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Interrelationships of Colorism, Violence, and Sexual Behaviors among Southern African American Women.

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Abstract

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by

Phaedra Renae Christensen

MA, Webster University, 2001

BSN, Temple University 1988

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health Epidemiology

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Abstract

Two significant public health concerns that threaten both the physical and mental health of African-American women are Intimate Partner Violence (IPV) and Human Immunodeficiency Virus (HIV). African-American women (AAW) in the south carry the greatest burden of HIV and disproportionately represent the region with an incidence of 71% for new HIV infections, and elevated rates of morbidity and mortality. In 2013, the murder rate among AAW was 2.5 times higher than it was among Caucasian women. Most of the published studies that explored the association between IPV and HIV had mixed populations, did not explore topics unique to AAs, or were qualitative studies. The aim of this study was to assess the associations between colorism, IPV, and high-risk sexual behaviors (HRSB)/HIV-risk among AAW and determine if colorism was a mediator in the IPV-HRSB relationship. The theory of power and gender and the social cognitive theory provided the theoretical framework of this study. The dissemination of this self-assessed quantitative, cross-sectional survey design was to a homogenous sample of 143 women. The analysis of the variables used correlation statistics and linear regression. Findings revealed a significant relationship between IPV-HRSB (r = .882, p =.001), colorism-IPV (r^2 = .371, p = .001) and colorism-HRSB (r = .377, p = .001); however, colorism did not mediate the IPV-HRSB relationship. This study has implications for positive social change in that practitioners may gain a better understanding of colorism's influence on IPV and HRSB, and may serve to modify existing programs. This knowledge may subsequently help to decrease adverse behaviors that are unique to AAW prone to IPV with an increased HIV-risk as a result of colorism.

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Dedication

I would like to dedicate my dissertation to the memory of my cousin, who will remain unnamed; my cousin was a victim of abuse and later died from HIV complications in 1991. I love you, and I miss you.

To my children, Ashley and Ian, life has not always been easy. There have been struggles, but please let God's Love be your beacon to fulfill your dreams and to have healthy relationships as you embark on your college careers and move into the future. Thank you for your understanding when I had to spend long hours in front of the computer, when the quality of our time together was lacking, when we ate separately, and when I showed signs of displaced irritability and frustration, you were always there with a hug. Always remember obstacles are just opportunities for greatness. To my husband, Torben, thank you for your support when I was tired and consumed with work. I love you all.

To my father who is no longer with us; I know you are watching over me as you did that fateful day in April 2005, I love you. To my mom thank you for your prayers, your support, and your inspiration.

To my friend Vicki, thank you for checking up on me and keeping me grounded when I became frustrated with the process.

Finally, and with the utmost reverence, none of this would be possible without my faith and my knowledge that God has never forsaken me. Thank you, God for delivering me and for directing my paths during this journey. I trust and honor you for without you I would remain a victim and not a Victor.

Acknowledgments

I would like to express my deepest gratitude and special thanks to my dissertation committee chair, Dr. Jeanne Connors, for her guidance and support during this journey. To Dr. Cheri Langley, thank you for serving as my committee member but also for your support and expertise regarding methodology. To my URR, Dr. Daniel Okenu, thank you for knowledge and experience. Thank you all for providing your wisdom and being patient. Thank you for the constructive critiques and the motivation necessary to propel me forward.

To the quantitative research team, Dr. Liu and Dr. Jones, thank you for the insight you provided during the office hours. Lastly, to everyone at Walden University who were involved in this process, thank you.

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Chapter 1

Introductory Overview

Misconceptions regarding the spread of the human immunodeficiency virus (HIV) that causes acquired immunodeficiency syndrome (AIDS) are prevalent. For instance, in 1981, the Centers for Disease Control and Prevention (CDC) reported their findings regarding a rare lung infection called pneumocystis carinii among healthy homosexual men in California (AIDS, 2012); cases were significant among both homosexual men and intravenous drug users. This finding led to the presumption that the risk of acquiring the infection was limited to homosexuals and intravenous drug users.

According to the American Foundation for AIDS Research (AMFAR) report published in 2014, end-of-year statistics for 1986 revealed that there were 28,712 cases of AIDS and 24,559 people who acquired the disease died, thus having a mortality rate of 85.5%. The development of the first antiviral drug, Zidovudine (AZT) in 1987, had the underlying goal of suppressing the spread of the disease and combating the high mortality rate. Although there were continuous medical innovations in treatment to fight against HIV, the numbers of cases continued to increase until the end of 2004. In a 2014 report by the American Foundation of AIDS Research (AMFAR), in 2004 there were 940,000 reported cases of AIDS and 529,113 people who acquired the disease died thus having a mortality rate of 56.3%. Even though the mortality had decreased over the years, what health professionals are concerned about are the increasing cases of AIDS among different populations all over the world, many of which are from marginalized

populations (AVERTing HIV & AIDS [AVERT], 2015a). Currently, more than 1.1 million people have been diagnosed with the HIV infection, and approximately 180,900 people are unaware of their infection in the United States alone (AIDS, 2012; CDC, 2014a). Data from the CDC indicates that the number of people living with HIV since 1986 has tremendously increased (CDC, 2013). Furthermore, the increase is disproportionate among certain ethnicities; African-Americans of which carry the highest burden (AIDS, 2012; CDC, 2014a). Of the top four groups with the highest rate of infection, homosexual African-American men and heterosexual AAW rank second and fourth, respectively (CDC, 2013).

The lifetime probability of an African-American woman being diagnosed with HIV is one in 32 and for Caucasian women the number is one in 526 (CDC, 2014b). For women, transmission is more prevalent through sexual intercourse from male to female contact (The Henry Kaiser Family Foundation [KFF], 2014a). African-American women account for 20% of the new HIV infections with 84% acquired through heterosexual transmission (KFF, 2014a). Besides the homosexual population, AAW are the single largest group significantly affected by the virus (KFF. 2014a). The highest concentration of new cases of HIV infections among women in the African-American community was in the 25–34 years old (29%), followed by 35–44 years old (25%) and then 13–24 years old (22%) age group (KFF, 2014a).

Background

The HIV that causes AIDS is a public health problem that affects individuals from all socioeconomic groups throughout global communities that includes the United States. In 2012, there were approximately 1 million people living with HIV in the U.S., and one in five or 20% of the population were unaware of their exposure (CDC, 2012; AIDS, 2012). African-Americans have been hit hardest by the illness, as a subset of the population, they comprise 46% of the incident cases of HIV (CDC, 2014) in the United States even though they represented only 13.1% of the population in 2012 (Census, 2014). Based on the statistical data, African-Americans are the ethnic group with the highest likelihood of HIV exposure (CDC, 2014b). Moreover, African-American women are the fourth largest group outside the gay community with the HIV (CDC, 2014a).

Intimate Partner Violence (IPV) shares many of the social, environmental, and psychological characteristics that increase the individuals' incidence likelihood for acquiring HIV. IPV or domestic violence statistics indicates that every 9 seconds a woman subjected to abuse is either assaulted or beaten in the United States (Domestic Violence Statistics, 2016). IPV victims lose approximately 8 million days of paid work, the equivalent of 32,000 full-time jobs; since 1995the United States has spent more than $5.8 billion for direct medical and health care for the victims of IPV, today the amount exceeds $8.3 billion per year (Maryland Departmwnt of Health and Mental Hygiene, 2013; National Coalition Against Domestic Violence, 2016).

There is a higher prevalence of IPV among women within the lower socioeconomic quartile and during periods of male unemployment with 9.7% occurring in households where the income is less than $25,000 per year (CDC, 2014d; Violence Policy Center [VPC], 2013a; VPC, 2013b). Such situations indirectly linked to the increased incidence of HIV cases among African women. One possible explanation, according to Cavanaugh, Hansen, and Sullivan (2010), involves high-risk heterosexual contacts because of IPV. IPV affects HIV risk indirectly through high-risk behavior engagement such as sex under the influence of drugs or alcohol, failure to negotiate the use of condoms, multiple sex partners, and directly from forced sexual contact with an infected partner (Cavanaugh et al., 2010; Go, Srikrishnan, Parker, Salter, Green, Sivaram,…Celentano et al., 2011). African-American women exposed to IPV report higher levels of threatening behaviors from their partners, subsequently, these women are 9.2 times more likely to experience acts of physical violence when asking their partners to wear a condom (Cavanaugh et al., 2010). Furthermore, El-Bassel, Gilbert, Witte, Wu, & Chang (2011) asserted that fear of partner violence is a risk factor for having unprotected sex. Exploring the lives of 125 African-American women, El-Bassel et al., stated that victims of sexual IPV did not negotiate condom use due to fear and the potential use of violence against them.

Sexual violence within the scope of this study is defined as any action that eliminates consent causing undue influence, forces, or coerces the individual to engage in unwanted sexual activities. The coercion could be in the form of financial manipulation

and trickery, intimidation or the use of intoxicating substances, or in extreme instances, may involve physical intimidation (University of Michigan, [UMICH], 2014). To date, the literature regarding violence towards women indicates that one out of every six American women has been a victim of an attempted or completed rape in her lifetime (Rape, Abuse, & Incest National Network [RAINN], 2014). Moreover, approximately one in 32 African-American women will receive an HIV diagnosis in her lifetime (AVERT, 2014a; CDC, 2014e). Of equal concern, one in five African-American women in their lifetime have experienced rape, and 41% of the African-American women have experienced various elements of sexual coercion or unwanted sexual encounters (West & Johnson, 2013).

In his seminal work, Williams (1999) postulated that racism within American society and the racial inequalities have a significant influence on health outcomes and disease rates among African-Americans. Racism and or discrimination are an additional burdens for minority populations directly affecting their health (Williams, 1999; Williams, Mohammed, Leavell, & Collins, 2012). According to Williams, racism is the ideology of classifying an individual or group of persons as being inferior and is a method to justify unequal treatment or discrimination. As a subset of racism, colorism is a discriminatory practice within an ethnic group based on skin tone (Norwood & Foreman, 2014). For example, within the African-American population lighter skin toned individuals may look down upon darker skinned individuals from the same group.

Alternatively, there may be the perception that darker skinned individuals have fewer privileges or opportunities than their lighter skinned counterparts.

According to Jina and Thomas, (2013), the disparity seen especially among African- American women signifies that the interconnectedness between high-risk behaviors, psychopathology, and HIV is of immediate concern that requires a synergistic approach. A synergistic perspective would involve early identification and prevention to mitigate the untoward effects of victimization that would lead to high-risk behaviors.

Consequently, fostering healthy, respectful family relationships demonstrates positive family interactions and dynamics with the goal of reducing HIV risk (Black, Basile, & Breiding, 2011; Jina & Thomas, 2013). As a growing public health concern, the impact of HIV and IPV on African-American women requires further research from different perspectives. The relevant literature posits that being a victim increase the likelihood of the African-Americans of contracting the HIV infection (Women's health, 2011). For African-American heterosexual women, the sexual risk for the HIV infection comes from unprotected sexual behaviors, lack of sexual communication, and sex with high-risk partners because of child or adult victimization (Clum, Chung, Ellen, Perez, Murphy, Harper, & Hamvas, 2012).

