship between the two, in the lives of Puerto Rican teens. Based on three years of ethnography with Puerto Rican teens in New York City, Marisol Asencio corroborates the idea that violence is a large issue for the teens she interviewed (Asencio, personal communication).

Aside from Angelina, many of the intensive interview participants spoke about their fear of violence in comparison to AIDS. Importantly, the teens' statements about the
relationship between AIDS and violence as perceived risks, were not all
unidirectional, in the sense that violence was always perceived as a larger risk than
AIDS. This eighteen-year old female talks about why she regards AIDS as a larger
problem than violence:

Yeah, first, you know, like if there be no AIDS I would say the gangs (is the
largest problem) because that’s destroying all the little kids, the teens they try to
get into a gang. AIDS is the number one problem. Once you get AIDS I think
it’s hard to prevent it. You know, gangs, you can do something about it, but not
AIDS.

The focus group and intensive interview data show a consistent pattern in the way the
teens conceptualized AIDS and violence. They tended to invoke violence in their
discussions about AIDS, implying that they associated the two issues with each other.
Less commonly, they raised their concern about AIDS when talking about violence.

Discussing the reasons for their preoccupation with violence, teens referred to the
unrelenting fear and sadness they associated with it:

(Violence) affects me to the point that I know I’m worried about going out of my
house and getting shot right there. That’s how it is. You never know when
you’re going to get it. You could just be going out to your car and they’re right
there. M, 18

I’m getting out of high school, they’re always in the schools fighting, the Kings
(a reference to the gang Latin Kings) or whoever, killing somebody because
they think that’s the person they’re looking for. Families crying because they
loved their son or daughter. F, 17

Cause there’s like gang violence-- my sister she got shot last year by a drive-by,
and all those things worry me. Walking out to the store in front and you get shot
or something like that, you’ve got to be worried about that. F, 16

The next section explores violence, as a competing health concern in relation to AIDS
Section 2: AIDS/Violence Survey Results

Findings from the AIDS/Violence Surveys (N=50) permit further clarification about participants’ perceptions of AIDS in contrast to, and in relation to, their perceptions of the risk of violence. Frequencies were calculated for the following demographic variables: 1) age; 2) gender; 3) whether the participant was sexually active; 4) birth place; and 5) language preference.

In total, twenty-four Puerto Rican males and twenty-six Puerto Rican females between the ages of fourteen and nineteen were surveyed. The mean age of the sample was 16. Since approximately half of the sample (46%, N=23) was born in Hartford; forty-four percent (N=22) were born in Puerto Rico, and another 6% (N=3) were born in New York, there is a good representation both of participants born in Hartford and those born in Puerto Rico. Two responses regarding birthplace were missing. In terms of language preference, 56% (N=28) stated they were more comfortable speaking English. The remaining 44% (N=22) were more comfortable speaking Spanish. Forty-eight percent (N=24) of the participants were sexually active, while 28% (N=14) reported they were not having sex. Twenty-four percent (N=12) opted not to answer whether they were sexually active or not because they felt this question was too intrusive in a survey format. These missing data may have
biased the results of the survey.

**Teens' Experiences and Attitudes Toward Violence**

Frequencies were calculated for the following variables examining participants' experience of violence: 1) the number of times participants experienced violence; 2) the number of times participants witnessed violence; 3) the types of violence they experienced; and 4) the types of violence they witnessed. Notably, the majority of the participants had been affected by violence. Eighty-four percent (N=42) of participants reported either being victims of violence, or having known people affected by it. The types of violence the participants most frequently cited being affected by are shown in Table 11.

| Number of Participants Affected by Specific Acts of Violence (N=50)* |
|-----------------|-----------------|
| **Robberies**   | 40% (N=20)      |
| **Gang warfare**| 38% (N=19)      |
| **Gang related beatings** | 22% (N=11) |
| **Shootings**   | 20% (N=10)      |
| **Rape**        | 4% (N=2)        |
| **Domestic Violence** | 6% (N=3)   |
| **Fights**      | 4% (N=2)        |
| **Not Affected by Violence** | 16% (N=8) |

*Some participants were affected by more than one type of violence.
Further analysis of this group indicated that eleven of the fifty participants (22%) had themselves been victims of violence. The type of violence they experienced is depicted in Table 12.

Table 12: Type of Violence Participants Reported Experiencing

<table>
<thead>
<tr>
<th>Type of Violence</th>
<th>Participants Reported Experiencing (N=50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rape</td>
<td>4% (N=2)</td>
</tr>
<tr>
<td>Abuse</td>
<td>2% (N=1)</td>
</tr>
<tr>
<td>Beating</td>
<td>8% (N=4)</td>
</tr>
<tr>
<td>Shooting</td>
<td>4% (N=2)</td>
</tr>
<tr>
<td>Fight</td>
<td>2% (N=1)</td>
</tr>
<tr>
<td>Stabbing</td>
<td>2% (N=1)</td>
</tr>
<tr>
<td>Did not directly experience violence</td>
<td>78% (N=39)</td>
</tr>
</tbody>
</table>

The remaining thirty-one respondents had witnessed friends, relatives or acquaintances being affected by violence. Thirty-four percent (N=17) had seen a friend beaten by a gang, and 16% (N=8) had seen a friend shot, as shown in Table 13.
Table 13: Number of Participants Witnessing Specific Acts of Violence

<table>
<thead>
<tr>
<th>Number of Participants Witnessing Specific Acts of Violence (N=50)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robberies</td>
</tr>
<tr>
<td>Gang warfare</td>
</tr>
<tr>
<td>Gang related beatings</td>
</tr>
<tr>
<td>Shootings</td>
</tr>
<tr>
<td>Domestic violence</td>
</tr>
<tr>
<td>Fights</td>
</tr>
<tr>
<td>Did not witness violence</td>
</tr>
</tbody>
</table>

* Some participants witnessed more than one type of violence.

Frequencies were also calculated on variables examining: 1) participants' fear of being affected by violence in the future; 2) participants' opinions about the ages at which people were most likely to be affected by violence; and 3) participants' perceptions of whether teens were more or less likely to be victims of violence than adults. Among all fifty respondents, 70% (N=35) were afraid that they would be victims of violence in the future (see Table 14).

Table 14: Participants' Fear of Violence in the Future

<table>
<thead>
<tr>
<th>Participants Fear of Violence in the Future (N=50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Afraid of Violence in the Future</td>
</tr>
<tr>
<td>Afraid of Violence in the Future</td>
</tr>
<tr>
<td>Sometimes Afraid of Violence in the Future</td>
</tr>
</tbody>
</table>

Participants were evenly split in their opinions as to the ages at which people were
most likely to be affected by violence. Nearly half (N=24) of the teens thought that individuals could be affected by violence “at any age,” because of domestic violence and child abuse, while the remainder (N=26) suggested that violence happened most frequently to adolescents because at this age teens “begin to socialize more,” and “cause more trouble.” Issues of adolescent impulsiveness, stubbornness, unpredictability and preoccupation with conformity were also raised as possible explanations for the likelihood of teens being affected by violence. One sixteen year old-girl suggested that teens were more apt than adults to be victims of violence because they were “more crazy nowadays,” while another sixteen year-old reasoned that teens were more often affected by violence because:

They are more into gangs and into becoming cool and popular. Adults can still be affected but might not play a major role in the actual violence, rather a victim.

Yet a third sixteen year-old female also noted that violence was especially likely among teens:

It’s like teens nowadays want to be better than anybody and they always want to prove their points of view rather than adults.

In fact, 78% (N=39) of the respondents stated that teens in general were more likely to be victims of violence than adults. Ten (20%) of the participants said they thought teenagers were not more likely to be victims than adults, and one participant (2%) stated that teens were only “sometimes” more likely to be victims of violence than adults. To explore the association between having been a victim of violence in the past and the perception of whether or not teens were more likely to be victims of
violence than adults, a chi-square was used. Because there was only one response of “sometimes,” the “sometimes” response was collapsed into the category of those who agreed that teens were more likely to be victims of violence than adults. The “sometimes” response was interpreted as reflecting the belief that teens “sometimes” were more likely to be victims of violence than adults, and thus it was collapsed into the latter category. After this category was collapsed, the association approached significance, but was not significant at the .05 level (p = .06), for participants who had themselves been victims of violence in the past, versus those who had not, to be slightly more prone to perceiving that teens are more likely to be victims of violence than adults. The $x^2$ value, using the Yate’s Correction is 14. Therefore, there is no significant association between being a past victim of violence, and the perceptions regarding which group, teens or adults, was more likely to be victims of violence.

Because it wasn’t clear that the perception of teens being more likely to be victims of violence encompassed the participants themselves, and not just “other teenagers” as a general category, participants were asked to do a self-assessment for risk of violence on a Likert scale of 1 to 10, with 1 being the least and 10 being the greatest amount of risk. Almost 48% (N=24) of the teens estimated their risk at a 5, and another 44% (N=22) were between 5 and 10. In all, 92% of the teens assessed their risk of violence between a 5 and a 10, between medium and high risk. This estimate supports the idea that almost half of the teens perceived themselves at neither exceptionally high or low risk for violence, but that they did think they had an average
chance of being affected by violence. The most common reason (N=36, 72%) for this assessment was that, “Violence can happen to anyone,” or as one sixteen year-old girl stated, “The trigger got no heart.” There was no significant relationship (p = .63) between participants’ rating of risk for violence and the stated reasons for this rating.

Although the majority (N=42, 84%) of AIDS/Violence Survey participants have been confronted with violence, either by experiencing or witnessing it, only 38% (N=19) reporting knowing someone living with HIV/AIDS. Therefore, it is possible that the participants’ perceptions of violence are based upon personal experience to a much greater degree than their perceptions of AIDS. Also, because violence, unlike AIDS, or other of the teens’ concerns, such as drug use and teen pregnancy, is not perceived as something that can be individually controlled or prevented, participants may view it as something that seemingly occurs with less explicit cause or predictability than other of their health concerns.

**Teens’ Experiences and Attitudes Toward AIDS**

When questioned about their daily concerns, nearly a third (N=15, 30%) of the participants were primarily preoccupied with AIDS on a daily basis, in contrast to the relatively small percentage (N=4, 8%) who were worried about violence. When asked to compare the two risks, exactly half of the respondents (N=25) said they were more afraid of AIDS than violence, while only 18% (N=9) felt the reverse. Thirty-two
percent (N=16) of the sample stated that they were equally afraid of both AIDS and violence (see Table 15).

<table>
<thead>
<tr>
<th>Participant Fear of Violence in Comparison to AIDS (N=50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Afraid of Violence</td>
</tr>
<tr>
<td>More Afraid of AIDS</td>
</tr>
<tr>
<td>Equally Afraid of both AIDS and Violence</td>
</tr>
</tbody>
</table>

Table 15: Participants' Fear of Violence in Comparison to AIDS

Due to the small cell size, it is not possible to explore whether there was any statistical association between being affected by violence in the past (either through direct experience or through witnessing it) and the fear of either AIDS or violence in the future through Chi-square analysis. There were not enough participants to make a valid three by two table showing the relationship between being afraid of either AIDS or violence and having been a victim of violence in the past. Therefore, to explore this relationship, it would have been necessary to collapse the category of participants who reported being equally afraid of both AIDS or violence into either: 1) those who were more afraid of AIDS, or 2) those who were more afraid of violence. There was no definitive way of knowing for certain which of these two categories would have best represented participants who responded that they were equally afraid of both AIDS and violence to this question. Therefore, these categories could not be collapsed. With a larger sample size, it would be useful to test the relationship between having been a victim of violence in the past with the fear of either AIDS or
violence, in order to establish whether any relationship exists between being a victim of violence and fearing violence in the future.

While similar to focus group findings that AIDS, in contrast to violence, was perceived as the teens' top concern, data describing the teens' fear of AIDS on a daily basis, and in contrast to violence, seem contradictory when analyzed within the context of the entire AIDS/Violence Survey, and the Intensive Interviews, in which many teens describe violence as a more immediate, consuming fear to them than AIDS. For example, when asked to predict their risk of AIDS or violence in the next year, 74% (N=37) of the AIDS/Violence survey participants hypothesized that they would be more at risk for violent experiences, rather than HIV infection, in the future (see Table 16).