Problem Statement

Despite the successes gained since the onset of the HIV/AIDS epidemic, obstacles remain. Eliminating and or reducing the barriers related to testing, improving access to health care, and re-educating individuals on risky sexual behaviors that predispose them

to acquire the HIV infection remains a primary focus. Globally, the number of persons diagnosed and living with the virus exceeds 35 million (KFF, 2016a). Specifically, African-American women have an incidence rate that is 20 times that of Caucasian women and four times that of Hispanic women (KFF, 2014b), and despite the growing need, less than 1% of the 2014 Federal budget, $29.5 billion, was spent on funding for HIV/AIDs programs here in the US and globally (KFF, 2014c). Based on recent literature there is limited research that explores the African-American woman's experience with both HIV and IPV. To the researcher's knowledge, no study has investigated the influences of colorism, intimate partner violence, and sexual risk behaviors despite the increasing incidences of HIV among AAW.

Purpose of the Study

The purpose of this quantitative cross-sectional study was to assess how colorism and IPV affect high-sexual risk behaviors of AAW residing in the southern region of the United States. A survey instrument comprised of demographic queries gathered information regarding Socioeconomic Status [SES] (Appendix C), a Modified Abuse Assessment Screen (Appendix D), a HIV Risk Assessment Tool (Appendix E), a Colorism Instrument (Appendix G), and a Sexual Coercion in Intimate Relationships scale (Appendix H), collected the data from 143 residents from the17 states of the southern region. The selection of the participants was through convenience sampling and the analysis of the data consisted of descriptive and correlation statistics as well as linear regression analysis. Chapter 3 contains an explanation of the methods used in the study.

Research Questions and Hypotheses

Mediation served as the basis for the development of the research questions and the subsequent analysis of the data. According to Baron and Kenny (1986), the use of mediator variables helps to describe how correlations exist between variables. The mediator variable does not describe when the effects will occur, which provides an explanation for the relationship between the predictor and criterion variable (Baron & Kenny, 1986). Baron and Kenny further postulated that a variable functions as a mediator when the following conditions exist:

- Variations in the levels of the independent variable (IPV) which significantly explains variations in the presumed mediator variable (Path 1).
- Variations in the mediator variable that significantly explain variations in the dependent variable (Path 2).
- When Paths 1 and 2 are controlled, a previously significant correlation between the independent (IPV) and the dependent variable (HIV risk) is no longer significant.

Therefore, the strongest evidence of mediation occurs when Path 3 is zero. Based on Baron and Kenny's (1986) mediator model these three steps must be satisfied for mediation to exist:

1. Confirmation that the IV is a significant predictor of the DV, IPV→ Sexual risk,

2. Confirmation that the IV is a significant predictor of the mediator, IPV → colorism. If the mediator is not associated with the IV (IPV), then the mediator variable could not mediate.
3. Confirmation that the mediator is a significant predictor of the dependent variable, while controlling for the IV, Colorism →Sexual risk.

Therefore, when colorism and IPV are used simultaneously to predict sexual risk, there will be a reduction in the path of Step 1 and it would be nonsignificant. Figure 1 represents a model based on Baron and Kenny's model.

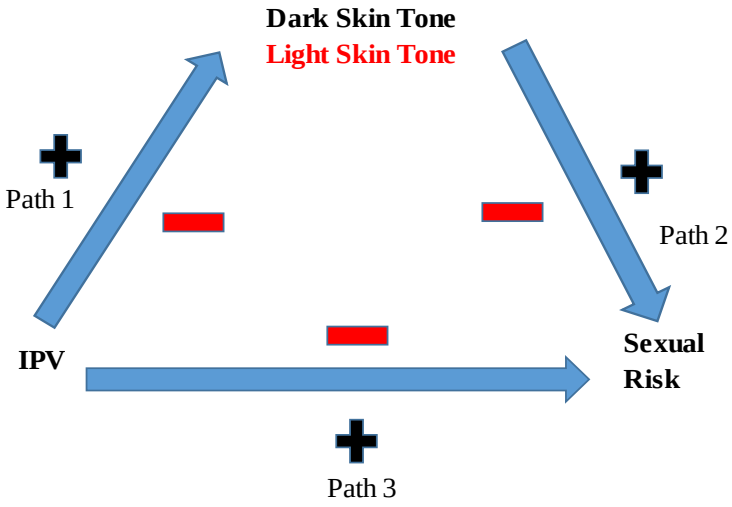

Figure 1 . Mediator Variable Example

The overarching research question is, does colorism have a mediation effect on the relationship between IPV and sexual risk behaviors among AAW living within the southern region? This question thus generates the following questions:

Research Question 1:

What is the association between IPV and high-risk sexual behaviors among African-American women who are residents of the southern region of the United States, after adjusting for potential confounders (age, marital status, and SES, which includes education, employment, and income)?

$H_0$1: There is no association between IPV and high-risk sexual behaviors among AA women who are residents of the southern region, after adjusting for potential confounders (age, marital status, education, employment, and income).

H_a1: There is an association between IPV and high risk sexual behaviors who are resident of the southern region, after adjusting for potential confounders (age, marital status, education, employment, and income).

Research Question 2:

What is the association between colorism and IPV among AAW who are residents of the southern region, after controlling for potential confounders (age, marital status, education, employment, and income)?

$H_0$2*:* There is no association between colorism and IPV among AAW who reside in the southern region, after controlling for potential confounders (age, marital status, education, employment, and income).

H_a2: There is an association between colorism and IPV among AAW who reside in the southern region, after controlling for potential confounders (age, marital status, education, and income).

Research Question 3:

What is the association between colorism and high-risk sexual behaviors among AAW who reside in the southern region, after controlling for potential confounders (age, marital status, education, employment, and income)?

$H_0$3: There is no association between colorism and high-risk sexual behaviors among AAW who reside in the Southern Region, after controlling for potential confounders (age, marital status, education, employment, and income).

H_a3*:* There is an association between colorism and high-risk sexual behaviors among AAW who reside in the southern region, after controlling for potential confounders (age, marital status, education, employment, and income).

Research Question 4:

Does colorism mediate the relationship between IPV and HIV sexual risk behaviors among AAW who are residents of the southern region, after adjusting for potential confounders (e.g. age, education, marital status)?

$H_0$4: Colorism does not have a mediating effect on the relationship between IPV and HIV sexual risk behaviors among AAW who are resident of the southern region (after adjusting for potential confounders, such as age, education, and marital status).

H_a4: Colorism is a mediator, which affects the relationship between IPV and HIV sexual risk behavior among AAW who are residents within the southern region

(after adjusting for potential confounders, such as age, education, employment, income, and marital status).

Theoretical Framework

The theory of gender and power and the social cognitive theory are two paradigms used in this study that provide a foundation for understanding why some African-American women are prone to high-risk sexual behaviors when exposed to intimate partner violence and colorism. Connell's (1987) theory of gender and power considers the hegemonistic dominance of males as women struggle for equality within male-dominated settings, which is the undergirding of the structural foundation. The gender and power theory forms a social structure that analyzes gender inequality and gender power imbalances (Wingood & DiClemente, 2000). Three prominent structures characterize the relationships between men and women (Wingood & DiClemente, 2000) Whereby, they serve as the underpinning of the theory and these are the sexual division of labor, the sexual division of power, and the cathexis (Wingood & DiClemente, 2002). The sexual division of labor examines the economic inequities with a preference for men (Wingood & DiClemente 2000; 2002). The exploration of a system that favors men highlights the inequalities and abuses of authority to include control within relationships and organizations, defines the sexual division of power (Wingood & DiClemente 2002). Finally, exploring social norms and affective attachments is the basis of the third structure, cathexis (Wingood & DiClemente, 2002). Through the application of this theory, research findings can help develop intervention programs that reduce the

hegemonistic influence over female sexual risk behavior. The theory of gender and power examines the power struggles between men and women in their quest for sexual control, dominance, and the practice of safe sex (Wingood & DiClemente 2000; 2002). Economic status and social factors that govern earning potential and education, structural, and environmental forces influence the gender vulnerability of African-American woman and increase HIV risk (Wingood & DiClemente, 2002).

Meanwhile, Bandura's (1986) social cognitive theory (SCT) provides the critical link between colorism, intimate partner violence, and the effect on sexual behavior and subsequently HIV risk among African-American women. Hence, employing the SCT is an opportunity to utilize both personal characteristics, social and environmental forces in predicting behavior (Crosby, Salazar, & DiClemente, 2013). Furthermore, the SCT involves the delineation into the reciprocal triadic causation, where the triad consists of the environment, the person, and the behavior; each factor does not exert an equal influence on the individual's actions, the influence exerted would depend on which factor is strongest at any given point in time (Wei, Teo, Chan, & Tan, 2010).

Nature of the Study

I used a quantitative cross-sectional approach to examine how colorism and IPV affected high-risk sexual behaviors of 143 African-American women who were residents within the southern region of the United States. The quantitative method was appropriate to measure trends or to describe the relationships between dependent and independent variables. A convenience, nonprobability sampling method was employed to select the

participants (Neuman, 2006). A compilation of instruments, which included the demographics, the Sexual Coercion in Intimate Relationships Scale, In-Group Colorism Scale, the modified abuse scale, and the HIV Screening Tool gathered the information regarding the study variables. Correlation analysis and linear regression were the tools used to assist in determining if there was a relationship between the study variables. The Statistical Package for the Social Sciences (SPSS) 23 was the software utilized in the data analysis.

Definition of Terms

The following were the operational definitions used within the text:

AIDS: Acquired immunodeficiency syndrome, body fluids such as blood, semen, and vaginal secretions are the primary means for HIV transmission (CDC, 2015a). CD4 cells are the body's defense against infection and disease; antivirals help protect the immune system function thus preserving T-cells—reduced T-cell counts increases host susceptibility to opportunistic infections, leading to AIDS (CDC, 2015a).

Colorism: The prejudiced or preferential treatment of same-raced individuals based on skin color or skin tone, hair texture, and facial features; privileging light skin tones over dark skin tones (Keith, 2009; Norwood & Forman, 2014; Wilder & Cain, 2010).

HIV: Human immunodeficiency virus, the virus that can lead to the development of AIDS, acquired immunodeficiency syndrome; unlike the flu virus or the virus, which

causes the common cold, once an individual contracts HIV, the virus remains replicating increasing the viral load and decreasing the CD4 cell count until treated (CDC, 2015a).

High-risk sexual behaviors: Behaviors that places the individual at an increased risk of contracting the HIV infection. According to the CDC (2015a) the following actions are considered high-risk behaviors:

- Having multiple sex partners.
- Sex with a known intravenous drug user.
- Sex while under the influence of drugs or alcohol.
- Engaging in sex for barter, for instance, money, drugs, shelter.
- Engaging in unprotected vaginal, oral, or anal sex with individuals with questionable or unknown background.
- Unprotected sex with an HIV-positive person.
- Engaging in unprotected sexual activities with men who have sex with other men (MSM).
- Engaging in intravenous drug use/sharing needles.

Intimate Partner Violence (IPV) /Domestic Violence (DV): The behavior or action within an intimate relationship that causes physical, sexual, or psychological harm (Swartzendruber, Brown, Sales, Murray, & DiClemente, 2012). Through the abusive behavior, the batterer uses coercion, manipulation, deception, humiliation, harassment and or force to establish and maintain power and control (Jordan, 2006).

Racism: Attitudes, beliefs, and institutional arrangements that degrade individuals or groups because of physical attributes and or ethnic group affiliation (Jones, 2016). As a system, it structures opportunity and value based on race leading to the restriction of personal potential, thus causing unfair disadvantages and the alteration of community resources based on the schema (Clark, Anderson, Clark, & Williams, 1999; Ford, Daniel, Earp, Kaufman, Golin, & Miller, 2009; Williams & Prather, 2010).

Socioeconomic status: The social standing or class of an individual or a group of people, which is often measured in terms of income, employment, and education. (American Psychological Association, 2015)

Assumptions

This research assumed that African-American women would want safe environments and protection against HIV infection. As such, this study further assumed that the respondents would answer all questions asked of them truthfully. Lastly, this study assumed that the respondents would remember all details that could help them answer the questions in the survey.

Scope and Delimitations

The study gathered data using four survey instruments: the demographic survey Abuse Assessment Screening, In-Group Colorism Scale, and HIV Screening Tool. These survey instruments assisted in appropriately measuring the variables considered for this study from the selected sample of African-American women. As such, the generalizations garnered as a result of the study would be limited to those African-

American women who participated in the study and possess similar characteristics of the study participants. The study was limited to a sample size of 143 African-American women. Also, this study was delimited to exploring the relationship between causes of IPV and HIV other than the factors considered in this study.

Limitations

The target recruitment was a homogenous sample of AAW. Specifically, only those AAW within the specified geographic locality, age range, and previous history met the inclusion criteria. Further, this study was also limited to the use of the survey instruments in eliciting data for the study variables. The survey used closed-ended questions, which could cause indecisiveness about the choices.

Significance of the Study

Within the global community and the United States, IPV and HIV are two public health concerns that have reached epidemic proportions. IPV and HIV share many of the same risk factors to include low income, low academics, alcohol and drug abuse, mental health issues (such as depression and borderline personality disorders), unemployment, and the lack of social support (CDC, 2015a; El-Bassel et al., 2009). Moreover, according to Maman, Campbell, Sweat, Gielen, (2000) IPV increases a woman's risk for HIV infection through forced sexual contact with an infected partner; inconsistent use of condoms or negotiation of safe sex practices; increased sexual risk behaviors (multiple partners, sex in exchange for drugs or money, sex while under the influence of drugs or alcohol). Furthermore, the diagnosis of HIV can incite occurrences of IPV (CDC,

2014a). The prevailing bodies of literature highlighted the intersection between IPV and HIV risk, yet most of the published studies are meta-analyses, conducted in developing countries, qualitative studies, racially/ethnically mixed, have conflicting results or do not focus on culturally sensitive issues that are relevant to African-Americans.

By addressing the gaps in the current body of knowledge as it pertains to IPV and HIV sexual risk behaviors among African American women, this current study has the following implications for social change:

- Increases the overall knowledge regarding colorism and how colorism affects IPV and HIV risk behaviors among African American women.
- Provides potential empirical evidence of colorism's influence of IPV and HIV sexual risk behaviors.
- Serves as the foundation for larger quantitative studies.
- Serves as the basis of risk reduction projects that include colorism as a potential risk factor.

Summary

The purpose of this quantitative correlational research study was to examine the relationships among colorism, IPV, and high-risk sexual activities/HIV-risk among African-American woman. Chapter 1 of the study provided an overview of the HIV/AIDS epidemic in the United States and provided statistical data referencing IPV and the need to explore the intersection of colorism. Chapter 1 continued with the theoretical framework, the research variables and the research questions and hypotheses.

The theory of gender and power and the social cognitive theory served as the foundation for understanding why some African-American women are prone to high-risk sexual behaviors when exposed to intimate partner violence and colorism. An a priori requirement of 104 African-American women would provide the minimal number to test the study hypotheses (see Appendix A, for the sample size calculation). Correlation statistics and linear regression analysis was utilized to determine the underlying relationships among the study variables.

In Chapter 2, the review of the literature examines HIV among African-Americans, Intimate partner violence as well as a discussion related to the historical constructs of racism in American society and colorism today. Chapter 3 is an explanation of the methodology utilized within the study. Chapter 4 presents the detail related to the data collection and analysis. The current research study concludes with Chapter 5, interpretations of the findings, implications for social change and recommendations for future practice and research.

Chapter 2: Literature Review

Overview

The purpose of this quantitative cross-sectional survey design was to assess how colorism and intimate partner violence affect sexual risk behaviors among African-American women, who are residents within the southern region of the United States. An examination of violence and colorism among African-American women could end the increasing prevalence of HIV infection among this group.

Electronic databases used in regards to IPV, sexually transmitted diseases/HIV, sexual risk behaviors among AAW, and colorism for this literature review included ProQuest Central full text, EBSCO (Academic Search Premier), CINAHL, and Medline including PubMed searches.

Google Scholar, the public library and cross-referencing academic resources found in journals and books assisted in the expansion of relevant reference material. The following search terms were used: *intimate partner violence, domestic violence, HIV, sexual risk, sexual risk behaviors, African-American women, colorism, discrimination, health effects, HIV among blacks in the US, HIV among Black women, Domestic violence among Black women,* and *sexual risk among African American youth*.

This chapter begins with a review of the germane literature and peer-reviewed studies on HIV/AIDS and the associated risk factors that could facilitate the pandemic spread of the virus. Next, there is a discussion on the morphological and biological descriptions of HIV, the general information of AIDS, followed by a discussion on the

prevalence of HIV. The chapter continues with the prevalence of HIV among women of African-American descent and the risky sexual behaviors enculturated among African-American youth. A section on media use and exposure to explicit sexual materials demonstrates the potential development of high-risk sexual behaviors in the context of the African-American female population.

Following the discussions on the prevalence of HIV and the sexual risk behaviors of African-American females, the theories of gender and power (Connell, 1987) and the social cognitive (Bandura, 1986) are presented. The protraction of this discussion serves to implicate the gender inequalities between men and women. A discussion of the social constructs of discrimination and prejudices to introduce the concept of colorism.

Along with the discussion of colorism, the dialogue culminates with the differentiation between colorism and racism. A summary section details the salient findings that the researcher used to conceptualize this proposed study.

H**uman Immunodeficiency Virus**

The HIV is a lentivirus, a virus classified under the retrovirus family, which targets the human immune system thus exposing the person to infection and diseases (Poundstone, 2004). A person affected with a lentivirus suffers infections that damage the immune system (Roundtree, 2010). An individual with HIV has an average survival time of nine to 11 years; depending on the subtype of HIV, the survival years may increase with appropriate treatment (Wyatt, Klotman, & D'Agati, 2008). Studies show that blood and secretion of body fluids such as breast milk and semen facilitate the

transference and spread of lentivirus to humans (Douek, Roederer, & Koup, 2009). These human bodily fluids contain free particles of the virus and viruses within the infected immune cells (Douek et al., 2009, p.478).

HIV impairs essential cells of the human immune system particularly "helper T cells, macrophages, and dendritic cells" (Cunningham, Donaghy, Harman, Kim, & Turville, 2010, p.526). The process of impairment of vital cells reduces the levels of helper T cells through direct viral extermination of infected cells (Garg, Mohl, & Joshi, 2012). A reduced number of helper T cells affects or damages the cell-mediated immunity, making an individual vulnerable to infections (Douek et al., 2009).

Classifications. The common characteristics of a lentivirus infection in many species are longer illnesses with long virus incubation period (Levy, 1993). An example of its morphology is its single-stranded transmission hidden in RNA viruses (Levy, 1993). The entry of the virus in marked cells requires the conversion of the RNA genome to double-stranded DNA through reverse transcriptase transported in the virus particle (Levy, 1993). Once there is an introduction of the affected DNA into the cell nucleus, it then integrates itself into the cellular DNA (Smith & Daniel, 2006). The integration allows longer incubation of the virus, which evades immune system detection (Smith & Daniel, 2006). Other pre-HIV acquisition processes genetically emulate affected DNA to produce new RNA genomes and viral proteins, which then release from the new cell prompting the presence of new virus particles (Rom & Markowitz, 2007).

HIV is classified into two types: HIV-1 and HIV-2(AVERT, 2015a). HIV-1, also known as LAV and HTLV-III, is more severe and is the source of global HIV infections (AVERT, 2015b; Kallings, 2008). HIV-2 has a lower infectivity, which means that individuals exposed with HIV-2 have lesser tendency to acquire infections (Kallings, 2008). The relative weakness of HIV-2 transmission is a reason for the observation of incident cases predominately in West Africa (AVERT, 2014a).

Chimpanzees and gorillas in western Africa have traces of HIV-1 virus (Sharp & Hahn, 2011). Moreover, research reveals HIV-2 in sooty mangabeys, an endangered West African ape (Kallings, 2008). These two subtypes are further categorized into groups. Group M viruses of HIV-1 are prevailing globally and account for more than 90% of the HIV-1 infections; thus significantly contributing to the AIDS epidemic (AVERT, 2014a). The group M is further categorized into several subtypes. Some of these subtypes are virulent, which resist medications (Kallings, 2008). While HIV-2 is less virulent and communicable than the HIV-1 M group, studies show that HIV-2 is the leading cause of AIDS (Kallings, 2008).

Acquired Immunodeficiency Syndrome (AIDS)

The progressive acquisition of HIV infection results in acquired immunodeficiency syndrome (AIDS). During the preinfection stage, an individual may acquire an influenza-like illness (Kallings, 2008). After which, another illness but without symptoms may follow this influenza-like illness (Kallings, 2008). The persistence of the infection gradually interferes with the function of the immune system,

which makes and individual vulnerable to common illness such as tuberculosis and other opportunistic infections (Kallings, 2008). AIDS is the third or end stage of the HIV infection (AVERT, 2015c). The development of AIDS covers the lung complications, severe weight loss, cancer, and other AIDS-defining conditions (AVERT, 2015c).

Transmission of HIV can be via unprotected sexual intercourse either vaginal, anal, or oral, contaminated HIV blood transfusions, childbearing of an HIV infected mother, hypodermic needles, delivery of infant, and breastfeeding (Rom & Markowitz, 2007). Saliva and tears are bodily fluids that cannot transmit HIV (CDC, 2015a). While there are methods of preventing HIV/AIDS such as adoption of safe sex practices, treatment of infections, and implementation of needle-exchange programs, AIDS remains an incurable disease with no vaccine as a preventative measure (Kallings, 2008). However, there are available medications such as antiretroviral treatment that could reduce the progression of the disease (Kallings, 2008). Even though, largely witnessed in West Africa, HIV-2 does not respond to the same treatment as HIV-1 (National Institute of Health, 2015; Kallings, 2008). HIV-2 has a natural resistance to non-nucleoside reverse transcriptase inhibitors (NNRTIs) used in HIV-1 treatment (AVERT, 2014a). While these medications may reduce death risk and other comorbid diseases, access to these treatments is expensive and has potential side effects; yet, there remains a need to determine the most effective manner to treat HIV-2 infections (AVERT, 2014a; Kallings, 2008).