Table 16: Participant Perceptions of Being More at Risk for HIV or Violence in the Next Year

<table>
<thead>
<tr>
<th>Participant Perceptions of Being More at Risk for HIV or Violence in the Next Year (N=50)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>12% (N=6)</td>
</tr>
<tr>
<td>Violence</td>
<td>74% (N=37)</td>
</tr>
<tr>
<td>Both</td>
<td>12% (N=6)</td>
</tr>
<tr>
<td>Neither</td>
<td>2% (N=1)</td>
</tr>
</tbody>
</table>

The reasons for this discrepancy are unclear. One possibility is that the interviewer may have unintentionally biased the respondents by informing them that the study was focused primarily on AIDS. Another possible explanation takes into account
the teens' perceptions of AIDS as it contrasts with violence. The participants themselves expressed the idea that although AIDS is perceived as less of an actual risk than violence, it still is perceived as a large, albeit abstract, risk. In fact, the abstract threat presented by AIDS may in some ways be more frightening than the concrete concern about violence for several reasons. AIDS, in contrast to violence, may be surrounded by a more heightened stigma than violence, through its association with homosexuality, which some researchers have suggested is a taboo issue among Puerto Ricans (Cunningham 1989; Singer et al. 1990a). Further, AIDS may also be associated with a mystique because of the fact that people living with HIV usually suffer in a more private sphere than victims of public acts of violence. Survey participants believed HIV infection invariably involved long, painful deterioration and inevitably, death, whereas an episode of violence might not always be fatal, or involve protracted suffering. For example, one seventeen year-old male said he was more frightened of AIDS than violence because:

AIDS is a non-curable disease and it could make you go through pain and suffer.

Another seventeen year-old male concurred:

AIDS takes more years in pain and to die, than violence.

This hypothesis about the mystique of AIDS is further supported by the fact that none of the AIDS/Violence Survey participants reported being HIV-positive, and less than half of the sample (N=19, 38%) knew someone with HIV, as opposed to the 84% (N=42) who had been affected by violence either directly or indirectly by knowing
someone who had been affected. The fact that respondents were less apt to know someone with HIV than they were to be affected by violence, or know someone who had, reinforces the idea that the AIDS Violence Survey participants were less familiar with AIDS than the Intensive Interview participants. As reported in Chapter V, 67% (N=24 out of 36) of the Intensive Interview participants (as reflected in the results of the 36 AIDS Knowledge Surveys) reported knowing someone with HIV. Thus, the lack of familiarity with HIV/AIDS among the AIDS/Violence Survey participants may also in part explain why the teens dread the abstract possibility of AIDS more than real exposure to violence.

Clearly, this explanation is only relevant to the AIDS/Violence Survey participants, since the Intensive Interview and AIDS Acquaintance Interview participants reported having many friends and relatives living with HIV. In the case of the Intensive Interview participants, this pattern possibly reflects the fact that a significant portion of the Intensive Interview participants were members of the research assistants’ social networks, and there may have been some overlap in the people they knew living with HIV/AIDS. In the case of the AIDS Acquaintance Interviews, the intentional recruitment of participants who knew someone with HIV/AIDS obviously resulted in all the participants being familiar, to varying degrees, with AIDS. The Intensive and AIDS Acquaintance Interviews participants’ level of acquaintanceship with people living with HIV suggests that lack of familiarity with HIV/AIDS as a partial explanation for the existence of an “abstract” fear about the disease is not applicable.
to all the Puerto Rican teens involved in this study.

Fear of HIV infection also may be more abstract than a concrete fear of violence because, as mentioned earlier in this section, participants perceive themselves to be realistically better able to protect themselves from HIV than from violence. Ninety percent (N=45) of the respondents rated their own risk for HIV infection as a 5 or less (on a Likert scale of 1 to 10, with “1” being least risk, and “10” being the most). Table 17 shows the top reasons given for the low rating for HIV (less than 5), and the four top reasons for high rating (greater than 5) for HIV. However, the fact that a fifth of the Survey participants (N=10) did not answer this question may have skewed these results, and these data should be interpreted with caution.

Table 17: Reasons for Low/High Rating of Risk for HIV*

<table>
<thead>
<tr>
<th>Reasons for Low Rating of Risk for HIV (N=18)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant protects self from it</td>
<td>44% (N=8)</td>
</tr>
<tr>
<td>Participant Doesn't Have Sex</td>
<td>33% (N=6)</td>
</tr>
<tr>
<td>Participant Doesn't Have Sex or Use Drugs</td>
<td>22% (N=4)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reasons for High Rating of Risk for HIV (N=22)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Many don't use condoms</td>
<td>5% (N=1)</td>
</tr>
<tr>
<td>Condom may break</td>
<td>23% (N=5)</td>
</tr>
<tr>
<td>It can happen to anyone</td>
<td>18% (N=4)</td>
</tr>
<tr>
<td>May have unknowingly been infected with HIV</td>
<td>54% (N=12)</td>
</tr>
</tbody>
</table>

* 10 responses missing

A frequency was also calculated to examine participants’ beliefs about the ages at
which people are most likely to be affected by HIV. As with violence, participants speculated that they thought adolescence was, in general, a time when people were more likely to become infected with HIV. Seventy-four percent (N=37) of the sample suggested that infection with HIV is more likely after the age of thirteen, because this is when people become "curious" about sex.

The Perception of AIDS and Violence as Risks to Adolescents in the Puerto Rican Community

To specifically compare participants’ perceptions of AIDS in comparison to violence in Hartford’s Puerto Rican community, frequencies were calculated on their assessment of the amount of violence versus AIDS in this community. In general, participants believed there exists more violence than AIDS in the Puerto Rican community. Only 2% (N=1) of the participants thought that there was more AIDS than violence in the Puerto Rican community; while 74% (N=37) thought there was more violence than AIDS. Twenty-two percent (N=11) perceived equal amounts of AIDS and violence. One participant said that neither AIDS nor violence were problems in the community.

To assess if there is an association between the belief that there was more violence than AIDS in the Puerto Rican community with a fear about being a victim of violence in the future. However, because of the small sample size and resulting small cell sizes, two categories were collapsed to reinforce the validity of this association in
a two-by-two table. The category of participants who were “sometimes afraid of violence in the future” was collapsed into those who were “afraid of violence in the future.” (Both categories are depicted in Table 14.) The $x^2$ value (with the Yate’s Correction) is $p=.40$. In addition, the perception that there was more violence than AIDS in the Puerto Rican community was not significantly associated with having been a victim of violence in the past ($p = .81$). It is not possible to draw conclusions about these two findings without a larger sample size that is more representative of Puerto Rican teens who have not been affected by violence.

Another theme which was explored through the surveys was the degree to which the teens thought both AIDS and violence affected Puerto Rican adolescents, in comparison to teens from other ethnic groups. The majority of participants did not think Puerto Rican teens were more likely to be affected with either violence or AIDS than teens from other ethnic groups. Only 32% of the participants ($N=16$) agreed that Puerto Rican teens were more likely than non-Puerto Rican teens to experience violence, while only three of the teens thought that Puerto Rican teens are more likely to become HIV-infected than other teens (see Table 18).
Table 18: Perceived Likelihood of Puerto Rican Adolescents Being Affected by AIDS or Violence in Comparison to Adolescents from Other Ethnic Groups

<table>
<thead>
<tr>
<th></th>
<th>Are Puerto Rican teens more likely than teens in other ethnic groups to experience violence? (N=50)</th>
<th>Are Puerto Rican teens more likely than teens in other ethnic groups to get HIV? (N=50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>32% (N=16)</td>
<td>6% (N=3)</td>
</tr>
<tr>
<td>No</td>
<td>60% (N=30)</td>
<td>88% (N=44)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>8% (N=4)</td>
<td>6% (N=3)</td>
</tr>
</tbody>
</table>

The sixteen participants who supported the idea that Puerto Rican teens are more often affected by violence than teens in other ethnic groups suggested that this was so because: 1) Puerto Ricans like to start trouble (N=6, 12%); 2) Puerto Rican teens are more likely to be targets of discrimination and racism (N=4, 8%); 3) in general, minority groups are more affected by violence (N=4, 8%); and 4) Puerto Ricans are more involved in gangs and drugs (N=2, 4%).

There were no similar statements made about Puerto Ricans and AIDS. In fact, when asked if they thought Puerto Rican teens were more likely than teens in other ethnic groups to contract HIV, nearly all respondents (N=44, 88%) disagreed with this statement, a common response (N=8, 56%) being; "Anyone can get AIDS." One female respondent, sixteen, offered this insight:

*No, I don’t think so (that Puerto Rican teens are more likely to get AIDS), but for some reason they tend to stand out more, maybe because we are a minority. But I think every ethnic group is affected the same way.*

Responses to questions about the likelihood of HIV and violence affecting Puerto
Rican teens indicate that the majority of the participants were less likely to perceive their peers as more at risk from either AIDS or violence in comparison to teens from other ethnic groups, than they were to view adolescents, in general, from all ethnic groups, in comparison to adults, in general, being more likely to be affected by AIDS or violence. This latter finding, reflected by the 78% of participants who thought that adolescents, as an entire group, were more likely to be affected by AIDS or violence than adults were, was discussed earlier in this section. The contrast in these two findings—the participants' perception that adolescents were more likely than adults to experience violence, or become infected with AIDS, rather than Puerto Rican teens being more likely than other teens to be affected by AIDS or violence—suggests that the more closely the respondents identified with the group in question by age and ethnicity, the less likely they were to view either HIV infection or violence occurring more often in that group.

A chi-square test was used to explore whether or not participants who had been affected by violence were particularly apt to believe in the likelihood of violence affecting all teens. To assure adequate cell sizes, the category of participants who answered that Puerto Rican teens were “sometimes” more likely to be affected by violence than teens from other ethnic groups (see Table 18 above) was collapsed into the category of participants who thought that Puerto Rican teens were more likely to be affected by violence than teens from other ethnic groups. This merge was considered reasonable because responses stating that Puerto Rican teens were
"sometimes more likely victims of violence" were interpreted as affirming the idea that Puerto Rican teens were more likely victims of violence. The $x^2$ (using Yate’s Correction) was ($p= .15$). Again, it would be necessary to explore this relationship with a larger sample size that was more representative of Puerto Rican teens who had not been affected by violence in order to draw conclusions from these data.

**Gender Differences in Participants’ Experiences of Violence**

Although the sample size for the AIDS/Violence survey is too small to indicate any conclusive relationships by gender, chi-square analysis showed several trends in gender differences toward experiences to violence. Girls appeared less likely to have been victims of violence or known someone who was affected by violence ($p = .04$). Of participants who had never known or been victims of violence ($N=8$), only one (12%) was male, in contrast to seven girls (88%). Because so much gang activity involves males and excludes females from active participation (Padilla 1992) it is possible that girls are less likely to be directly involved in public incidents of violence. Another potential reason for this trend is that boys may have felt more social pressure to appear knowledgeable and savvy about violence, whether or not they actually experienced or witnessed violence. Male survey respondents were more apt to believe that violence so commonly affects teens because they are more likely to socialize with gang members. Yet it is unclear how pervasive the social pressure for males to appear knowledgeable about violence may be: among Intensive Interview
participants, girls were as likely as boys to talk about violence in their lives.

The data also show a trend approaching significance for girls to be more afraid of violence than boys ($p = .06$). Eight of the females (31%), versus one of 24 males (4%) responded that they were more afraid of violence than AIDS (see Table 19). Also of note, exactly half of both the male and female sub-sets stated they were more frightened about AIDS than violence.

Table 19: The Relationship Between Gender and Likelihood of Being Afraid of AIDS or Violence

<table>
<thead>
<tr>
<th></th>
<th>More afraid of violence (N=9)</th>
<th>More afraid of AIDS (N=25)</th>
<th>Equally afraid of both (N=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>male (N=24)</td>
<td>4% (N=1)</td>
<td>50% (N=12)</td>
<td>46% (N=11)</td>
</tr>
<tr>
<td>female (N=26)</td>
<td>31% (N=8)</td>
<td>50% (N=13)</td>
<td>19% (N=5)</td>
</tr>
</tbody>
</table>

This trend is important given research that explores women’s particular vulnerability to violence, especially in relationship to HIV and drug use (Connors 1996; Farmer 1996; Simmons et al. 1996; Singer 1996). In relation to HIV, some women may be at risk for domestic violence from their partners when they attempt to insist on condom use (Weeks et al. 1996). Female intravenous drug users and women who use crack are at risk for violence from their sex partners, or other men who supply them with drugs (Fullilove et al. 1990; Singer 1996; Singer et al. 1990a).
Section 3: Comparison of Participant Attitudes Toward Violence from Two Instruments

At the time of both the Intensive Interviews and the AIDS/Violence Surveys, gang violence was an escalating problem in Hartford, and gang arrests were prominent in the media. In the time since these interviews, the problem of gang violence has decreased. The Hartford Courant quotes city officials stating that since March of 1994, when a seven year-old Puerto Rican girl was killed in a gang skirmish, the gang situation in Hartford has shifted “one-hundred and eighty degrees” (The Hartford Courant 11/19/96, pA1). More than fifty members of a prominent area gang, Los Solidos, have been indicted and convicted of racketeering, narcotics, and weapons charges (The Hartford Courant 11/19/96, pA1), and many members of other local gangs (e.g., the Latin Kings, the Netas, Los Solidos, Twenty Love, etc.) have been arrested as well.