Prevalence of HIV

In 1981, six U.S. women were noted to have an unexplained cellular immune deficiency (Zierler & Krieler, 2000). This immune problem was of unknown etiology, but similar to those recorded among five previously healthy homosexual Caucasian men (Zierler & Krieger, 2000). These incidences led the CDC to conduct a retrospective study and the subsequent MMWR report, which suggested that the deaths of 48 women from 1980 to 1981 were AIDS related (Zierler & Krieler, 2000). The data from the MMWR report marked the first cases of HIVAIDS among women in the United States (Zierler & Krieler, 2000). Now in its fourth decade, the HIV/AIDS epidemic affects millions of people worldwide and the numbers since 2010 has increased (KFF, 2016a). Currently, 36.7 million people are living with HIV, 1.2 million living in the United States; 2.7 million newly infected people worldwide each year, with approximately 50,000 in the United States; and a loss of 1.8 million people to HIV- related death each year, with 17,374 in the United States as of 2011, of which 4,796 were women (CDC, 2015b; KFF, 2016a). In the United States, death from HIV/AIDS was one of the top 10 leading causes of death for African-American women since 2008 (CDC, 2015b). African-Americans and ethnic minorities represent the majority of new HIV infections, AIDS diagnoses, and AIDS deaths in the United States (Prejean, Song, Hernandez, Zeibell, Green, Walker,…Hall, 2011).

Over several decades, AIDS has been ranked the topmost disease among African-Americans, particularly among the between 13 to 19-year olds (36%) followed by the 30

to 39-year olds (24%) (CDC, 2015b). Many of the African-Americans who died of this disease developed the infection in their teens (Kallings, 2008). This led researchers to examine the prevalence of this disease in the African-American community. For example, Reif, Pence, Hall, Hu, Whetten, & Wilson, (2014), found an HIV prevalence rate of 49% in nine of the 17 states that compromise the southern region. This rate is 15.9% higher than the prevalence of HIV across all states in the U.S (Reif et al., 2014).

African-American women (AAW) represent the largest number of persons living with HIV/AIDS (PLWHA) in the United States not receiving HIV treatment including highly active antiretroviral therapy (HAART), and the smallest percentage of participants in HIV medication research (Gwadz, 2014). As recently as June 2014, studies have continued to show significant underrepresentation of racial/ethnic groups in medical research, with only 30% African-American (AA) represented in medical research, while over 50% of the PLWHA are AAs (Gwadz, 2014).

Dramatic scientific progress improving the understanding of how the virus attacks the body coupled with a more sophisticated understanding of treatment, drug resistance, and adherence has changed the landscape of the HIV spectrum. PLWHA who are successfully treated with medications targeting HIV and HIV-related illnesses can potentially look forward to a full life for 20 to 30 or more years than was imaginable in 1981 (Anastos, Schneider, Gange, Minkoff, Greenblatt, Feldman, & Cohen, 2005).

In global data, women have exceeded men in diagnosed cases, representing over half of all adults and adolescents living with HIV/AIDS (CDC, 2015a). In the United

States, 2011 HIV surveillance data reports that women comprise over 50% of the U.S. population and 20% of the newly diagnosed HIV cases (CDC, 2015a). One of every 32 AAW will be at risk for HIV in a lifetime, as compared to one in 106 Hispanic women or one of 526 White women (CDC, 2015a). AAW are newly diagnosed with HIV at a rate that is 20 times higher than their Caucasian counterparts and five times higher than Latinas (CDC, 2015a). HIV/AIDS is one of the leading causes of death for AAW ages 25–44 (Heron, 2012).

Despite the rates of HIV infection among women in general and AAW in particular, women continue to be underrepresented in data reported regarding enrollment in HIV medication research trials, with current rates for the latter similar to those in the late 1980s (El-Sadr, Mayer, & Hodder, 2010; Squires, Hodder, Feinberg, Bridge, Abrams, Storfer, & Aberg, 2011). HIV-positive patients treated with HAART have demonstrated dramatic declines in morbidity and mortality (Palella, Delaney, Moorman, Loveless, Fuhrer, Satten, & Holmberg, 1998). However, the decreases are much smaller for AAs overall and particularly AAW, who only saw a 44% drop as compared to all other groups (CDC, 2007). Findings from studies in which AAW are underrepresented may mean that even basic medication information such as dosage, combination therapy, and side effects may be inaccurate. Several studies indicate that undiagnosed and/or untreated HIV disease facilitates transmission to others (Bradley, Hall, Wolitski, Van Handel, Stone, LaFlam, ...Valleroy, 2014; Fullilove, 2006). Thus, both undiagnosed and

untreated HIV disease contributes significantly to the ongoing cycle of close to 50,000 new cases annually in the United States (Bradley et al., 2014).

HIV/AIDS care is moving to a chronic disease state model as the treatments have simplified and a primary care approach is required as patients live into their older years (World Health Organization, 2011). Historically, expert providers have provided provisions for HIV care in HIV clinics. In addition, tertiary hospital HIV clinics have provided care. In many cases, the Ryan White Program (RWP) provided funding to support expert care in the community health care (CHC) setting (Crowley & Kates, 2013; KFF, 2016b). The implementation of the Affordable Care Act, primary care medical homes, and the failure by some states to expand Medicaid will continue to place a financial strain on the RWP, as the program will remain a crucial source of health care (Kates, 2013).

High-Risk Sexual Behaviors among African-Americans

Several African-American authors have focused on the disparities within the African-American community regarding illiteracy, colorism, self-hatred, and poverty (Dagbovie-Mullins, 2011). While these factors made African-Americans, particularly the southern U.S. African-American population, vulnerable to this progressive virus, the disproportion of the HIV/AIDS cases in the U.S territories are unknown (Wyatt, Klotman, & D'Agati, 2008). Consistent explanatory variables that the CDC offers include exposure of sex at a very young age, which increases the risk for having several lifetime sexual partners, teenage pregnancy, and early exposure to STDs (Bradley et al.,

2014). Other studies cited the relationship of substance intake during sexual intercourse, which interferes with the practice of safe sex (Lillie-Blanton, Stone, Snow-Jones, Levi, Golub, Cohen, & Wilson, 2010; So, Wong, & DeLeon, 2005). Choices of behavior among rural African-American youth during their childhood increase the odds of engaging in high-risk behaviors throughout adolescence and adulthood (Yancey, Goodin, & Wang, 2004).

Studies show that poverty and environment with cases of violence are demographic variables that put African-American youth at risk for committing unsafe sexual practices, thus increasing the odds to acquire HIV infection (Roberto, Zimmermann, Carlyle, & Abner, 2007; El-Bassel et al., 2009). In a study of Voisin, Hotton, and Neilands (2014), determined whether community violence is a risk factor for HIV infection among African-American youth. Voisin et al.,(2014) utilized 563 samples of African-American adolescents (61% of which are females) to determine if emotional stressors, the lack of school involvement, and negative perceptions from peers regarding safe sex practices to explain community violence exposure and sexual behaviors. The findings of the study show that aggression among boys is associated with community violence, early sex engagement, and sexual risk behaviors. Results further show that negative perceptions of safer sex from peers mediate the relationship between community violence exposure and sexual risk behaviors. Voisin et al., (2014) found that early sex engagement and violence are mediating factors toward increased aggression and negative perceptions of peer attitudes about safer sex. The research work of Voisin et al.,(2014)

provided evidence that aggressive behaviors of youth influences their early engagement with sex thus increasing their risk of HIV infection.

The average probability of African-American youth to HIV infection is three times higher with African-American men who have sex with men and women (MSMW) (Operario, Smith, Dillard, Arnold, & Kegeles, 2011). Operario et al., (2011) conducted a cross- sectional survey among 68 African American men who self-identified as urban non-gay- or non-bisexual, who also identify as having sex MSMW for substance use and sexual behaviors. These participants completed a computer-assisted behavior assessment survey. The study revealed that 17.6% of the participants admitted having HIV. Operario et al.,(2011) further found that in a three-month period, 50% to 70% of the respondents committed insertive sex and anal sex with female and male partners. Receptive anal sex was also committed with no protection by 10% to 25% of the respondents. The data show that the prevalence of unprotected sex among African-American youth was high and that 17% of the 68 participants have high probability of infecting their respective sexual partners. Similarly, substance use before the sexual acts is high at 71% to 80%. When the risk of HIV infection was computed, the odds of men who used drugs and had sex with other men were 10 times more likely to commit unsafe sex, while men who have used drugs and had sex with transgender women are five times more likely to engage in unsafe sex. The findings illustrate the need to address recurring issues of substance abuse as well as safer sex education particularly among African-American young men.

Risks Associated with Media Use & Exposure to Sexually Explicit Materials (SEM)

According to a recent study conducted by the Kaiser Family Foundation (Rideout, Foehr, & Roberts, 2010), youth spends approximately 11 hours each day engaging in some form of media use. The most common form of media use is television (TV), followed by music, computers and video games, in addition to portable media platforms such as cell phones, laptops, and handheld video players (Rideout et al., 2010). Depending on depicted content, TV serves as a great potential for influence as one of the more common uses of media that youth utilize for entertainment, communication, and information. The average American teenager will view nearly 14,000 sexual references on television (Committee on Public Education, 2001), given 70% of programs contain sexual content (Kunkel, Eyal, Finnerty, Biely, & Donnerstein, 2005; Rideout et al., 2010) where sexual risks and responsibilities were portrayed in approximately 15% of prime time TV (Kunkel & Cope-Farrar, 2003; Kunkel, Eyal, Donnerstein, Farrar, Biely, & Rideout, 2007). Collins and colleagues (2004) found that youth who viewed content that is more sexual on TV were also more likely to have intercourse and related activities (e.g., oral sex) over the following year compared to those who viewed less sexual content on TV (Collins, Elliot, Berry, Kanouse, Kunkel, Junter, & Miu, 2004). While the literature points to TV having considerable power over the developmental attitudes about sex, its programming can also be viewed via Internet formats including computers and smart phones (Collins, Martino, & Shaw, 2010), just as much as the Internet can be a

function of TV sets. Thus, researchers would do well not to assume which media format users prefer as their primary source of consumption for entertainment or information.

Given its accessibility, affordability, and anonymity, the Internet has become a modernized media source for seeking out sensitive information (Cooper, Shapiro, & Powers, 1998). Compared to individuals of other age groups, youth occupy the largest presence online, with more than 90% who are currently on the Internet (Jones & Fox, 2009) since 60% have their own laptops or computers (Lenhart, 2009) and 84% have Internet access in the home (Collins et al., 2004). Knowing the percentages of youth using the Internet suggests that consumers have a greater likelihood of encountering unsolicited sexually explicit material (Nosko, Wood, & Desmarais, 2007).