Given the magnitude of the problem of violence in Hartford, it is not surprising that, in general, both the AIDS/Violence Survey participants and the Intensive Interview participants thought that violence was a larger problem for Puerto Ricans than AIDS. Angelina’s story exemplifies how violence is perceived as an overwhelming problem to these teens, despite their acknowledgment that AIDS is also a large concern.

Intensive Interview participants perceived AIDS differently than AIDS/Violence
Survey participants, however. Almost twice as many of the Intensive Interview participants (N=24, 67%), than the AIDS/Violence Survey participants (N=19, 38%), were acquainted with someone living with HIV. Intensive Interview participants were more familiar with HIV/AIDS, more apt to know someone living with the disease, and less likely to fear it as an abstract possibility. Because they are less familiar with AIDS, AIDS/Violence Survey participants seemed to fear the prolonged suffering they perceived accompanying AIDS more so than the immediate pain, injury or death they associated with violence. In contrast, Intensive Interview participants saw violence as likely to cause more pain and suffering, especially for the relatives and friends of victims, since it often resulted in immediate death. Angelina stated that she thought that people who contracted HIV had a chance of survival, in contrast to people who were victims of violence. In Section 1 of this chapter, another Intensive Interview participant was quoted stating that she thought AIDS was a larger problem than violence. These differences in perceptions about AIDS among Intensive Interview and AIDS/Violence Survey participants suggest that AIDS is more familiar, and therefore possibly less stigmatized, to the Intensive Interview participants.

Section 4: Summary

Building upon the Intensive Interview participants’ (N=42) experiences of living in Hartford’s Puerto Rican community, the chapter has explored the teens’ perceptions
of living in Hartford. From this perspective, the chapter then identified issues in the teens' lives, such as unemployment, drug use, teen pregnancy, and violence, that they perceived as being topics of equal or greater concern to them than AIDS. As De La Cancela and Martinez (1983) have argued, it is crucial to assess the impact of historical and structural factors on the manifestation of cultural beliefs and behaviors. Considering the structural context of the teens' lives, it is possible that the teens who stated that they were not concerned about AIDS, or who speculated that their peers were not, may simply perceive themselves less at risk for HIV infection than from other perceived risks.

To demonstrate the complexity of determining the existence of feelings of invulnerability among this group of teens, the issue of fatalism was briefly raised in this chapter because researchers have previously written about its importance in Latino culture. Participant statements of apathy can in some cases be interpreted as exemplifying fatalistic attitudes. However, none of the participants specifically ascribed the term "fatalism" to their thoughts or feelings. More research is necessary to fully establish the role of fatalism, if any, in shaping these Puerto Rican adolescents' perceptions of AIDS.

Among the competing health concerns, violence was so often discussed as a concern overshadowing that of AIDS that an instrument was developed to specifically examine teens' perceptions of violence in their lives, as these contrasted with their
perceptions of AIDS. Findings from this instrument, the AIDS/Violence Survey (N=50), indicated that the majority of the participants (N=42, 84%) had been directly affected by violence, or had witnessed a friend or family member affected by violence. Participants thought they were more likely to be affected by violence than AIDS in the next year because they viewed violence as a more concrete risk to them. Yet surprisingly, the majority of participants also said that they were more concerned with AIDS (N=15, 30%) on a daily basis than violence (N=4, 8%). Further, half of the respondents (N=25, 50%) stated that they were more afraid of AIDS than violence. These two latter seemingly contradictory findings were primarily attributed to the fact that the participants were less apt to know someone living with HIV, than they were to know someone affected by violence. Because they were less familiar with AIDS, participants appeared to have an abstract dread of it. Rooted in this dread, they expressed concern about the protracted suffering they saw as accompanying AIDS, whereas they perceived violence resulting in a more immediate, and ultimately less painful, death.

Participants speculated that teens were more likely to be affected by both violence and AIDS than adults, because: 1) they were more reckless; 2) apt to be involved in gangs; and 3) more curious about sex. The majority of participants did not think that Puerto Rican teens were more likely than teens from other ethnic groups to be affected by either violence or AIDS. This finding differs from some of the statements, presented in Section 1 of this Chapter, made by Intensive Interview participants about Puerto
Rican proclivity towards violence. This contrast reflects the variations in perspectives between the Intensive Interview and AIDS/Violence Survey participants.

Because of the small sample size, and the unequal distribution of participants who had been affected by violence versus those who had not, it was not possible to establish any associations between having been affected by violence in the past and 1) fear of AIDS or violence in the future; 2) perceptions about teens being more or less likely than adults to be affected by violence; 3) perceptions about the likelihood of Puerto Rican teens, in comparison to teens from other ethnic groups, being affected by violence. These relationships should be explored in future research with a larger sample of Puerto Rican teens.

Also due to the small sample size, findings about the relationship between gender and perceptions of violence are inconclusive. However, there are trends in the data which suggest that girls are less likely than boys to have experienced violence or been affected by it. Also, girls appeared to be more frightened of the possibility of violence in their lives than boys. The relationship between gender and perceptions of violence should be evaluated in greater detail in later studies.
CHAPTER VIII CONCLUSION

This dissertation is an exploration of how Puerto Rican adolescents living in Hartford, Connecticut, perceive AIDS, and rank it as a risk in relation to other perceived health concerns. In order to assess this, the cultural and social structural context of the teens' perceptions of AIDS was examined. Specifically, the following cultural domains were evaluated to assess their relevance to the teens' constructions of risk: conceptualizations of gender, sexuality, religion, family and ethnic identity. These particular domains were studied because previous research had suggested them to be potentially significant factors in the Latino experience of AIDS. However, as noted in Chapter II, the use of these categories likely influenced the way the teens expressed their perceptions about AIDS. The categories used may not necessarily have corresponded with the way the teens conceptualized aspects of Puerto Rican culture. Had aspects of Latino culture been operationalized in a different way, or had the teens been given the opportunity to articulate their own perceptions of what constitutes Latino culture, the findings from this study may have been entirely different.

Ultimately, however, the cultural domains used serve to shape and provide means of further interpreting the findings. Operationalizing culture in this way, by exploring the five domains of gender, sexuality, familism, ethnicity, and religion, facilitated the exploration of how this group of Puerto Rican teens perceived AIDS. It would have
been difficult to identify themes in the teens’ responses without defining categories of cultural influence.

As it stands, this study has limited generalizability, primarily because the sample sizes were too small to allow for generalizations about patterns in the data. Also, because the research assistants recruited participants socio-economically similar to themselves, the findings are not necessarily representative of a group of working class teens in Hartford, Connecticut. At the same time, it is important to note that the participants, despite their demographic similarities, expressed diverse opinions and beliefs about AIDS, competing health concerns, and the five cultural domains explored, underscoring the importance of analyzing the differences as well as the similarities in their responses. The diversity of opinions expressed is not in itself a limitation, but coupled with the small sample size, it further reduces the generalizability of the results. Additionally, the study design did not include any comparison groups. In future research, a comparison of the responses of the teens in this study to a comparison group of non-Puerto Rican teens, or a comparison of a group of more and less acculturated Puerto Rican teens may provide different and useful results.

Despite small sample size, the data are suggestive of several themes. To some degree, all of the cultural domains examined, gender dynamics, notions of sexuality, ethnic identity, sense of family, and religiosity, were influential in each teen’s beliefs about
AIDS. The domains most overtly tied to perceptions of HIV/AIDS were: perceptions of gender, sexuality, and family. Yet the salience of these domains in the lives of each participant varied greatly from individual to individual.

Cultural understandings about gender were consistently basic to the teens' perceptions about AIDS. Large portions of each interview were devoted to discussions of gender usually in response to open-ended questions not directly concerned with gender roles. Usually the female participants had the most to say about gender, and it appeared important for them to convey to me their experiences of growing up as Puerto Rican females. The male participants possibly felt less comfortable talking about gender, or perhaps they thought I was less likely to understand their point of view. However, there were points that both males and females agreed upon. In terms of division of family economic responsibility, both sexes agreed that both males and females should be willing to earn money to support their families. Also, many of the teens suggested that their own mothers, whether single or living with a male partner, possessed the final say about decisions affecting the family. In terms of gender roles with respect to sex, males and females agreed that girls, in general, had less freedom sexually because of having to adhere to stricter social morals in order to maintain respect from their peers. For example, participants suggested that community standards condone male sexuality, but often deem sexually active girls “tramps,” or “whores.”

Although both males and females raised issues about sexuality in discussions about...
AIDS. references to sex were integrally tied to, and in some ways absorbed by discussion about gender roles. The teens rarely mentioned anything about sex without connecting it to broader implications about gender. For example, a girl might say that most of the boys she knew were sexually active, or had sex with multiple partners, and then contextualize this information in a statement such as: “That’s because all men are dogs.” In general, boys were more comfortable responding to questions about sexuality, or at least more willing to talk openly about it, than girls. In some cases, their willingness to talk about sex may have been because they did not want to appear sexually inexperienced or naive.

Gender role behavior was also a standard used to assess the risk of exposure to HIV through potential sex partners perceived to be more likely to be HIV infected. This group of teens’ cultural logic systems about AIDS, as defined by Swanson et al. (1992), drew upon several different cultural notions. Boys emphasized the necessity of finding “clean” partners, who were less assertive and outspoken about sex, as a means of reducing possible HIV risk. Girls, on the other hand, adopted a strategy of looking for “quiet” sex partners, who seemed shy, and gave the impression of being sexually inexperienced. Both males and females implied that partners who claimed never to have had sex were likely the safest sex partners, although males articulated plans to deliberately seek virgins for sex partners, both because of their respect for virgins, and because these girls would seemingly be at low risk for HIV infection. Although both girls’ and boys’ strategies to protect themselves from HIV are

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
ultimately similar, the comparison in strategies is notable because it reflects the impact AIDS has had on “traditional” Puerto Rican definitions of gender among this group of teens. Looking for quiet and unassertive partners, boys appear to be seeking sex partners who behave according to traditional standards, while girls look for sex partners possessing qualities opposite to traditionally defined machismo, since they believe these boys are less likely to be sexually experienced.

Familial bonds also had a strong effect on how the teens’ thought about sex, and through their beliefs about sex, AIDS. The importance of family in shaping perceptions about AIDS was most clearly evident among teens who knew someone with HIV either in their immediate or extended family. For teens in this sample, particularly for those living with someone with HIV, close bonds to a PLHA is linked with a greater tendency to high risk sex behaviors for HIV infection. This finding contradicts Fisher’s (1988) theory that adolescents who know someone with HIV are less likely to practice risky sex. Importantly, Fisher’s research was conducted among predominantly Anglo college students. This group of older and likely middle class white students likely had different life experiences and beliefs about AIDS than a younger group of inner-city Puerto Rican teens. In part, these socioeconomic and demographic differences may explain the inapplicability of his theory for understanding this group of Puerto Rican teens’ risk-taking.

Despite the inconclusiveness of the results, given the small sample size, there are
several possible reasons why participants from the YOUTH sample who are closest to PLHAS appear to be more likely to take HIV risks. Theresa Kribeck, a psychiatrist who works with Latino families affected with HIV in Hartford, has proposed that these teens identify with their family members to the point of wanting to share their HIV infection (Kribeck 1997). It is also possible that these teens come from families in which risk-taking is a behavioral pattern shared and learned among family members. Again, however, because Puerto Ricans are a socially marginalized and devalued minority in the U.S., it is crucial to evaluate the social and historical context of the experience of HIV/AIDS risk in their lives (De La Cancela 1989). Whatever familial dynamic potentially influences their perception of AIDS risk and possible tendencies toward high risk behavior is undoubtedly patterned by, and possibly rooted in, the larger social structural forces in the communities in which these families live. For example, in some Puerto Rican families, more than one member of the immediate or extended family may become infected with HIV through selling and using injection drugs. The family may sell drugs because they perceive it to be a lucrative option for economic welfare. In addition, the fact that Puerto Rican families living in Hartford are likely to be headed by single mothers, with incomes inadequate for their families (The Child Council, Inc. 1995), only exacerbates the devastation AIDS visits upon these families, if a family member is infected. Therefore, teens with seropositive parents may be too overwhelmed with caring for their parent or siblings to concern themselves with considering their own vulnerability to HIV infection.
Further underlying much of what the teens said about gender, sex and AIDS was a sense of morality shaped by Catholicism. In fact, Catholicism is so deeply intertwined with Puerto Rican cultural identity that it was at times difficult to assess whether religion should be considered a separate cultural domain. Even participants who did not claim a great sense of religiosity invoked various religious ideals and values to articulate their perceptions about AIDS: for example, by linking negative feelings about having sex to a belief that sex before marriage displeases God. Yet few participants made overt statements about the importance of religion in their lives.

For some of the participants, a sense of what has been termed “fatalism” in the literature appeared to be partly a manifestation of their religious beliefs. Others seemed fatalistic about the present state of their lives, as well as their future prospects because of what they perceived as a community-wide apathy about health and well-being. On a broader level, the teens’ seeming fatalism about their basic survival, primarily, and lack of opportunities for success, more secondarily, seems directly rooted in their experiences of being members of an economically and politically marginalized minority group. Singer et al. (1990a) suggested that Latino adolescents who feel incapable of protecting themselves from HIV may adopt an attitude of “you have to die of something” towards their survival (1990a:81). Some of the teens did talk about peer attitudes towards AIDS they interpreted as apathetic or fatalistic. Fatalistic attitudes were not formally measured in this study, so it is remains uncertain whether or not fatalism in any way shapes perceptions of HIV risk.
Participants’ sense of ethnic identity proved to be a dominant sphere of influence on their perceptions about several different health risks in their lives, only one of which was AIDS. Many of the participants’ descriptions of Puerto Rican culture and identity were embedded in racist stereotypes and negative generalities about Puerto Ricans. It is not entirely clear why the teens seemed prone to express their beliefs about Puerto Rican ethnicity through stereotypes. Possibly, the teens internalize these stereotypes as they increasingly acculturate to mainland U.S. society. This is not to say that these teens fully accepted or identified with these stereotypes. Also, the fact that I was an Anglo researcher and not Puerto Rican possibly made the participants feel they should tell me what they thought I expected to hear, although this may have occurred even if I was Puerto Rican. Perhaps they thought I agreed with prevailing stereotypes about Puerto Ricans, and spoke disparagingly about them accordingly. Or, they may not have been comfortable expressing their beliefs about Puerto Ricans and the dynamic between Anglos and Puerto Ricans in Hartford. Nonetheless, many of them openly attributed the poverty in Hartford’s Puerto Rican community to the relationship between the Puerto Rican and Anglo communities. They had numerous insights into the complexity of the problems facing Puerto Ricans living on the mainland. Despite this awareness, stereotypes about Puerto Ricans seem to strongly influence the way these teens thought about themselves and their community. Taking all the above possibilities into account, it is difficult to draw definitive conclusions, without further research, about whether the teens often linked Puerto Rican ethnicity
to issues such as violence, drug use, teen pregnancy and abuse of welfare because they actually believe these are likely issues confronting Puerto Ricans, or because they are not able to express their beliefs about ethnicity without resorting to existing stereotypes about Puerto Ricans.

Teens' perceptions of what it means to be Puerto Rican, and what non-Puerto Ricans think about Puerto Ricans are issues essential to this dissertation, because these beliefs had a large impact on the way the teens ranked AIDS on a continuum of health risks in their lives. AIDS was perceived as a threat to the community, but it was not perceived as being as large a threat as violence. In addition, some teens stated that competing health concerns such as poverty, unemployment, drug use, and teen pregnancy were of equal or greater concern than AIDS to them. In a few instances, participants stated that they were more concerned about personal matters, such as their school work, their relationships, or their sense of self-worth than they were concerned about AIDS.

There are several probable reasons why violence was consistently raised as both an individual and community concern. On a macro level, the teens' perception of violence as a more preoccupying problem than HIV/AIDS reflects Hartford's Puerto Rican community norms about exactly which conditions or activities constitute risk (Douglas and Wildavsky 1982; McDaniels and Gregory 1991). If the teens' perceptions are viewed as reflecting community standards of risk, Hartford's Puerto
Rican community is less concerned about the problem of AIDS than they are about the problem of violence. As described in Chapter VII, at the time of the interviews, gang violence was a serious and well-publicized problem in Hartford. It is then not surprising that community identification of risk, and consequently teens’ perception of risk, are more focused on violence than on HIV/AIDS. Given the existence of their deep concern about violence, it is important to examine exactly how the teens calculated and articulated their concerns about AIDS within the context of their constant preoccupation with violence. These findings are important to AIDS intervention programs for inner-city teens who contend with violence on a daily basis.

The perception of violence as a greater problem than AIDS also provides information about institutionalized social hierarchies and power differentials in Hartford (Douglas and Wildavsky 1982; Nelkin 1989). Whether or not they actually agree with racial stereotypes about Puerto Ricans being more prone to violence and gang activity, the teens use these caricatures to voice their perceptions about the magnitude of the problem of violence in the Puerto Rican community. The teens’ use of these stereotypes to describe violence as a risk eclipsing AIDS reflects their internalization, on some level, of some of these stereotypes (Singer 1995).

Due in part to the existence of racial stereotypes of Puerto Rican gangsters and drug dealers, coupled with the teens’ understandable preoccupation with violence, images of violent Puerto Ricans were much more familiar to the teens than images of a
Puerto Rican person living with HIV. Overwhelmed by the pressing problem of violence, and able to easily voice their concerns about violence through prevalent stereotypes, the teens did not perceive or articulate HIV/AIDS as the largest community problem. Further contributing to this issue is the fact that Puerto Ricans who are HIV infected often have a shorter life span than Anglos and African-Americans who have HIV (Friedman et al. 1987). Thus, there may be fewer Puerto Ricans living with HIV for long periods of time to begin with, and even fewer who are willing to be public spokespersons about it.

The issue of familiarity with people living with HIV/AIDS is a complex one. Intensive Interview and AIDS Acquaintance Interview participants were more familiar with HIV/AIDS than AIDS/Violence Survey participants. As stated in Chapter V, the majority of Intensive Interview participants reported knowing someone with HIV, and some recalled knowing multiple friends or relatives who were infected with HIV. Data were presented in Section 4 of Chapter VI, and in other Hartford-based research (Horowitz et al. 1996; Trotter et al. unpublished data) supporting the idea that Hartford Puerto Ricans are familiar with HIV. In contrast to the AIDS/Violence Survey participants, Intensive Interview participants seemed less likely to perceive AIDS as an abstract possibility. On the whole, Intensive Interview participants believed that violence, and not HIV, was more immediately and inevitably linked to death. AIDS/Violence Survey participants thought that AIDS more than violence, resulted in extended suffering.
AIDS/Violence Survey participants' beliefs about AIDS can partially be explained by the fact that street violence is inherently much more public and visible, than the often private despair and suffering engendered by AIDS. Ironically, the AIDS/Violence Survey participants' unfamiliarity with AIDS, relative to violence, has seemingly resulted in a sense of dread about the abstract possibility of HIV infection, which when conceptualized in this context, looms larger than their fear of violence. Still, the reasons for the discrepancies between the AIDS/Violence Survey participants' fear of AIDS more than violence on a daily basis, on the one hand, and their preoccupation with violence on the other, are not entirely clear. More research, focused specifically on this question, and based on a larger sample size, will be necessary to fully address this issue.
"THE CULTURAL CONTEXT OF AIDS RISK PERCEPTION AMONG PUERTO RICAN ADOLESCENTS"

PARTICIPANT INFORMATION SHEET

This project is examining Puerto Rican teenagers' beliefs about AIDS. You will be asked to participate in a (key informant, focus group, intensive) interview. This study is entirely voluntary, and your responses and identity will be kept entirely confidential. An identification number will be used in any written transcripts of the interview, rather than your own name.

Because you are legally underage, your parent or guardian will also have to provide consent for your participation in this study.

You will not be exposed to any risks by participating in this study.

This research has been approved by the Human Subjects Committee at Case Western Reserve University.

Thank you for your cooperation. If you have any questions, you may contact Delia Easton at the Hispanic Health Council, 527-0856.
Appendix 2

"THE CULTURAL CONTEXT OF AIDS RISK PERCEPTION AMONG PUERTO RICAN ADOLESCENTS"

CONSENT FOR PARTICIPATION IN AN INTENSIVE INTERVIEW (PHASE II)

I understand that this study is exploring how teenagers think about AIDS. Participation in this study is entirely voluntary. My participation will involve taking part in a two hour interview.

I understand that the interview session will be tape-recorded, and my responses will be entirely confidential. Because I am a minor, my parent or guardian must also sign a separate consent form. However, my parent or guardian will not have access to the recording or transcription of the interview to protect my confidentiality.

I understand that this study involves no physical risk, and has been approved by the Human Subjects Review Board at Case Western Reserve University in Cleveland, Ohio.

I understand that I will be compensated for my time with $5.00.

I can withdraw from the study at any time.

I can refuse to answer any questions.

If I have any questions about this study, I can contact Delia Easton at the Hispanic Health Council, 527-0856.

__________________________________________
SIGNATURE

__________________________________________
DELIA EASTON
Appendix 3

PARENTAL CONSENT FORM FOR PARTICIPATION IN INTENSIVE INTERVIEW STUDY (PHASE II)

I understand that this study is exploring how teenagers think about AIDS. Participation in this study is entirely voluntary, and if I do not want my son or daughter to participate this will not in any way affect his or her involvement with activities related to the Hispanic Health Council. My child’s participation will involve taking part in a two-hour interview.

I understand that I am being asked to provide consent for my child’s participation in this study because he or she is a minor.

I understand that although the interviews will be recorded and transcribed, I will not be able to hear or read my child’s responses, to protect his or her confidentiality. I will be able to read a final report of the study, if I am interested.

I understand that this study involves no physical risk to my child, and has been approved by the Human Subjects Review Board at Case Western Reserve University in Cleveland, Ohio.

I understand that my child will be compensated for his or her time with $5.00.

I can withdraw my child from the study at any time.

My child can refuse to answer any questions.

If I have any questions about this study, I can contact Delia Easton at the Hispanic Health Council. 527-0856.

_________________________________
SIGNATURE

_________________________________
DELIA EASTON
Entiendo que el propósito de este estudio es el de explorar lo que los adolescentes piensan sobre el SIDA. La participación en este estudio es totalmente voluntaria, y si yo no quiero que mi hijo/a participe, esto de ninguna forma afectará su participación relacionadas con el Concilio Hispano de la Salud. La participación de mi hijo/a consistirá en tomar parte en una entrevista individual corta.

Entiendo que se me pide dar mi autorización para que mi hijo/a participe ya que él/ella es menor de edad.

Entiendo que aunque las entrevistas serán grabadas y transcritas, yo no podré oír o leer las respuestas de mi hijo/a para así proteger su derecho a la confidencialidad. Si estoy interesado/a podré leer el informe final del estudio.

Entiendo que este estudio no conlleva ningún riesgo físico para mi hijo/a, y que ha sido aprobado por el Human Subjects Review Board de la Universidad Case Western en Cleveland, Ohio.

Entiendo que para compensar a mi hijo/a puede dejar participar en el estudio en cualquier momento que lo desee.

Entiendo que mi hijo/a puede dejarme de participar en el estudio en cualquier momento que lo desee.

Entiendo que mi hijo/a puede rehusarse a contestar preguntas que no considere apropiadas.

Si tengo preguntas acerca de este estudio puede ponerme en contacto con Delia Easton en el Concilio Hispano de la Salud, teléfono 527-0856.

FIRMA

DELIA EASTON
Appendix 5
KEY INFORMANT INTERVIEW FOR STAFF

1. What is your job here at the Hispanic Health Council? (Probe for details of what the job is.)

2. Why do the majority of teens you see come to the Hispanic Health Council?

3. Describe the economic characteristics of the neighborhood the Hispanic Health Council serves, in general.

4. What other organizations serve this population?

5. What are some of the worries that these kids have in their lives, in your opinion?

6. What do you think are the five greatest concerns in the community served by the Hispanic Health Council (Probe). Besides these five, are there any other concerns?

7. What do you think are the five greatest concerns of the teens who attend the Hispanic Health Council?

8. Does the Hispanic Health Council have any programs focused on AIDS? Please describe these programs.

9. Do the teens request information about AIDS? Is there any AIDS education program that HHC clients must receive as a condition for participating in HHC programs?