Without being subject to federal decency regulations (Gunter, 2012; Akdeniz, 2000), the Internet circulates a considerable selection of hard-core and fetishized images (McNair, 2002) that predominantly requires minimal effort to encounter (Cooper, Shapiro, & Powers, 1998). While Internet users can be exposed to sexually explicit material (SEM) through active or passive methods, many exposures are unintentionally accessed through unsolicited or unwanted means, including pop-up advertisements, inbox messages, or SPAM email (Cameron, Salazar, Bernhardt, Burgess-Whitman, Wingood, & DiClemente, 2005).

Alarmingly, 90% of children aged 8- to 16-years-old have viewed Internet pornography while doing homework on their home computer, the majority of which is unsolicited (Ropelato, 2007).

Several studies reported the extent to which SEM exposure affects youth. Cameron and colleagues (2005) found that younger Internet consumers had received 10-20 daily emails related to SEM. Similarly, the leading Internet security company, Symantec Internet Security Corporation [Symantec] (2003), found that 80% of surveyed children with their own email address had received inappropriate messages. The same survey found 47% of children receiving SPAM email on a daily basis of which 21% would open and view the SPAM email (Symantec, 2003). In the 2005 Youth Internet Safety Survey (YISS) survey, 42% of the 1,500 youth reported exposure to Internet pornography while 66% of those had also reported that all of their exposure was unsolicited (Wolak, Mitchell, & Finkelhor, 2007).

Most noteworthy, the Kaiser Family Foundation sponsored a study that examined the analysis of the 1999-2000 YISS Survey, the analysis disclosed that 70% of youth during their internet searches for health information when inadvertently exposed to Internet pornography (Collins et al., 2004). The same study indicated that unsolicited exposure was not only due to search results but also to website links, misspelled URL web addresses, pop-up advertisements, or SPAM email (Collins et al., 2004; Mitchell et al., 2003). Nosko and colleagues (2007) supported this finding that innocuous search terms stealthily guided online surfing toward sexually explicit content thereby promoting further exploration that would otherwise not been encountered. However, while the YISS surveys present a broad representative sample, they failed to include youth who spend an infrequent amount of time on the Internet in addition to disadvantaged youth. Only one

study found that 46 % of minority and disadvantaged youth attending a primary care clinic were inadvertently exposed to pornographic material online (Braun-Courville & Rojas, 2009) suggesting that disadvantaged youth may have equal susceptibility to unsolicited Internet pornography.

Another study surveying college students found that over 90% of males and 60 % of females were exposed to pornography before the age of 18 (Sabina, Wolak, & Finkelhor, 2008). For males, the average age of first encounters was at 14, the majority intentionally seeking out pornography, whereas the average age for females was 15, the majority reporting involuntary exposure (Sabina, Wolak, & Finkelhor, 2008). A more recent survey found that 15% of 10- to 12-year-olds, 23% of 13- to 15-year-olds, and 28% of 16- to 17-year-olds had unwilling exposure to online SEM (Jones, Mitchell, & Finkelhor, 2012).

According to the 1999-2000 YISS, approximately 8% of 1,500 younger aged youth reported purposefully seeking online pornography whereas 7% sought pornographic material offline (i.e., magazines, movies, telephone sex hotlines; Ybarra & Mitchell, 2005). However, the surreptitious nature of online information seeking virtually eliminates shame or guilt associated with searching for such material through other long-established media resources, such as adult bookstores, magazines, or videos (Carnes, 2003).

Moreover, a 2014 survey conducted by the Covenant Eyes Corporation found that 71% of youth cleared their browsing history to ensure their online sexual activity remain

hidden from their parents (Covenant Eyes Corp., 2014). A previous 2011 survey supported this claim indicating that 42% of youth cleared their browser history subsequent to using the Internet (GFI Software, 2011) but, it also displays a significant increase. As youth have commonly been deliberately or inadvertently exposed to online pornographic material, a 2015 survey found that 92% of youth viewed SEM at home of which 49% occurred when their parents were also home because the parents did not monitor their internet activity (Cox Communications, 2015).

Researchers and public health officials suggest that blocking and filtering software can help reduce the occurrence of unwanted exposure to Internet pornography (Wolak, Mitchell, & Finkelhor, 2007). Even though many parents maintain the appropriate measures to keep their children from Internet SEM exposure, an equal majority of parents do not ensure their children's safety by securing parental controls or filtering software (Covenant Eyes., 2014).

Potential Problems Related to SEM Exposure

Risky behaviors. In general, there is an association between sensation seeking to other risk behaviors including substance use or delinquent behaviors (Ybarra & Mitchell, 2005). This finding is consistent with research indicating an association between risky behaviors such as substance use or delinquent behaviors and early initiation of sexual activities (Brown, 2008). Furthermore, the literature designates that the degree and amount of sexual content through media exposure can influence sexual behaviors among youth. Research has identified predictors to Internet pornography indicating that older

youth and males are more likely to be exposed (Peter & Valkenburg, 2006; Wolak et al., 2007; Ybarra & Mitchell, 2005), in addition to reporting higher scores in sensation seeking (Peter & Valkenburg, 2006). For example, Sinković and colleagues (2013) studied male and female youth tendencies toward sexual sensation seeking (SSS) or the propensity toward the impulsive drive of sexual arousal and stimulation. The authors of this study suggest that high SSS and early exposure to SEM are risk factors for sexual risk-taking.

A number of additional studies have identified relationships between SEM consumption (specifically pornography) and sexual risk taking (Štulhofer et al., 2010; Valkenburg & Peter, 2009; Valkenburg & Peter, 2011; Ward & Wyatt, 1994; Wright & Randall, 2012). Including substance abuse during sexual encounters, having a greater number of sexual partners (Ybarra & Mitchell, 2005; Braun-Courville & Rojas, 2009), and lower self-efficacy surrounding condom use (Castora & Jasinski, 2005; Brown & Vanable, 2007; Kennedy & Limmer, 2007; So, Wong, & DeLeon, 2005). Among college students, substance use and alcohol are some of the major risk factors for practicing unsafe sex (Brown & Vanable, 2007; So et al., 2005). Castora & Jasinski (2005) also found a significant portion of young participants reporting risky sexual behaviors including having sex without a condom due to being under the influence of drugs and/or alcohol, continuation of sex after the condom broke, and refusal of using condoms when their sexual relationship grew more comfortable.

Since Internet SEM is easily accessible, Strasburger, Jordan, & Donnerstein, (2010) further argue that pornography exposure is primarily responsible for encouraging earlier sexual experi-mentation by use of sex and alcohol and by shaping sexual attitudes and behaviors of youth. Specifically, Kennedy and Limmer (2007) investigated the links between sexual health, self-esteem, and alcohol use among 14-15- year-olds attending Roman Catholic high schools in the United Kingdom. This study found that youth who reported being heavy drinkers were more likely to engage in sex and were less likely to use condoms even while holding an ambivalent attitude concerning young parenthood. Participants who had engaged in sex at an earlier age had also reported heavier drinking use than lighter or non-drinkers. However, heavy drinkers were more likely to report unwanted sexual activity as a result of being intoxicated. The same study also found that participants with low self-esteem reported having unprotected sex (Kennedy & Limmer, 2007).

Later studies confirmed that youth's experience with viewing Internet pornography has resulted in more permissive sexual attitudes (i.e., acceptance of casual sex; Braun-Courville & Rojas, 2009; Strouse & Buerkel- Rothfuss, 1987; Zillmann & Bryant, 1988a, 1988b), overrating popular or trending sexual activities, decreased personal satisfaction with sex (Huston, Wartella, & Donnerstein, 1998; Zillmann, 2000), and engaging in anal sex (Braun-Courville & Rojas, 2009).

Research has also found that younger youth were also more likely to engage in oral or vaginal sex compared to others with less exposure (Brown & L'Engle, 2009).

Gender dividing lines. While the Internet contains material that is informative and interesting, significant portions of online content is inaccurate and considered offensive to some consumers (Boies, 2002). Limmer (2010, 2014) has deduced the integration of several themes within pornographic material:

1) Sex is entirely physical and void of emotional response

2) Female pleasure is a by- product of male pleasure, which is paramount by means of ejaculation

3) Heterosexism is normal and to be enforced

4) The expectation that males are to initiate and not decline a sexual opportunity

5) Females are ever-willing sexual objects even if they perform reluctantly

6) Responsibility and consequences of sex are absent.

Within mainstream pornography, sex is a representation of modern masculinity while sending out the message that sex is a competition and women are sex objects, for man's pleasure (Ward & Rivadeneyra,1999). Barron and Kimmel (2000) found that pornography commonly follows a more stereotypical gender role pattern (e.g., men are dominant and women are submissive). The common portrayal female pornstars carries them as sexually available beings, whereas females in real-life may not be as sexually available. Thus, viewing pornography may invoke a state of conflict between the perceptions of one's actual environment and one's physiological reactions to arousal. Moreover, Ward et al.,(1999) attempted to explore gender comparison and "sexual

scripts" and found a positive correlation between the times spent viewing pornography and the tendency for females to believe that women are indeed sex objects and that the motivation underlying male behavior is sex. These "scripts" or value systems depicted on the Internet and in the media may be inconsistent with the values and beliefs shared in family households or that taught in religious or educational institutions (Steele, 1999; Brown, Steele, Walsh-Childers, 2011).

Studies have reported that gender was a significant main effect for online sexual material as a prime indicator of developing sexual lifestyles. History asserts that compared to females, males commonly hold more permissive attitudes toward pornography (Braun-Courville & Rojas, 2009; Fisher & Byrne, 1978). In general, research indicates that males spend more hours online using the Internet for sexual entertainment purposes, while females are more interested in chat rooms and messaging (Albright, 2008; Boies, 2002; Cooper, Shapiro & Powers, 1998; Cooper, Sherer, Boies, & Gordon, 1999; Peter & Valkenburg, 2006). It appears that males and females have different goals when engaging in online sexual behaviors. Females were more likely to choose relationship-oriented material (Brown, 2002) because of the relational context provided through chat rooms (Albright, 2008), whereas males preferred more action-oriented material (Brown, 2002) as they might be seeking sexual gratification through viewing Internet pornography (Albright, 2008).

Researchers attempted to investigate potential variables that lead to positive attitudes toward online SEM. Common predictors of Internet pornography consumption

include being male, politically liberal, unhappily married, and having engaged in paid sex, having poor religious affiliations and prior occasions of adultery (Stack, Wasserman, & Kern, 2004).

Researchers further reported that male college students found SEM material to be arousing (Boies, 2002; Goodson, McCormick, & Evans, 2001). Additionally, the sheer number of hours that males spent on the computer and their curiosity for online SEM predicted searching behaviors, positive attitudes, and a greater tendency to explore unsolicited SPAM emails and pop-up advertisements (Nosko et al., 2007).

Since males tend to seek online SEM (Boies, 2002; Peter & Valkenburg, 2006) they are also more likely to find such material arousing compared to females who may consider SEM disturbing (Nosko et al., 2007). Consistent with this finding, Goodson and colleagues (2001) reported that female college students were more likely to experience disgust and anger toward online SEM. Nosko and colleagues (2007) supported the findings that females had more a distasteful reaction toward online pornography than males. However, one study found no gender difference among those who found online SEM boring or disturbing; and younger females preferred viewing online SEM rather than chatting online (Boies, 2002). Nevertheless, while data suggests that female viewers of pornography have risen, research indicates that females generally view pornography with a partner (Poulsen, Busby, & Galovan, 2013), which could be interpreted as females adhering to gratify her partner's sexual interests or curiosities. Furthermore, the literature found that females held less positive views on unsolicited SEM and may find such

material degrading towards women (Nosko et al., 2007). These findings are best understood when one considers the misogynistic nature of pornography.

Yet, out of 813 students attending U.S. schools, one study found that approximately 67% of young males and 49% of young females agreed that pornography was acceptable method of sexual expression (Carroll, Padilla-Walker, Nelson, Olsen, Barry, & Madsen, 2008). Cooper and colleagues (1998) further investigated the effects of SEM on the cognitive, behavioral, emotional, and physiological levels of Internet users and found that both males and females experienced some degree of satisfaction with their online activities. Nearly 90% of this sample did not endorse feelings of guilt or shame; however, 70% indicated that they kept their online activities a secret from others (Cooper et al., 1998). If this secrecy were the case for a large portion of Internet pornography consumers, then it would contradict the public's justification that pornography is a normalized product of mainstream society and socially acceptable form of media (Paul, 2005).

As SEM is an increasingly more recognizable product in society, the literature has also recognized that seeking online pornography could equally serve as a valuable therapeutic tool during sex therapy treatment with long-term couples experiencing sexual boredom or disinterest in their relationships (Albright, 2008). One study found unique outcomes in a sample of 760 young adults who reported that viewing SEM online had allowed them to learn new techniques thereby improving offline sexual relationships in addition to satisfying curiosity, fulfilling sexual fantasies, and increasing arousal (Boies,

2002). A more recent study found that partners who viewed pornography together not only enhanced their sexual relationship, but also increased positive sexual communication while decreasing male arousal difficulties and negative self-views for females (Daneback, Traen, & Mansson, 2009).

Sexual communication includes discussions about safe and satisfying sexual practices that promote positive sexual satisfaction and healthy sexual functioning (Whitaker, Miller, May, & Levin, 1999; Oattes & Offman, 2007). However, a lack of sexual communication often impedes the chance for positive and healthy disclosure for specific sexual likes and dislikes (Oattes & Offman, 2007). Recent research found that compared to non-viewers, porn viewers are more likely to report negative communication with a partner, contempt, criticism, defensiveness, and lower relationship quality (Poulsen et al., 2013). This relationship dissatisfaction can greatly affect an individual's sexual self- esteem.

However, Weinberg, Williams, Kleiner, & Irizarry, (2010) suggests that pornography can help serve a positive purpose for female sexuality. A small percentage of females in Albright's (2008) study had integrated online pornographic scenarios with their partners, which was likely to provide opportunities for them to look and feel sexual. Additionally, Albright's (2008) female sample was found to feel more comfortable in open conversation about trying new activities to increase arousal. However, female participants were also more likely to engage in less sex with their partners due to feeling

pressured to perform similar sex scenarios and feeling criticized about their bodies as a result of their partner's viewing SEM (Albright, 2008).

Prolonged exposure to pornography has not only been found to reduce trust, attraction, and intimacy within significant relationships, but also increase an exaggerated perception of human sexuality while exaggerating the benefits of promiscuity (Zillmann, 2000). For instance, Pamela Paul, author of *Pornified* (2005), interviewed mostly male Internet users and found that pornography heavily dictated their thoughts about sex while often needing to replicate scenes or images in order to achieve an orgasm during intercourse with their partners. Additionally, the interviewees reported experiencing unwanted sexual images from pornography that would penetrate their thoughts during sex with their partners (Paul, 2005).

According to social exchange theory, Internet users will remain in romantic relationships if alternatives that are more attractive are not immediately accessible (Rusbult & Buunk, 1993). However, the Internet provides consumers with a direct expression of their fantasies that is uninhibited by the morals, ethics, and legalities of society (Barron & Kimmel, 2000). Consequently, partners of those with online SEM involvement reported feeling abandoned, humiliated and rejected, and had often compared their body image and sex appeal to pornstars (Schneider, 2000). As a result of their partner's use of pornography, the research found that 42% of women felt insecure, 41% felt less attractive, and 30% felt sexually objectified (Manning, 2005; Zurbriggen, Collins, Lamb, Roberts, Tolman, Ward, & Blake, 2007). Because of this, a large

majority of females go to great lengths to conform to the sexual ideals of stars acting in pornography, including plastic surgery for breast augmentation, vaginal tightening, labiaplasty, and hymen replacement (Albright, 2008).

Additional adverse consequences from their partner's pornography compulsion included meeting minimum diagnostic criteria for post-traumatic stress disorder and displaying severe functional impairment in daily life (Steffens & Remmie, 2006). Risky behaviors, compulsive overuse, and pornography are recurrent Internet-related problems that are treated by mental health professionals (Mitchell, Becker-Blease, & Finkelhor, 2005).

Sexual violence. Earlier research reported that the habitual consumption of pornography could result in a weakened satisfaction with less explicit forms of pornography and an equally stronger desire for more deviant and violent material (Marshall, 1988). The literature has explored the content of pornography signifying the negative effects of sexual violence, especially on men's attitudes toward women (Barron & Kimmel, 2000; Mayerson & Taylor, 1987). In particular, research indicates that a majority of Internet pornography depicts victims of violence as female (Barron & Kimmel, 2000). Investigators speculate that since male pornstars are primarily depicted in a more dominant stereotyped gender role as the aggressor, action taken by both producers and consumers of pornography have democratized violence and facilitated the sexual objectification of women through misogyny (i.e., females are victims; Barron & Kimmel, 2000).

Exploring a parallel process, studies investigating the effects of violent video games on aggression have shown that repeated exposure to a violent stimulus resulted in eventual desensitization (Bartholomew, Sestir, & Davis, 2005). Similarly, Goodson and colleagues (2001) found computer users with frequent exposure to online SEM became less shocked and more comfortable by responding positively to passive means of access. Additional research supports this finding suggesting that repeated exposure to SEM raises a person's positive appraisal of such material over time (Byrne & Osland, 2000) and may encourage the consumer to seek out more violent SEM that will heighten their arousal (Barron & Kimmel, 2000).

Even more convincing, Vega and Malamuth (2007) found that violent pornography appears to affect sexual aggressiveness (i.e., through reinforcing and normalizing aggressive sexual behavior) in youth, but only with those who are prone to aggressive tendencies. Consistent with earlier studies investigating the adverse consequences from exposure to sexually violent materials (Norris, 1991), a review of two meta-analyses totaling a collective sample of 16,591 found that exposure to violent pornography was positively correlated with accepting rape myths and other deviant behavior (Manning, 2005; Owens, Behun, Manning, & Reid, 2014). This finding was confirmed in an earlier study by Malamuth & Check (1985) and further supported by cross-sectional and longitudinal research (Mallet & Herbé, 2011).

One study (Corne, Briere, & Esses, 1992) found that the early consumption of pornography among female university students likely contributed to the socialization and

acceptance of rape fantasies. Thus, viewing pornography may adversely shape women's attitudes regarding sexual aggression against women in such manner; the event is pleasurable. Research suggests that early exposure to SEM can have a number of effects, including social, emotional, and psychological consequences such as traumatic or negative emotional responses, misinformation about human sexuality, overestimation of unusual sexual activities, sexual compulsivity and addiction, and reinforcement of objectification of humans and commoditization of sex (Manning, 2005). Few studies found that greater negative affect (Malamuth, Haber, & Feshbach, 1980) and decreased self-esteem (Mayerson & Taylor, 1987) was associated with a woman's reaction to violent pornography that supports acceptance of violence against women. Furthermore, the literature indicates that holding rape myth beliefs predicts dating violence in young males (Mallet & Herbé, 2011). One study surveyed a program for battered women and found a significant increase in sexual abuse when their abusers consumed pornography while sexual abuse was three-times more likely when alcohol was involved (Shope, 2004).

Equally concerning, a recent meta-analysis found that exposure to pornographic material promoted additional risks such as sexual deviancy and sexual offenses (Manning, 2006). In fact, Mancini, Reckenwald, and Beauregard (2012) recently discovered that early exposure to porn was a significant predictor of victim violence perpetration and humiliation. Similarly, some populations of youth who experience early exposure to pornography (under 14 years of age) were more likely to participate in

deviant sexual practices, predominately adult men who rape women. Marshall (1988). Zillman and Bryant (1984, 1986,1988) further found that male youth who had viewed more pornography were more inclined to trivialize rape against women. Thus, pornography takes violence against women, sexualizes it, and ultimately renders violence invisible.

Intimate Partner Violence

Like HIV, Intimate partner violence is a significant public health problem and is a pervasive problem within the African-American community. Estimates of the lifetime prevalence of IPV among African American women is 29.1% compared to 24.8% among Caucasian women (Finfgeld-Connett, 2014). In 2011, 94% of the African-American women knew their murderers and of this number 52% were intimately involved (VPC.org, 2013a). In the same year, African-American women were also murdered at a rate more than two and a half times higher than Caucasian women (VPC.org, 2013). In the state of Georgia, in 2010, there were 130 deaths related to intimate violence. Intimate partner violence sometimes referred to as domestic violence is defined as the behavior or action within an intimate relationship that causes physical, sexual, or psychological harm (Swartzendruber et al., 2012). Through the abusive behavior, the batterer uses coercion, manipulation, deception, humiliation, harassment and or force to establish and maintain power and control (Jordan, 2006).

Theories explaining the higher prevalence among African-American women include poverty, racism, discrimination, social disorganization, hyper-masculine, anti-

social, promiscuous roles, and stereotypes related to both African-American men and women (Finfgeld-Connett, 2014).

Intimate Partner Violence and HIV

Physical assault is common among women in the United States with more than 5 million assaulted annually, and these women are 5 to 8 times more likely to know and to be in a relationship with the perpetrator of the assault (Zierler et al., 2000). The epidemiology of intimate partner violence against women mirrors the epidemiology of HIV infection. The risk factors common to both include poverty: unemployment, drug dependency, childhood sexual abuse, physical abuse, being younger than the age of 30, lower educational levels, low self-esteem, mood disorders, and homelessness (Campbell 1993; Cohen et al., 2000; Kalichman & Kelly, 2000; Zierler et al., 2000). Other studies indicate that women with HIV infection are prone to partner violence at the time of disclosure or due to associated alcohol or drug abuse (Cohen et al., 2000 Zierler et al., 2000).

Seth et al., (2014) concluded that young African-American women experiencing intimate partner violence were unable to appropriately negotiate condom use or practice preventative measures against sexually transmitted illnesses. Thus, causing associated adverse health outcomes and increased health care expenditures.