10. Do you think that AIDS is considered a major concern within this community? Do the teens at the Hispanic Health Council consider AIDS a major concern?

11. Are many of your clients at risk of AIDS, to your knowledge? If yes, why do you think they are at risk?

12. Do the teens talk about HIV risk? What do they say about AIDS and their own risk of getting it? How does this affect the nature and content of the Hispanic Health Council’s AIDS education programs?

13. Research shows that several things may influence how someone thinks about AIDS. I’d like to discuss with you how you think these factors influence the teens attending programs here.

   a) How do you think exposure to AIDS education affects how teens think about AIDS?

   b) Do many of your clients know someone affected by AIDS? Has this influenced their beliefs or behavior relating to AIDS?

   c) Are there any patterns or differences between how girls and boys think about AIDS? What are the differences? Similarities?

   d) Do you think an individual’s ethnic background influences his or her ideas about AIDS? If so, how? How do you think being Puerto Rican would influence ideas about AIDS?
e) Do you see any differences in beliefs about AIDS between your older and younger clients?

f) Do you think the teens whose families have been in the U.S. (mainland) for longer amounts of time have different beliefs about AIDS than teens from families living in the U.S. only a short time?

g) How much do teens’ religious beliefs affect their ideas about AIDS?
Appendix 6

FOCUS GROUP DISCUSSIONS

Prior to the focus group interviews, a brief questionnaire will be distributed. While I read these over, the teens will be offered refreshments. The direction of the focus group discussions will be determined by the teens' response to these questionnaires. Before beginning the focus group I will explain to the teens why I am interested in talking with them.

1. The teens will be asked to talk about why they ranked AIDS as they did, and why they have ranked other concerns as more important than AIDS, if they have.
   Sample probes: (a) I see that a lot of you have written that unemployment is a big concern. Why are you worried about unemployment?
   (b) This group is split in terms of how much of a risk or worry AIDS is. Some of you think of it as a major concern but others of you do not. Why did you rank AIDS as you did? [Probe will seek to find similarities among those rating AIDS as a concern, e.g. knowing someone with AIDS) and amongst those who do not see AIDS as a threat.]

2. Based on how the teens answer the pre-focus group questionnaire, I will explore different cultural domains.
   Sample probes: (a) Some of you think that women should initiate condom use. (To males:) If your girlfriends suggested that you use a condom during sex would you agree to? Why or why not? What would your male friends think if a girlfriend asked them to use condom? (To females:) Would you feel comfortable asking your boyfriend to use a condom during sex? Do you think your female friends feel comfortable asking their boyfriends to use condoms? Why or why not?
   (b) It seems a few of you think that a Puerto Rican living in Hartford for a longer period of time would be more at risk for AIDS? Why do you think this?
   (c) Some of you say a religious person is less likely to get AIDS than a less religious person. Why do you think this is? What is it about being a religious person that reduces risk?

3. I notice that many of you have ranked some of the items as greater worries to you personally than to the community as a whole (or more important to the community than to you personally). Why is this? (Probe about why specific items are more of a problem to them than the community or vice versa.)

4. If you needed financial or emotional support, would you first turn to your family or your friends, why?

5. Do you think it is the role of the man or a woman in a household to support the family emotionally and to make important decisions? Do you think these roles can be shared?

6. Do you think it's OK for a heterosexual couple to have sex without being married? Do your beliefs about this issue differ from your family's? Your friends?

7. Do you think that it is acceptable for two men or two women to have a homosexual relationship? What does your religion say about this? What has your family taught you?

8. Do you attend Puerto Rican festivals? Is it more important to you to remember your heritage, or would you rather become more "Americanized?" Why? How important is your Puerto Rican heritage to the rest of your family?

9. Were you raised in a religious family? Do you still identify with these religious beliefs? Give some
concrete examples of how religion influences your ideas.
Appendix 7
PRE-FOCUS GROUP QUESTIONNAIRE

Instructions: For each of the following questions, write your response beneath the question, or for questions with a selection of responses, circle the one you think is true.

1) Age: 
2) Sex  a. Male  b. Female

3) Where were you born?

4) How long have you lived in Hartford (years)?

5) Years of schooling completed: 
   a) grade school/elementary school
   b) junior high/middle school
   c) some high school
   d) graduated high school

6) Marital status: 
   a) single
   b) married
   c) divorced/separated

7) Number of children, if any?

8) Are you employed? 
   a) yes, full-time
   b) yes, part-time
   c) no, not employed

9) If employed, what is your job?

10) What is your religion? 
    a) Catholic
    b) Protestant
    c) Lutheran
    d) Episcopalian
    e) Jewish
    f) Muslim
    g) Other

11) Are you more likely to speak Spanish at home than at school? 
    a) yes
    b) no

12) Are you more likely to speak Spanish: 
    a) with friends
    b) with family
    c) never
13) Are you currently sexually active?
   a) yes
   b) no

14) How many sexual partners do you currently have?

15) How many sexual partners have you had in the last year?

16) How often do you have sex?
   a) once a week or more
   b) less than once a week
   c) a few times a month
   d) a few times a year
   e) not sexually active

17) What kind of sex do you have?
   a) heterosexual sex (sex with opposite sex)
   b) homosexual sex (sex with the same sex)
   c) bisexual (sex with both the same and opposite sexes)

18) How often do you use condoms during sex?
   a) always
   b) frequently
   c) sometimes
   d) never

19) Whose responsibility is it to decide whether or not to use condoms in a heterosexual relationship?
   a) the man
   b) the woman
   c) both
   d) neither
   e) don’t know

20) Of the following items rate the five that worry you the most:
   unemployment
   poverty
   drug use
   violence
   discrimination
   AIDS
   alcoholism

21) Which of the items you listed do you think are the greatest worries in your community?

22) What kinds of risks to your health or safety exist in your everyday life?

23) Do a lot of people in your community worry about AIDS?
   a) yes
   b) no
   c) don’t know
24) Do a lot of people have AIDS in the community?
   1) yes
   2) no
   3) don't know

25) Do you think Puerto Rican families who have been in the U.S. for longer periods of time have
different beliefs about AIDS than Puerto Rican families who have been in the U.S. for shorter periods
of time?
   a) yes
   b) no
   c) don't know

26. Do you think very religious people have different beliefs about whether they will get AIDS than
less religious people?
   a) yes
   b) no
   c) don't know
Appendix 8
AIDS KNOWLEDGE QUESTIONNAIRE

All participants will be asked to complete this questionnaire prior to the key informant interviews, the focus group interviews, and the intensive interviews.

For each statement circle the answer you think is correct.

1) Have you heard about the AIDS virus called HIV?
   a) yes
   b) no
   c) don’t know

2) How much would you say you know about AIDS?
   a) a lot
   b) some
   c) a little
   d) nothing
   e) don’t know

For the following questions please show whether you think the question is definitely true, probably true, definitely false, or you don’t know. Circle your answer.

3) AIDS is an infectious disease caused by a virus.
   a) definitely true
   b) probably true
   c) probably false
   d) definitely false
   e) don’t know

4) A person can be infected with the AIDS virus and not have the disease AIDS.
   a) definitely true
   b) probably true
   c) probably false
   d) definitely false
   e) don’t know

5) Any person with the AIDS virus can pass it on to someone else through sexual intercourse.
   a) definitely true
   b) probably true
   c) probably false
   d) definitely false
   e) don’t know

6) A pregnant woman who has the AIDS virus can give it to her baby.
   a) definitely true
   b) probably true

---

1 Adapted from a National Health Survey examining Hispanic knowledge of HIV/AIDS. This survey is a continuous, cross-sectional survey.
c) probably false
d) definitely false
e) don’t know

7) There are drugs available to treat the AIDS virus which can lengthen the life of an infected person.
   a) definitely true
   b) probably true
   c) probably false
   d) definitely false
   e) don’t know

8) There is no cure for AIDS at present
   a) definitely true
   b) probably true
   c) probably false
   d) definitely false
   e) don’t know

For the following statement show whether you think that the question is very likely, somewhat unlikely, very unlikely, definitely not possible, or whether you don’t know. Circle your answer.

9) How likely is it that someone will get AIDS from sharing forks, plates, or glasses with someone who has the AIDS virus?
   a) very likely
   b) somewhat unlikely
   c) very unlikely
   d) definitely not possible
   e) don’t know

10) How likely is it that someone will get AIDS from sharing needles for drugs with someone who has the AIDS virus?
    a) very likely
    b) somewhat unlikely
    c) very unlikely
    d) definitely not possible
    e) don’t know

11) How likely is it that someone will get AIDS from mosquitos or other insects?
    a) very likely
    b) somewhat unlikely
    c) very unlikely
    d) definitely not possible
    e) don’t know

For each statement below circle the answer you think is correct.

12) Have you ever heard of the blood test which can detect HIV infection?
    a) yes
    b) no
    c) don’t know
13) Have you ever had your blood tested for HIV infection?
   a) yes
   b) no
   c) don’t know

14) How effective do you think the use of a condom is to prevent getting the AIDS virus through sexual activity?
   a) very effective
   b) somewhat effective
   c) not at all effective
   d) don’t know how effective
   e) don’t know what a condom is

15) What are your chances of having the AIDS virus?
   a) high
   b) medium
   c) low
   d) none
   e) don’t know
   f) not applicable because I already have the virus

16) Have you ever personally known anyone with the AIDS virus?
   a) yes
   b) no
   c) don’t know
Appendix 9
INTENSIVE INTERVIEW (version 2: 1/18/96)

Instructions: For each of the following questions, write your response beneath the question, or for questions with a selection of responses, circle the one you think is true.

DEMOGRAPHICS

1) Age:  
2) Sex:  a) Male   b) Female

3) Where were you born?

4) How long have you lived in Hartford (years)?

5) Years of schooling completed
   a) grade school/elementary
   b) junior high/middle school
   c) some high school
   d) graduated high school

6) Marital status:
   a) single
   b) married
   c) divorced/separated

7) Number of children, if any:

8) Are you employed?
   a) yes, full-time
   b) yes, part-time
   c) no, not employed

9) If you are working, what job do you have?

10) What is your religious background?
    a) Catholic
    b) Protestant
    c) Lutheran
    d) Episcopalian
    e) Jewish
    f) Muslim
    g) Other  If so, what ________________________

11) Do you still observe religious practices, or go to church?
    a) yes
    b) no

12) Where are you most likely to speak Spanish?
    a) at home
    b) at school
    c) speak Spanish equally in both places
13) Who are you most likely to speak Spanish to?
   a) friends
   b) family
   c) speak Spanish with both friends and family

14) Are you currently sexually active?
   a) yes
   b) no

15) How many sexual partners do you currently have?

16) How many sexual partners did you have in the last year?

17) How often do you have sex?
   a) once a week or more
   b) less than once a week
   c) a few times a month
   d) a few times a year
   e) not sexually active

18) What kind of sex do you have?
   a) heterosexual (sex with the opposite sex)
   b) homosexual (sex with the same sex)
   c) bisexual (sex with both the same and opposite sexes)

19) How often do you use a condom during sex?
   a) always
   b) frequently
   c) sometimes
   d) never

20) Do you use alcohol or drugs?
   a) yes
   b) no

21) If so, what do you use?
   a) alcohol
   b) marijuana (weed, pot)
   c) crack or cocaine
   d) heroin

STOP HERE

AIDS

22) When did you first hear about AIDS? How did you learn about AIDS? Do you and your friends ever talk about AIDS? If yes, what do you talk about? Do you and your family ever talk about AIDS? If yes, what do you talk about?

23) How worried are you about AIDS? On a scale of 1 to 10, with 1 being not worried at all and 10
being very worried, how worried are you about AIDS? What do you think are your chances of getting HIV? Why do you feel this way? What do you think puts you at risk of getting AIDS? Are any of your friends at risk? Why or why not? Do you know anyone who has HIV?

24) Who do you think is likeliest to get AIDS? Do you think men or women are more likely to get AIDS? Why? In a heterosexual relationship, do you think the man or the woman is responsible for protecting against AIDS? Why?

25) If someone in your family had AIDS, how would you feel? (If partic. knows someone with AIDS, talk about their experience.) Would you provide them material or financial support? What if one of your friends had AIDS?

GENDER ROLES/DYNAMICS

26) In your relationships (if applicable) do you use condoms? Do you and your boyfriend/girlfriend talk about using condoms? Do you talk about AIDS? If you don't use condoms, why not? What are some of the problems with using condoms? Whose responsibility is it to buy condoms? To use condoms?

27) Whose responsibility is it to support the family financially? If both the man and a woman in a family situation work, whose responsibility is it to do housework?