Theoretical Framework

This study utilized the theory of gender and power (Connell, 1987) and the social cognitive theory of Bandura (1986) in the analysis of social struggles that marginalize

women in the aspect of sexual control, dominance, and the practice of safe sex. The theory of gender and power focuses on the social structure mechanisms that impose gender-based roles while social cognitive theory focuses on the motivations of women to end violence, inequalities, and social disparities that affect their overall wellbeing. This section details the theoretical postulations of each of these theories.

Theory of Gender and Power. In 1987, Robert Connell developed the theory of gender and power to explain the sexual inequity and imbalances associated with gender and power. As applied to public health, the theory of gender and power postulates that societal and institutional levels detect factors of exposure and risks, biological, and other issues that affect the health of women such as risks of HIV and sexually transmitted disease due to condom usage and violence experienced by women (Wingood & DiClemente, 2000). In the theory of gender and power, the society in general and its institutions play roles in the operationalization of gender and power. Various researchers in public health utilized the theory of gender and power to examine health issues among women affected by gender-based inequalities and health disparities. The theory was popular as a framework for the analysis of acquired risks associated with economic, physical, and social exposures including biological factors related to the health and wellbeing of women in the society.

In the philosophical writing of Connell (1987), explored the presence of social structures underlying the relationship between gender and power. Connell postulated that sexual division of labor, sexual division of power, and the structure of cathexis explain

social inequity and heterosexual relationship between men and women. These constructs are separate structures but overlap in certain situations, which influence the physical wellbeing of women (Connell, 1987).

At the societal level, Connell (1987) claimed that "sexual division of labor" marginalizes the economic role of women. When compared to men, women receive the assignments of low paying occupations. The society imposes gender specific occupations where men are entitled to engage in leadership and management positions while professional careers of women are limited to clerical positions. At the institutional level, women struggle to perform uncompensated tasks such as rearing of children and doing household chores.

Familial responsibilities were the "work of women" and often regarded with no economic value. Women who work as house helpers earned menial pay despite performing hard labor responsibilities. The economic disparities associated with gender labor assignments affect the health and wellbeing of women. Moreover, socioeconomic disadvantages further marginalize women in both societal and institutional levels. Ethnicity, age, poverty, and education are among the factors that determine the levels of women's marginalization in the society.

Bueno (2015) demonstrated this phenomenon among women workers in the Dominican Republic. Bueno determined the implication of race, gender, and class to social and economic opportunities for low-income African women. The authors utilized a qualitative inquiry approach in observing the stratification processes that women

struggled to access their social and economic opportunities. Bueno found that social and economic hierarchies devalued the contribution of women in the workforce by suppressing their wages and benefits. In Connell's study, women who are young, poor, and less educated have double the marginalization when compared to women who are old, affluent, and educated. The former group is more at risk for deprived health outcomes than the latter group.

In terms of the sexual division of power, Connell (1987) postulates that the disparities of power between women and men emanates from the societal level. Meaning, the social culture views power as the strength that men should possess more so than women. At the institutional level, the operationalization of the construct of the sexual division of power is by how the individual's maintain and control the power. Raj, Silverman, Wingood, & DiClemente, (1999) who investigated abuse of power among heterosexual relationships explored this theoretical assumption. Raj et al., (1999) claim that the manifestation of abuse of power is through men's jealous accusations of women. Men lack the empathy for women because of the social belief that women have a caring responsibility to men, and that the feelings of women should not supersede to the feelings of men. When applied to public health these theoretical postulations place women at risk of sexually transmitted illnesses, which include HIV. The sexual division of power situates women in an environment of violence, poverty, substance abuse, and sex education.

The third construct in the theory of gender and power is the structure of cathexis, where "social norms and affective attachment" are valued in social and political decisions. The cathexis as a theoretical construct emerged based on the need to explain the affective side of the social relationship (Connell, 1987; Connell et al., 2005). At the institutional level, cathexis structure assigns cultural gender specific roles that further marginalize women in a heterosexual relationship (Connell, 1987). Examples of these gender roles include the belief that women should carry the caring responsibilities to men. At the societal level, operationalization of the concept of cathexis is by exemplifying the women's sexual attachments, which dictates their sexual behavior. An example of this includes the inhibitions of women against sexual education. As applied in the public health, women are at risk of HIV infection due to limited HIV knowledge and the perceived notion that women are not vulnerable to this type of infection. Women have power-limited control over condom use, which makes them more vulnerable to STDs and HIV.

The three structures (the sexual division of labor, sexual division of power, and structure of cathexis) of the theory of gender and power are interrelated and often overlap with each other. Connell's (1987) theoretical postulations are essential in understanding health-related issues among women and in the design of public health policy and programs that affect women. The standpoint of public health and psychology posits that gender-based inequities and disparities are factors that influence the health and well-

being of women. This belief made the seminal work of Connell at the forefront of the discussion concerning women and their access to safe and healthy environments.

In public health research, several scholars hypothesize that acquired risks or exposures of women to economic, physical, and social problems increase their risk of developing a disease. The scholars, who focus on the psychosocial exposures such as the knowledge, attitude, beliefs, and skills of women, claim that these exposures increase the risk of women to develop or acquire a disease. These risks are not limited to a single level but acquired at the levels of interpersonal, individual, and demonstrated in either socioeconomic, personal, or behavioral areas. In the field of medicine, for instance, researchers explored the risk at the individual level and the concern often focuses on the biological exposure risk of women.

Summarizing these concepts, the theory of gender and power suggests that the labor, power, and cathexis social structure occurs at the social and institutional levels controlled and maintained by certain social mechanisms. The mechanisms operating in these structures result in inequities and disparities that specifically affect the women. Among the controversial gender-based inequities are control of resources and social roles imposed on women. There is agreement among the fields of social and behavioral sciences including public health and medicine that these social mechanisms existing in these social structures increase women's vulnerability to acquiring diseases particularly HIV and STDs.

Social Cognitive Theory. The social cognitive theory originated from the earlier work of Holt and Brown (1931) who opined that actions of animals including humans are results of the psychological needs to feel, think, and desire. The original postulation of the social cognitive theory is that imitations occur when there is precedence of imitations (Holt & Brown, 1931). For imitation to occur, an individual has to undergo the process of imitation, which is a learned process. As used in the fields of psychology, communication, and education, the social cognitive theory states that observations in social interactions and the learned experiences influence the acquisition of individual's knowledge. In social cognitive theory, an individual remembers the sequence of observed behavior and utilizes the learning gained from the observation as a guide in the individual's subsequent behavior (Bandura, 1986, 1999). The replication of certain observed behaviors is dependent on the rewards or punishments associated with the behaviors.

Social cognitive theory is the belief that one has the power to produce self-efficacy by completing a given task or activity related to that competency. People's perceptions of their ability or inability to attain goals relates to the social cognitive theory. The stronger the perceived self-efficacy, the more active the efforts are. Self-efficacy is a trait that allows one to gain corrective experiences that reinforce the ability to achieve goals through personal choice, motivation, effort, and persistence (Bandura, 1977, 1997, 1999). The importance of self-efficacy in the theoretical construct of the

social cognitive theory motivated Bandura to explore further the concept and introduced a more recent model.

Albert Bandura (1999) postulated the theory of self-efficacy to explain the indications of individual behavior change. The conceptualization of the theory was from the social cognitive framework (Bandura, 1999). Bandura claimed that psychological change is a process of individual's alteration of expected mastery learned from the experiences. Bandura demonstrated his theory on people with depressive disorders who distort the meaning of his or her accomplishments with failures. The Self-efficacy theory purports that 'efficacy beliefs' play a large role in influencing how a person thinks, feels, motivates oneself and behaves.

An essential element in the self-efficacy theory of Bandura is the delivery of information to influence change in behavior. Efficacy beliefs develop from four main resources that include (a) mastery experiences, (b) vicarious experiences, (c) social persuasion, and (d) physiological and emotional states (Bandura, 1986,1999). These sources reached individual's discernment through cognitive appraisal. Bandura identified the factors that affect the successful discernment of an individual through modeling, desensitization, and exposure of performance, and self-instruction. The use of live and symbolic modeling affects vicarious experience while persuasion by words affects self-instruction and interpretive meaning of actions. Exposure to experience, attribution of actions, and symbolic desensitization influence emotional arousal.

According to self-efficacy theory, individuals can affect their own capabilities, depending on the level of their belief in their own capacity and competency (Bandura, 1977,1999). An individual can change the behavior with self-motivation and determination required to make the change happen (Bandura, 1986). The precursors of self-efficacy are developing understanding and practice of self-management behaviors. Research has demonstrated that understanding self-management behaviors improves when efficacy perceptions are not ignored (Beck & Lund, 1981).

The theoretical postulations of Bandura's theory suggest that dimensions of beliefs of self-efficacy are task-specific, which requires different means of evaluation (Gist, 1987). Studies show that utilization of certain behaviors is effective in measuring the effects of self-efficacy (Martin-Ginis, Latimer, Arbor-Nicitopoulos, Bassett, & Wolfe, 2011). A functional self-efficacy requires skills in self-managing the behavior as well as positive disposition (Busby, Ingram, Bowron, Oliver, & Lyons, 2012). Research demonstrates that beliefs of self-control and regulations of an individual's behavior relate with how an individual perceived the impact of these actions. The perceptions and acquired experiences of an individual contribute to his or her understanding concerning control and regulations of behaviors. The conceptual inclusion of individual's experiences and awareness of actions illustrates Bandura's view of social cognitive theory.

In line with self-efficacy theory and the cognitive model, three factors influence self-efficacy, namely behaviors, the environment, and personal cognitive factors

(Bandura, 1977). External environment plays an important role in improving self-efficacy, as do personal cognitive factors. Because of the complexity of the social structures and mechanisms that hinder women to control over their lives, women tend to become discouraged about their ability to change these structures. However, the self-efficacy theory implies that by influencing these women to believe they can change these mechanisms, their internalized conviction manifests in the improvement of their behaviors particularly on matters that affect their health.

Social Discrimination and Prejudices

While social discrimination has been widely understood as differing social treatments to individuals, sociologists argued that social discrimination is essentially a social phenomenon resulting from differing culture, ethnicity, race, and sexual orientation (Ponterotto, Utsey, & Pedersen, 2006). The phenomenon is particularly observable in social groups that impose prejudgments or prejudices against other social groups. Sociologists, as well as psychologists, contend that prejudice is an attitude against a person, which includes loathing and dislikes (Fiske, 2016; Jones, 1997).

Social discrimination is an ideological term that is associated with power relationships among individuals and groups of individuals in the community. As an ideology, social discrimination has three systematically distinct elements. These elements are: (a) discrimination as a means of unifying social relationships, (b) discrimination as a means of establishing power over others, and (c) discrimination as a set of political and organizational practices affected by formal and informal structures in

the realm of the state, market, and civil activities (Harriss-White & Prakash, 2010). Social discrimination operates as a requisite of social engagements among individuals who have roles and responsibilities within a social system. Because relations of people within the system are interactive, each group acquires power to impose social rules. The imposition of rules and the increasing dominion of power relations create gaps, which economically and socially affect individuals. These imposing social rules eventually become the norms and practices that affect the individuals who are powerless to assert their rights (Harriss-White & Prakash, 2010).