28) Who is currently living in your household (list people). What is each individual's responsibility in the household? Who makes the decisions in your household? (Probe in terms of household responsibilities and power dynamics).

RISKS/CONCERNS/WORRIES

29) Rate the five most serious concerns in your life, from most to least upsetting.

30) Rate the five most serious concerns in the Puerto Rican community (even if they don't affect you personally).

31) Talk about violence in the P.R. community. Talk about AIDS in the P.R. community. Which is a bigger problem, do you think? Why?

EMPLOYMENT/EDUCATION

32) (If participant has job:) Are you satisfied with your job? (Probe in terms of type of work, salary.) How long did it take you to find a job? Describe your experiences. (If participant does not have a job:) Are you looking for a job now? Why or why not? What kind of work are you looking for? What kind of barriers are there to you getting a job? Do you feel you have ever been discriminated against because you are Puerto Rican? Have any of your friends?

33) What do you see yourself doing five years from now? Where do you hope to be living?

34) Do you plan to go to college? Why or why not? Has anyone else in your family gone to college? Do many of your friends plan to go to college?

35) Do you have relatives working in Puerto Rico? If so, where do they work? What kinds of jobs do they have there? Do you think job opportunities for Puerto Ricans are better here or in Puerto Rico?
RELIGION

36) Are/is your parents/mother/father religious? What do they do that makes you think so? How religious are you in comparison to your parents?

37) How do your religious beliefs (if applicable) affect the way you think about sex? About AIDS? Do you think it is acceptable for people to have sex before marriage? How do your church feel about this issue? How does your family feel? Your friends? Does your church have a position on why people get AIDS, and how to treat people infected with HIV?

ETHNICITY

38) Have you ever lived in Puerto Rico? Which do you prefer, living here in Hartford, or in Puerto Rico, and why? How close is the Puerto Rican community here in Hartford? Do you go to Puerto Rican festivals? Is it important to you to remember your Puerto Rican heritage, or to become more "Americanized?" Do you visit Puerto Rico often? Why?

39) How important is speaking Spanish to you? Where do you speak Spanish most often?

40) Will you teach your children (if you have any in the future) Spanish? Will you want them to visit Puerto Rico? Why? Will you pass Puerto Rican cultural customs and values on to them? Which ones?

41) Because of their cultural beliefs, do you think Puerto Rican families are different from other families in terms of how they think about AIDS?

42) Have you ever experienced racism or discrimination? Has anyone you know? Please talk about it.

43) (Ask if they know what a stereotype is.) Ask what some stereotypes of Puerto Ricans are.

44) What is the ethnic background of your friends? Do you date other Puerto Ricans, or do you date people from different ethnic backgrounds? Why? What ideal characteristics are you looking for in someone you date? Are you looking for anything different in someone you marry?

FAMILY

45) Describe your family life. Do you consider your family to be more or less traditional (in terms of observing Puerto Rican beliefs and practices) than other Puerto Rican families? How important is your Puerto Rican background to your family? What makes you think this?

46) Do you feel that you have obligations to your family? What kind of obligations? Do you feel more loyal to friends or to your family? What kind of obligations? To whom would you go to for support or advice about financial matters? About an issue of discrimination? About a religious issue? About relationships/sex?

SEXUALITY

47) How would your parents feel if they knew you were sexually active (if applicable)? Do you think their attitudes are similar or different to other people in your community? (Probe about relatives, friends, teachers, religious officials)
48) Are most of your friends sexually active? Who is more sexually active, your male or female friends? What do people in your community think about girls who are sexually active? What do you think? What do people in your community think about boys who are sexually active? What do you think?

49) (To females:) Do you have a sexually exclusive relationship with your boyfriend? Do you think he’s faithful to you? What makes you think so? Are you faithful to him? Are your other female friends involved in monogamous relationships?

(To males:) Do you have a sexually exclusive relationship with your girlfriend? Are you faithful to her? Do you think she’s faithful to you? What makes you think so? Are your other male friends involved in monogamous relationships?

(To both:) Do you think boys or girls are more likely to be sexually faithful? Why?
Appendix 10
AIDS/VIOLANCE SURVEY (version 5: 3/5/96)

Participant #
Date
Gender
Age
Place of Birth
Years lived locally
Sexually Active
Preferred language

1) What kind of violence (e.g., robberies, gang warfare, gang beat-downs, muggings, rape, shootings, etc.) occurs in your neighborhood?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

2) If there is violence in your neighborhood, please describe what type of violence you see most often.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

3a) Have you or anyone you’ve known ever been a victim of violence?

________________________________________________________________________

b) If so, what happened? (If more than one incident, describe all.)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

c) Have you ever witnessed violence? (If more than one incident, describe all.)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
272

d) Are you afraid you'll be a victim of violence?

4a) Do you know anyone who has been infected with HIV or who has AIDS?

b) How serious a concern is violence to you?

c) How big a problem is it in your neighborhood?

5a) What are your worries on a daily basis?

b) (If AIDS or violence is mentioned) What are you more afraid of on a daily basis, violence or AIDS? Explain why.

6a) During the next year, do you think you are more at risk of contracting HIV, or of being affected by violence?

b) On a scale of 1 to 10, with 1 being little risk and 10 being high risk, how much risk are you at for getting HIV?

c) On a scale of 1 to 10 with 1 being little risk and 10 being high risk, how much risk are you at for being affected by violence?
7a) At what age do you think people are most likely to contract HIV? At what age are they most likely to be affected by violence? Please explain why you think AIDS/violence is likely to occur at the age you’ve stated.

b) Do you think teens are more likely to be affected by violence than adults? Why?

c) Do you think teens are more likely to be affected by AIDS than adults? Why?

d) Do you think Puerto Rican teens in Hartford are more likely to be affected by AIDS than other ethnic groups? Why?

e) Do you think Puerto Rican teens in Hartford are more likely to be affected by violence than other ethnic groups? Why?

8a) What kinds of things do you do to protect yourself from violence?

b) What do you do to protect yourself from AIDS?

9) In the Puerto Rican community, do you think more people die or suffer from AIDS or from violence?
Appendix 11
AIDS ACQUAINTANCE INTERVIEW

Prior to interview, administer AIDS/Knowledge Survey

Date:

Participant ID Number:

Section I. Demographics

1. Age:

2. Sex:
   a. male
   b. female

3. Where were you born?
   a. Hartford
   b. Puerto Rico
   c. Other (where?)

4. How long have you lived in this area (in years?)

5. Last grade of education completed:

6. Are you still in school?
   a. yes
   b. no

7. Are you employed?
   a. yes, full-time
   b. yes, part-time
   c. no, not employed

8. If employed, what job do you have?

9. What is your religion:

10. Do you attend church regularly?
    a. At least once a week
    b. At least once a month
    c. At least once every 2-3 months
    d. A few times a year
    e. Never

11. Do you believe in God?
    a. Yes
    b. No
12. If you believe in God, how does this belief affect your life?

13. Do you prefer to speak Spanish, or English, or are you comfortable with both?
   a. Spanish
   b. English
   c. Both

14. When you are with your friends, do you prefer to speak Spanish or English?

15. At home with your family, do you prefer speaking Spanish or English?

16. If you have children later, will you teach them Spanish? Why?

17. How important is your identity as a Puerto Rican to you? (In terms of how much you continue to practice Puerto Rican customs and observe Puerto Rican rituals.)
   a. Very important
   b. Somewhat important
   c. Not very important
   d. Not at all important

18. Have you had sex in the last 30 days?
   a. Yes
   b. No

19. If yes, how many sexual partners have you had in the last 30 days?

20. Do you have sexual (vaginal) intercourse?

21. If so, how often do you use condoms?
   a. Always
   b. Frequently
   c. Sometimes
   d. Never

22. Do you have oral sex?
   a. Yes
   b. No

23. If so, how often do you use a dental dam/barrier protection?
   a. Always
   b. Frequently
   c. Sometimes
   d. Never

24. Do you have anal sex?
   a. Yes
   b. No

25. If so, how often do you use condoms?
   a. Always
   b. Frequently
   c. Sometimes
26. How often do you have any kind of sex?
   a. At least once a week or more
   b. A few times a month
   c. A few times a year
   d. Not sexually active

27. Have you ever used alcohol?
   a. Yes
   b. No

28. If so, how often do you use it?
   a. At least once a week or more
   b. A few times a month
   c. A few times a year
   d. Don't use alcohol

29. Have you used any type of drugs? (e.g. marijuana, heroin, cocaine, crack, etc.: have participant list)

30. If so, how often do you use _______?
   a. Once a week or more
   b. Less than once a week
   c. A few times a month
   d. A few times a year
   e. Don't use any drugs

**Section II. Attitudes and Perceptions (Tape recorded)**

31. What are your thoughts and feelings about people with AIDS?

32. How worried are you about AIDS?

33. On a scale of 1 to 10, with “1” being the least and “10” being the most, how would you scale your worry about AIDS?

34. Would you say you have no chance, a small chance, a medium chance, or a high chance of contracting HIV?

35. If you’re in a relationship, and having sex, do you use condoms on a regular basis? Why or why not? Who raised the issue of condoms in your relationship? How was it raised?

36. Talk about the person you know who has HIV. (Probes: How long have you known this person? How did you find out that they have HIV? How has having HIV/AIDS affected them, and you?)

37. Do you think people who know someone with HIV/AIDS are more frightened of AIDS, or not? Why?

38. Do you think people who know someone with HIV/AIDS take more precautions against getting HIV than people who don’t? Why or why not?

39. How has knowing this person with HIV changed the ideas you had about AIDS before knowing...
this person?

40. In general, what do you think people learn about AIDS from someone infected by it?
Appendix 12

INTENSIVE INTERVIEW CODES AND LABELS:

1. ACQAIDS - descriptions of acquaintances with AIDS
2. ACQRISK - acquaintances at risk for HIV infection
3. ADVICE - who the participant goes to for advice
4. AIDSLEAR - where and how the participant learned about AIDS
5. AIDSPART - references to conversations about AIDS with partner
6. AIDSRISK - discussion of risky activities
7. AIDSTALK - talk about AIDS between participant and friends
8. AIDSTRAN - beliefs about how AIDS is transmitted
9. AIDSTEST - beliefs and experiences about AIDS test
10. AIDSVIO - comparisons between the impact of AIDS versus that of violence
11. ATRISK - participants' theories about people at risk for HIV
12. BOYSEX - community attitudes about sexually active boys
13. CASUAL - perceptions about casual transmission
14. CHANCE - participants' self-assessments about their chances of being infected with HIV
15. CLEAN - references to clean sex partners
16. CONDOMS - references to condom use
17. CONDPOL - descriptions of the politics of condom use
18. CONDPERS - problems with condom use
19. CONDUSE - references to friends' condom use
20. CULTAIDS - beliefs about how culture influences AIDS beliefs
21. CULTDIFF - cultural differences in AIDS beliefs
22. DENIAL - participants' discussion of denial of risk
23. DETRISK - how potential risk of HIV infection from a sex partner is determined
24. DIVORCE - discussions of divorce
25. DOUBSTD - discussions of sexual double standard
26. DRUGADD - references to drug addicts
27. ETHNICID - discussions about ethnic identity
28. FAMAIDS - response if participant's family member had HIV
29. FAMDECIS - references to family decision maker
30. FAMDY - discussions alluding to family dynamics
31. FAMFIN - beliefs about who should be the family breadwinner
32. FAMOB - perceived obligations to the family
33. FAMTALK - references to AIDS talks with family members
34. FATALISM - references to fatalism
35. FIDELITY - participant notions of fidelity
36. FINDJOB - experiences finding a job
37. FRIENAIM - reaction if friend was HIV positive
38. FRIENED - friends' plans to pursue higher education
39. FRIENETH - friends' ethnicity
40. FUTFAM - descriptions of future family
41. FUTFEAR - participant's fears about the future
42. FUTGOALS - participant's future goals
43. GANGL - references to gangs
44. GENAIDS - belief about which gender more susceptible to AIDS
45. GENDER - participants' notions of gender roles
46. GENSEX - beliefs about which gender is more sexually active
47. GIRLSEX - community attitudes about sexually active girls
48. HEARD - where and when participant first heard about AIDS
49. HIGHED - participant plans to pursue higher education
50. HOMOSEX - participant's belief and attitudes about homosexuality
51. HOUSE - description of who lives in participant's house
52. INTRAETH - references to intraethnic diversity
53. INVULNER - references to teen invulnerability
54. JOB - discussions about jobs
55. JOBSPR - descriptions of relatives jobs in Puerto Rico
56. KIDSLANG - which languages participant plans to teach future children
57. LANGBAR - references to language barrier
58. LANGPREF - what language is preferred
59. LOYALTY - whether participant is more loyal to family or friends
60. MARIJUANA - references to marijuana
61. MARRQUAL - desirable qualities preferred in marriage partner
62. MONOGRAM - discussions about participant's sexual fidelity
63. NOPRJOB - job availability in Puerto Rico
64. PARTETH - partner's ethnicity
65. PARTQUAL - desirable qualities in a partner
66. PERCONS - participant's concerns about self
67. PLAYERS - references to noncommittal sex partners
68. POLITICS - discussions about politics
69. PR/HART - preferences for living in PR or Hartford
70. PRCLOSE - beliefs about cohesiveness of Puerto Rican community
71. PRCOMM - perceptions of problems Puerto Rican community faces
72. PREMAR - attitudes toward premarital sex
73. PRFEST - discussions about Puerto Rican festivals
74. PRHERI - importance of Puerto Rican heritage
75. PROSTIT - references to prostitutes
76. PRPOV - discussions about poverty among Puerto Ricans
77. PRTRAD - descriptions of Puerto Rican cultural traditions
78. PRTRAIT - cultural traits thought to be Puerto Rican
79. PRVALUES - references to Puerto Rican cultural values
80. RACISM - references to racism and discrimination
81. RELATE - discussions about participant's relationship
82. RELIGAID - connection between religious beliefs and perceptions of HIV
83. RELIGPAR - religiosity of parents
84. RELIGSEL - participant's religiosity
85. RESPECT - references to respect
86. RETPR - discussions about trips back to Puerto Rico
87. ROLEFATH - role of participant's father
88. SELFCOND - participant's household responsibilities
89. STEREOT - references to stereotypes about Puerto Ricans
90. STDS - references to s.t.d.s
91. STIGMA - references to the stigma of HIV/AIDS
92. STREETS - description of life on the streets
93. SUICIDE - references to suicide
94. SWEET15 - description of the Sweet 15 ritual
95. TEENPREG - references to teen pregnancy
96. TREATTH - participant's theories about how to treat HIV
97. TRUST - references to trust
98. TYPFAM - participant's beliefs about family
99. VIOINC - violent incidents in participant's life
100. VIOLENCE - references to violence
101. VIOTHEO - theories about violence
102. WORAIDS - degree of concern participant has about AIDS
103. WORScale - participant's self-measure of concern about AIDS
<table>
<thead>
<tr>
<th>Code #</th>
<th>Age</th>
<th>Birthplace</th>
<th># of Kids</th>
<th>Religion</th>
<th>Sexually active now</th>
<th># Partners Now</th>
<th># Partners last year</th>
<th>Frequency of sex</th>
<th>Condom use</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>16</td>
<td>PR</td>
<td>0</td>
<td>Catholic</td>
<td>no</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2</td>
<td>17</td>
<td>PR</td>
<td>0</td>
<td>Catholic</td>
<td>yes</td>
<td>3</td>
<td>missing</td>
<td>few times a year</td>
<td>always</td>
</tr>
<tr>
<td>3</td>
<td>18</td>
<td>PR</td>
<td>0</td>
<td>Catholic</td>
<td>yes</td>
<td>1</td>
<td>1</td>
<td>few times a year</td>
<td>sometimes</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>16</td>
<td>Hartford</td>
<td>0</td>
<td>Catholic</td>
<td>no</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>9</td>
<td>17</td>
<td>Hartford</td>
<td>0</td>
<td>Catholic</td>
<td>no</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>17</td>
<td>Springfield, MA</td>
<td>0</td>
<td>Catholic</td>
<td>yes</td>
<td>0</td>
<td>2</td>
<td>once a week or more</td>
<td>sometimes</td>
</tr>
<tr>
<td>15</td>
<td>19</td>
<td>PR</td>
<td>0</td>
<td>Catholic</td>
<td>yes</td>
<td>0</td>
<td>1</td>
<td>once a week or more</td>
<td>never</td>
</tr>
<tr>
<td>16</td>
<td>15</td>
<td>PR</td>
<td>0</td>
<td>Pentecostal</td>
<td>yes</td>
<td>0</td>
<td>2</td>
<td>few times a month</td>
<td>sometimes</td>
</tr>
<tr>
<td>24</td>
<td>17</td>
<td>PR</td>
<td>0</td>
<td>Catholic</td>
<td>yes</td>
<td>1</td>
<td>1</td>
<td>few times a year</td>
<td>always</td>
</tr>
<tr>
<td>25</td>
<td>18</td>
<td>PR</td>
<td>0</td>
<td>Catholic</td>
<td>yes</td>
<td>5</td>
<td>8</td>
<td>&lt; once a week</td>
<td>frequently</td>
</tr>
<tr>
<td>26</td>
<td>14</td>
<td>PR</td>
<td>0</td>
<td>Catholic</td>
<td>yes</td>
<td>3</td>
<td>1</td>
<td>few times a year</td>
<td>always</td>
</tr>
<tr>
<td>28</td>
<td>18</td>
<td>PR</td>
<td>0</td>
<td>Pentecostal</td>
<td>yes</td>
<td>0</td>
<td>5</td>
<td>few times a month</td>
<td>always</td>
</tr>
<tr>
<td>29</td>
<td>15</td>
<td>Hartford</td>
<td>0</td>
<td>Catholic</td>
<td>no</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>31</td>
<td>16</td>
<td>Hartford</td>
<td>0</td>
<td>Catholic</td>
<td>yes</td>
<td>missing</td>
<td>missing</td>
<td>few times a month</td>
<td>always</td>
</tr>
<tr>
<td>Code #</td>
<td>Age</td>
<td>Birthplace</td>
<td># of Kids</td>
<td>Religion</td>
<td>Sexually active now</td>
<td># Partners Now</td>
<td># Partners last year</td>
<td>Frequency of sex</td>
<td>Condom use</td>
</tr>
<tr>
<td>--------</td>
<td>-----</td>
<td>------------</td>
<td>-----------</td>
<td>----------</td>
<td>---------------------</td>
<td>----------------</td>
<td>---------------------</td>
<td>-----------------</td>
<td>------------</td>
</tr>
<tr>
<td>40</td>
<td>18</td>
<td>Hartford</td>
<td>0</td>
<td>Catholic</td>
<td>yes</td>
<td>1</td>
<td>1</td>
<td>missing</td>
<td>always</td>
</tr>
<tr>
<td>Code #</td>
<td>Age</td>
<td>Birthplace</td>
<td># of Kids</td>
<td>Religion</td>
<td>Sexually active now</td>
<td># Partners Now</td>
<td># Partners last year</td>
<td>Frequency of sex</td>
<td>Condom use</td>
</tr>
<tr>
<td>--------</td>
<td>-----</td>
<td>------------</td>
<td>-----------</td>
<td>----------</td>
<td>---------------------</td>
<td>---------------</td>
<td>---------------------</td>
<td>-----------------</td>
<td>------------</td>
</tr>
<tr>
<td>4</td>
<td>16</td>
<td>PR</td>
<td>0</td>
<td>Catholic</td>
<td>yes</td>
<td>1</td>
<td>1</td>
<td>once a week or more</td>
<td>always</td>
</tr>
<tr>
<td>5</td>
<td>16</td>
<td>Hartford</td>
<td>0</td>
<td>Catholic</td>
<td>no</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>6</td>
<td>15</td>
<td>PR</td>
<td>0</td>
<td>Catholic</td>
<td>no</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>7</td>
<td>15</td>
<td>NYC</td>
<td>0</td>
<td>Catholic</td>
<td>yes</td>
<td>1</td>
<td>1</td>
<td>few times a year</td>
<td>never</td>
</tr>
<tr>
<td>10</td>
<td>15</td>
<td>Hartford</td>
<td>0</td>
<td>Catholic</td>
<td>yes</td>
<td>1</td>
<td>1</td>
<td>once a week or more</td>
<td>always</td>
</tr>
<tr>
<td>11</td>
<td>16</td>
<td>PR</td>
<td>0</td>
<td>Catholic</td>
<td>no</td>
<td>0</td>
<td>1</td>
<td>once a week or more</td>
<td>always</td>
</tr>
<tr>
<td>12</td>
<td>18</td>
<td>PR</td>
<td>0</td>
<td>Penta-costal</td>
<td>no</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>13</td>
<td>16</td>
<td>Hartford</td>
<td>0</td>
<td>Catholic</td>
<td>yes</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>17</td>
<td>17</td>
<td>Hartford</td>
<td>0</td>
<td>Penta-costal</td>
<td>yes</td>
<td>1</td>
<td>1</td>
<td>few times a month</td>
<td>never</td>
</tr>
<tr>
<td>18</td>
<td>16</td>
<td>PR</td>
<td>0</td>
<td>Catholic</td>
<td>yes</td>
<td>1</td>
<td>1</td>
<td>&lt; once a week</td>
<td>sometimes</td>
</tr>
<tr>
<td>19</td>
<td>16</td>
<td>PR</td>
<td>0</td>
<td>Penta-costal</td>
<td>yes</td>
<td>0</td>
<td>3</td>
<td>few times a month</td>
<td>sometimes</td>
</tr>
<tr>
<td>20</td>
<td>17</td>
<td>Springfield, MA</td>
<td>1</td>
<td>Penta-costal</td>
<td>yes</td>
<td>1</td>
<td>1</td>
<td>once a week or more</td>
<td>never</td>
</tr>
<tr>
<td>21</td>
<td>17</td>
<td>Hartford</td>
<td>0</td>
<td>Penta-costal</td>
<td>yes</td>
<td>1</td>
<td>1</td>
<td>missing</td>
<td>never</td>
</tr>
<tr>
<td>22</td>
<td>16</td>
<td>Springfield</td>
<td>0</td>
<td>Catholic</td>
<td>no</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>23</td>
<td>15</td>
<td>PR</td>
<td>0</td>
<td>Catholic</td>
<td>no</td>
<td>N/A</td>
<td>1</td>
<td>few times a year</td>
<td>N/A</td>
</tr>
<tr>
<td>Code #</td>
<td>Age</td>
<td>Birthplace</td>
<td># of Kids</td>
<td>Religion</td>
<td>Sexually active now</td>
<td># Partners Now</td>
<td># Partners last year</td>
<td>Frequency of sex</td>
<td>Condom use</td>
</tr>
<tr>
<td>--------</td>
<td>-----</td>
<td>------------</td>
<td>-----------</td>
<td>----------</td>
<td>-------------------</td>
<td>---------------</td>
<td>---------------------</td>
<td>-----------------</td>
<td>------------</td>
</tr>
<tr>
<td>27</td>
<td>14</td>
<td>Hartford</td>
<td>0</td>
<td>Catholic</td>
<td>yes</td>
<td>1</td>
<td>0</td>
<td>once a week or more</td>
<td>always</td>
</tr>
<tr>
<td>30</td>
<td>16</td>
<td>Hartford</td>
<td>0</td>
<td>Catholic</td>
<td>no</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>32</td>
<td>16</td>
<td>Hartford</td>
<td>0</td>
<td>Catholic</td>
<td>yes</td>
<td>3</td>
<td>2</td>
<td>once a week or more</td>
<td>always</td>
</tr>
<tr>
<td>33</td>
<td>16</td>
<td>NYC</td>
<td>0</td>
<td>Catholic</td>
<td>yes</td>
<td>1</td>
<td>1</td>
<td>few times a year</td>
<td>never</td>
</tr>
<tr>
<td>34</td>
<td>14</td>
<td>Hartford</td>
<td>0</td>
<td>Catholic</td>
<td>no</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>35</td>
<td>15</td>
<td>PR</td>
<td>0</td>
<td>Catholic</td>
<td>no</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>36</td>
<td>14</td>
<td>Hartford</td>
<td>0</td>
<td>Catholic</td>
<td>no</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>37</td>
<td>13</td>
<td>Hartford</td>
<td>0</td>
<td>Catholic</td>
<td>no</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>38</td>
<td>15</td>
<td>PR</td>
<td>0</td>
<td>Catholic</td>
<td>no</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>39</td>
<td>16</td>
<td>PR</td>
<td>0</td>
<td>Catholic</td>
<td>no</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>41</td>
<td>15</td>
<td>PR</td>
<td>0</td>
<td>Catholic</td>
<td>no</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>42</td>
<td>17</td>
<td>PR</td>
<td>0</td>
<td>Pentacostal</td>
<td>no</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Acosta-Belen, E. 1988


Aguirre-Molina, M. and R. Caetano 1994

Alers, J. 1978

Alonso, A. and M. Koreck 1989

Andrade, S.J. 1982

Ankrah, E.M. 1991
“AIDS and the Social Side of Health.” *Social Science and Medicine* 32(9): 967-990.

Arnett, J. 1992

Arguelles, L. and A.M. Rivero 1988
“HIV infection/AIDS and Latinas in Los Angeles County: Considerations for prevention treatment and research practice.”

Asencio, M. 1996
Personal communication.

Azjen, I. and M. Fishbein 1973

Backstrand, J. and S. Schensul 1982

Baer, H. 1997

"Beliefs about AIDS: Data from Five Cultures." Unpublished data.

Bandura, A. 1977

Basch, C. 1987

Basen-Enquist, K. 1992

Berle, B.B. 1958

Bernard, H.R. 1988
Bok, M. and J. Morales 1991

Bolton, R. 1989


Bourgois, P. 1996

Bowler S., Sheon A.R., D’Angelo L.J. and S.J. Vermund 1992


Brandt, A. 1987


Burbank, V.K. 1988

Cardosa, L.A. 1987
Caron S.L., Davis C.M., Wynn R.L. and L.W. Roberts 1992

Carr. R. 1984

Carrier, J. 1989

Carrier J. and R. Bolton 1991


Carrillo E., and S. Uranga-McKane 1994

Castro, K. and S. Manoff 1988

CDC 1995

The Child Council, Inc. 1995
Hartford and Her Children: A Demographic Description. Hartford, CT: The Child Council.

Christenson, E.W. 1979
Clatts, M. 1993

Clatts, M. and K. Mutchler 1989

Cochran, V. and S. Mays 1989

Comas-Dias, L. 1982

Connecticut Department of Health 1995

Connors, M., Catan, V., Brown, S., Escolano, I. and R. Gadol 1992

Connors, M. 1996


Cortes, D.E. 1991
Cromwell, R.E. and R.A. Ruiz 1970

Cunningham, I. 1989

Dake, K. 1992

Davis, C., Hoob C. and J.L. White 1988

Day, S. 1988

De La Cancela, V. 1988

De La Cancela, V. 1989

De La Cancela V., and I.Z. Martinez 1983

dezalduondo, B. 1991

Dinnerstein, L. and D.M. Reimers 1975

Diclemente, R.J. 1993
"Confronting the challenge of AIDS among adolescents: Directions for


Dominguez, V.R. and J.I. Dominquez 1981

Douglas, M. 1985

Douglas, M. 1966

Douglas, M. 1985

Douglas, M. 1993

Douglas, M. and A. Wildavsky 1982

Drummond, L. 1980

Elder-Tabrizy, K., Wolitski, R., Rhodes, F., and J. Baker 1991

Elkin, D. 1967

Espin, O.M. 1986
Farmer, P. 1990

Farmer, P. 1992

Farmer, P. 1996

Farmer, P. and J. Kim 1991

Fisher, J.D. 1988

Fisher, J. and S. Misovitch 1990

Fitzpatrick, JP 1976

Flaskerud, J.H. and E.R. Cavillo 1991

Flaskerud, J.H. and A.M. Nyamathi 1989

Flaskerud, J.H. and G.Uman 1993
Ford, K. And A. Norris 1991


Fullilove, M.T., Fullilove, R.E., Haynes, L., and S. Gross 1990

Gaines, A. 1991

Garcia-Preto, N. 1989

Gil, R.M. 1982

Glik, D., Kronenfeld, J. and K. Jackson 1991
“Predictors of risk perceptions of childhood injury among parents of preschoolers.” Health Education Quarterly, Fall.

Good, B. 1977

Good, B.J. 1994
Good, B.J. and M.J. Delvecchio-Good 1980

Gonzalez, M., Barrera L.V., Guarnaccia, P., and S.L. Schensul 1982

Guzman, P. 1980

Hansen, W., Hahn, G.L., and B.H. Wolkenstein 1990

Hartford Public Schools 1990
“Urban Partnership for Alcohol and Drug Abuse Prevention and Intervention Grant Application to the Office of Substance Abuse Prevention.”

Harwood, A. 1977
Rx-Spiritist As Needed: A Study of a Puerto-Rican Community’s Mental Health Resources. New York: John Wiley and Son.

Harwood, A. 1981
“Introduction.” In: Ethnicity and Medical Care. Cambridge, MA: Harvard University Press.

Hein, K. 1989
“AIDS in adolescence: Exploring the challenge.” Journal of Adolescent Health Care 105-35S.

Herdt, G. and A. M. Boxer 1991

Hernandez, A. 1997
Personal communication.

Hooper, E. 1987


Hurtado, A. 1995

Ingstad, B. 1990

Irwin, C. 1993

Jessor. R. 1990

Johnson, B.B. 1991

Jorge, A. 1988

Keefe, S.E. 1980

Keefe, S.E. and A.M. Padilla 1987  
Chicano Ethnicity. Albuquerque: University of New Mexico Press.

Klor de Alva, J.J. 1988  

Kribeck, T. 1997  
Personal communication.

Kronenfeld J.J. and D.G. Glitz 1992  

Krueger, R. 1988  


Levine, M.P. 1992  

Lewis, O. 1959  


Lewis-Fernandez, R. 1992

Lindenbaum, S. 1992

Luborsky, M. 1994

Lutz, K. 1985

MacDonald, G. and C. Smith 1990
"Complacency, risk perception and the problem of HIV education." AIDS Care 2(1):63-68.

McDaniels, T.L., and R.S. Gregory 1991


Magura, S., O'Day, J., and A. Rosenblum 1992

Mahoney, E. 1996 (July 2).
Marin, G. 1989

Marin, G. and B.V. Marin 1991
Research With Hispanic Populations. Newbury Park: SAGE.

Mays, V.M. and S.D. Cochran 1989

McCombie, S. 1990


McGoldrick, M., Garcia-Preto, N., Moore Hines, P., and E. Lee 1989

Mead, M. 1949
Coming of Age in Samoa: New York: Mentor.

Medina, C. 1987

Mendez, S. 1996
“Airbridge Research Project,” unpublished data, Latinos Contra SIDA.


Millstein, S.G. and C.E. Irwin 1993
“Accident related behaviors in adolescents: a biopsychosocial view.”
*Alcohol, Drugs, and Driving* 4(1):21-29.

“Social acceptability of HIV screening among pregnant women.”
*AIDS Care* 2(3):213-222.

Mondragon, D., Kirkian-Lift, B., and E.S. Schiller 1991
“Hostility to people with AIDS: Risk perception and demographic factors.”
*Social Science and Medicine* 32(10):1137-1142.

Moore, S.M. and D. Rosenthal 1991
“Condoms and coitus: Adolescents attitudes to AIDS and safe sex behavior.”

*Journal of Adolescent Research* 7(2): 177-191.

Morsy, S. 1990
“Political Economy in Medical Anthropology.” In: *Medical Anthropology: Contemporary Theory and Method*.

Muir, M.A. 1991
“Environmental Contexts: Adolescents and AIDS.” In: *The Environmental Contexts of AIDS*.
New York: Praeger.

National Center for Health Services 1989
“AIDS Knowledge and Attitudes of Hispanic Americans: Provisional Data from the 1988 National Health Interview Survey.”
*U.S. Department of Health and Human Services.*

*U.S. Department of Health and Human Resources.*

Nelkin, D. 1989
“Communicating technological risk: The social construction of risk perception.”

Nova Research Company 1996
A Framework of Tools for Ethnographic Research: AFTER for Windows

Nyamathi, A., Bennett, C., Leake, B., Lewis, C., and J. Flaskerud 1993

Ortiz, V. 1995

Oswalt, R. and K. Matsen 1993

Padilla, F. 1980

Padilla, F. 1985

Padilla, F. 1992

Pazniokas, M. 1996 (November 19).

Pelto, P.J. and G.M. Pelto 1990
“Field methods in medical anthropology.” In: Medical Anthropology: Contemporary Theory and Method. TM Sargent and CE Sargent (eds).
New York: Praeger.

“Community Nutritional Problems Among Latino Children in Hartford,
Connecticut.” The University of Connecticut Nutrition Program.

Portillo, C.T. 1987
“Poverty, self-concept and health: Experience of Latinas.” Women and
Health 12(3-4): 229-242.

Quam, M.D. 1990
“The Sick Role, Stigma and Pollution: The Case of AIDS.” In: Culture and

Quimby, E. 1992
“Anthropological Witnessing for African Americans: Power
Responsibility, and Choice in the Age of AIDS.” In:The Time of AIDS:
Social Analysis,Theory and Method. G. Herdt and S. Lindenbaum (eds.):159-
184. Newbury Park: SAGE.

Rapkin, A.J. and P.I. Erickson 1990
“Differences in knowledge of and risk factors for AIDS between Hispanic and
non-Hispanic women attending an urban family planning clinic.” AIDS 4:
889-899.

Rodriquez, C. 1997(January 5).
“Coming of age Latino style: Special rite ushers girls into adulthood.” The
Boston Globe pC1.

Rodriquez-Trias, H., and A.B. Ramirez de Arellano 1994
“The Health of Children and Youth.” In: Latino Health in the U.S.: A

Rodriquez, C.E. 1980
“Puerto Ricans: Between Black and White.” In: The Puerto Rican Struggle:
New York: Puerto Rican Migration Research Consortium.

Rogler, L.H. and R.S. Cooney 1984
Puerto Rican Families in New York City: Intergenerational Processes.
New Jersey: Waterfront Press.
Rosario, L.M. 1982
"The Self-Perception of Puerto Rican Women Towards Societal Roles.”

Rosenstock, I.M. 1974

Sabatier, R. 1988

Safa, H. 1988

Schensul, S. and M. Borrero 1982

Schlegel, A. 1995

Schoepf, B.G. 1991

Schoepf, B.G. 1992

Selik, R.M., Castro, K., and M. Pappaioanou 1988

Sibthorpe, B. 1992
“The social construction of sexual relationships as a determinant of HIV Risk Perceptions and condom use among IVDUs.” Medical Anthropology Quarterly 6(3):255-270.
Simmons, J., Farmer, P., And B.G. Schoepf 1996

Singer, M. 1986

Singer, M. 1991

Singer, M. 1992

Singer M. 1994

Singer, M. 1995

Singer M. 1996
“A dose of drugs, a touch of violence, a case of AIDS: Conceptualizing the SAVA Syndemic.” Free Inquiry in Creative Sociology, in press

Singer, M. 1997

Singer, M. and H. Baer 1995

Singer, M., Flores, C., Davison, L., Burke, G., Castillo, Z., Scanlon, K., M. Rivera 1990a
Singer, M., Castillo, Z., Davison, L., and C. Flores 1990b

Singer, M., Flores, C., Davison, L., Burke, G., and Z. Castillo 1991a

Singer, M., Irrizarry, R. and J. Schensul 1991b

"AIDS Risk Perceptions among women drug users in Hartford, CT." Women and Health, in press.

Sobo, E.J. 1993
"Inner-city women and AIDS: The psycho-social benefits of unsafe sex." Culture, Medicine and Psychiatry 17.

Sobo, E.J. 1996

Solis, J. 1995

Stall, R. 1991


Streibel, A. 1996
Strunin, L. 1991
"Adolescents' perceptions of risk for HIV infection: Implications for future research." Social Science and Medicine 32(2):221-228.


Swanson, N.M., Patton, C., McNamara, R.P., and S. Molde 1992

Taylor, C. 1990

Tienda, M. 1989

Treichler, P. 1992

Trotter, R., Weller, S., Baer, R., Pachter, L., Glazer, M., Garcia de Alba, García, and R. Klein 1997
"Consensus theory model of AIDS/SIDA beliefs in four Latino populations." To be published. AIDS.

U.S. Census Data 1990

Van der Vlede, F.W. and C. Hooykaas 1992

Van Landingham, M.J., Supraset, S., Werasit, S., C. Vaddhanaphuti 1993
Vega, W.A. 1995

Vigil, J.D. 1980

Wagenheim, K. 1970

Waterson, A. 1993


Weinstein, N.D. and M. Nicolich 1993

Whiting, B.B. and J.W. Whiting 1975
Children of Six Cultures: A Psychocultural Analysis. Cambridge, MA: Harvard University Press.

Widdus, R., Meheus, A. and R. Short 1990

Wildavsky, A. and K. Dake 1990

Wilson, J.R. 1996
Worth, D. 1988

Wyatt, G. 1991

Zambrana, R.E., C. Dorrington, and D. Hayes-Bautista 1995