Documentation of several forms and manifestations of social discrimination exist. These forms vary from one view to the other. A discussion of social discrimination manifestations is essential in this study, as the concept of colorism is a form of discrimination. For the purpose of this paper, differentiation regarding acts of social discrimination is from the perspective of the legal system. Within this view, social discrimination can be classified according to (a) direct and indirect, (b) unequal treatment and impact, and (c) deliberate, institutional, individual, and structural (Altman, 2011). Direct discrimination involves the intentional acts of individual or social groups to impose difficulty of other social groups. For instance, a policy maker enacts a policy, which makes no explicit reference yet intentionally imposes drawbacks to a social group (Altman, 2011). Indirect discrimination, on the other hand, emphasizes the absence of malicious intentions to harm or discriminate a person or social group. Both direct and

indirect acts of discrimination impose unequal treatment and impacts to the lives of the affected individual (Altman, 2011).

In the case of institutional and structural discrimination, agents act in a collective capacity to discriminate directly or indirectly against a person or certain social group. Institutions within a community (e.g., school, a government ministry, and business corporations) impose intentions through policies, through the enactment and implementation set forth by the official powers of the leaders. This form of discrimination cuts across the individual and social group discrimination because leaders that deliberately allow the discrimination to happen share the extents of the acts. When acts of discrimination penetrate into the social system and become common practice by other social groups, the acts become pervasive and appear to be part of the social norm (Altman, 2011).

Many researchers have identified various forms of structural social discrimination. Ayala, Bingham, Kim, Wheeler, and Millet (2012) claimed that segregation, social exclusion, and racial stereotyping are forms of social discrimination encountered by an individual. In the case of this study, I determined if the acts of social discrimination against persons of color particularly among AAW increases the risk of developing HIV. Often viewed as a less significant public health issue, the impact social discrimination could potentially contribute is alarming. Acts of social discrimination can be a public health issue, particularly when cases of social discrimination result in limiting access to health care and in committing violence. In the study of the Rojas, Reser, Usher,

& Toland, (2012), individuals who live in community violence suffer stress and trauma, which could result to further health implications such as suicide. The effects of social discrimination can include social, economic, and political implications.

The examination of the sources and the typology of social discrimination are important in the context of (a) determining the interrelatedness of social, structural, and interpersonal factors that shape discrimination, and (b) identifying possible interventions for the consequences or impacts associated with discrimination (Han, 2008). For the purpose of the review, the researcher intended to associate colorism as a form of social discrimination. Among the expressions of these social phenomena are an exclusion of the discriminated individual or social group in community events and denial of the rights as a member of the society (Kudler, 2007). When discriminated individual experience social exclusions, the individual may experience social prohibition such as claiming the available rights and benefits (Han, 2008). This social prohibition can contribute to psychological stress.

Prejudices. Jones (1997) claimed that one cannot understand the concept of social discrimination without understanding the concept of prejudice. Allport (1979) was among the researchers who provided a concrete conceptualization of prejudice. Allport defined prejudice as a term with negative connotations. Allport (1979) defined the term as forming an a negative opinion of an individual without cause or with actual experience. This definitions articulate two components. These are attitude and belief.

Ponterotto, Utsey, and Pedersen (2006) posited that the attitude component could be either negative or positive, which conceptually links to an erroneous belief.

While the concept of prejudice may have positive or negative views, racial and ethnic prejudices in many White countries uphold negative connotations (Allport, 1979). Allport (1979) offered a concrete definition of negative ethnic prejudice when he stated, Ethnic prejudice is a negative opinion, which is based on untrue preconceived judgements and notions about a group of people or an individual within that group.

Ponterotto (1991) conducted an analytical review of the earlier views of prejudice. The author cited that Allport's (1979) definition of prejudice had three important elements. First, the nature of prejudice comes with a negative view of a group or individuals. Second, prejudice is part of an individual belief system that carries demonstration without substantial data. Third, prejudice is an unbendable belief that an individual may not express the prejudice through actions. In light of the Ponterotto (1991) and Allport (1979) studies, prejudice is an internal belief system and attitude against a person or group of persons that are not always express through actions.

The psychologist Gordon Allport (1979) offers an analytical view of the expressions of prejudices. While Allport's (1979) five-phase model of prejudice expression delineated a psychological view that at some point contradicts a sociological view, the model remains relevant in the context of determining possible prejudice acts that an individual experienced in a group. As applied in the present study, the expressions of prejudice may manifest among perpetrators involved in inter- minority

racism. In Allport's (1979) model, discrimination is the third phase of expression among antilocution, avoidance, physical attack, and extermination. Allport argued that expression of prejudice works in a continuum system, which escalates from passive actions to a more active movement.

In the first phase, *antilocution,* like-minded individuals, and a stranger engage in prejudicial communication. Antilocution is the mildest form of prejudice, and its demonstration is in a controlled expression of views to a limited number of individuals.

Ponterotto, Utsey, and Pedersen (2006) cited an example of an antilocution incident where White people express fears that the number of African-Americans in the neighborhood may affect the value of their land property and may expose their children to violent children of African-American families.

In the second phase, *avoidance,* the individual with prejudice avoids social contact with the prejudiced group. The actions escalate from mere mild discussion to conscious effort of avoiding the individual even if it means sacrificing the convenience. Ponterotto et al., (2006) cited an incident that demonstrates how the avoidance phase works in the model. Ponterotto et al., (2006) articulated that a Caucasian professor might get off at a certain bus stop and walks six blocks to get his or her way to work just to avoid the bus stop where majority of the bus riders are African-American.

In the third phase, discrimination, the actions of an individual escalate from mere discussion and demonstration of avoidance to active moves of excluding or denying member of the prejudiced group the access and participation to an activity that is

supposed to be available to all. Discrimination practices have led various issues of political, social, and economic segregation, which prevented minority groups' access to government services for the achievement of quality of life.

The fourth phase, physical attack, involves violent actions between two opposing parties. Under this phase, both parties are in emotional conditions that resort to physical violence. Ponterotto, Utsey, and Pedersen (2006) cited an example of gang wars of Caucasian and African-American high school students. Ponterotto et al., (2006) further claimed that physical violence even happens during religious rights of both races.

The final phase, *extermination*, involves an intentional destruction of an individual or group of individual within a society. The phase may involve indirect physical violence, particularly when the prejudiced individual struggles to assert their rights in society. However, the majority of the extermination cases involve life destruction such as massacre. Ponterotto et al., (2006) cited Hitlerian genocide, Nazi destruction of the Jewish people, mass destruction of millions of African people, and the story of the massacre of American Indians in the lower 48 states of the United States as classical examples of extermination. Though the continuum model of expression of prejudice proposed by Allport (1979) is within the field of psychology, the model remains one of the valid constructs in explaining individual tendencies.

Colorism

One of the physical attributes of the human race is skin color (Hersch, 2006). Although genetic markers show an insignificant variation of the human race, the skin

color displays greater distinction between each race particularly their responses to ultraviolet radiation exposures (Hill, 2002). For instance, darker skin individual have a high probability of originating from countries close to the equator. Biological studies explain that darker skin is nature's remedy to prevent from sunburn, sweat gland damages, skin cancer, and photolysis of folate (Jablonski, 2006). Although skin color is associated with race, the term "race" is a social construct that differentiates human population groups. In fact, there are several attempts to abolish racial and ethnic information as a variable in epidemiologic, biomedical, and public health research (Wolf, 2006). The skin color is a potential variable that could replace racial and ethnicities due to its ability to provide information concerning the past living environments of people and, therefore, restricted in describing racial identity (Jablonski, 2006).

In 1982, Alice Walker introduced the term "colorism" to describe a social prejudice based on an individual's skin color. Colorism is a term associated with discrimination attached to a perception that an individual whose color of skin is socially and economically less valuable (Hughes et al., 1990). Walker (1982) argued that colorism is not a synonym word of racism because race as a form of social discrimination is determined based on multiple factors that include ancestry of an individual. Racism is a concept that deals with the belief in superiority and inferiority of a race of an individual. Although the social and moral traits of a person are inherent with biological characteristics associated with a racial group (Cornell & Hartmann, 1998), exposure to different environments gave individuals views and perceptions that may not be similar to

other members of the group. Influenced by belief or prejudices, racism contends that a person's characteristics such as skin color, customs and practices, origin, and language are associated with social class.

According to Hughes & Hertel, (1990), skin color is one out of several mechanisms that socially assign an individual to a specific race. However, the society has set of assumptions attached to racial categories, which makes skin color an insignificant indication of race (Parra, Kittles, & Shriver, 2004). Moreover, racism is associated with social and economic status attached to specific race. Colorism, on the other hand, only depends on the associated social meaning of an individual's skin color. Hughes et al.,(1990) stressed that differential treatment of an individual because of their skin color alone is colorism.

Throughout the globe, the case of colorism is prevalent in Africa, East and Southeast Asia, United States of America, Latin America, and India. The prevalence of colorism is a result of studies that explore the phenomenon of "pigmentocracy" in a society where wealth and social status of an individual equates with the color of the skin. Social scientists who explored the cases of pigmentocracies claimed that individuals with light skin tone achieve higher social status than those with dark skin tones. Social hierarchy places, the light-skinned individual at the highest level of the pyramid, brown-skinned at the middle, and the dark brown-skinned individual occupy the bottom of the hierarchy. The darker the skin tones of an individual, the lower social and economic opportunities are available to him or her.

The rise of the concept of pigmentocracy urged social scientist to developed reliable measures of skin color. Among prominent scholars who introduced these measures were Massey, Martin, Charles, Lundy, and Fischer. Martin, Massey, Charles, Lundy, and Fischer originally conceptualized the skin tone scales in 2003 to carry out the National Longitudinal Study of Freshmen (2003 NIS). In 2006, Massey and Martin enhanced the scales after the need to conduct the New Immigrant Survey. Interviewers who memorize the chart before interviewing the respondent administer the skin tone scale or the M&M scale. The scale is an 11-point scale instrument, where 0 represents an absence of color and 11 the darkest possible skin tone

Hersch (2008) proved the relationship of the skin color of an individual to access of social and economic services. Hersch analyzed the United States' New Immigrant Survey (2003 NIS) to determine the effect of skin color and height in the salary wage of new immigrants in the country. Hersch utilized the NIS skin color 11-point scale to determine the respondents' skin tone. The author controlled the effect of other variables such as proficiency in English, educational attainment, occupation in the home country, country of birth, background of the family, race, and ethnicity to specifically understand the contribution of an individual's physical characteristics to their economic success. From the sample of 2,084 legal immigrants, the interviews based on their skin tone and current earnings revealed that immigrants with lighter skin tone earned 8-15% higher than immigrants with darker skin tones. Hersch claimed that discrimination appeared to explain the wage disparity. Hersch (2008, 2010) noted that even among immigrants with

similar educational attainment, immigrants who are one shade lighter than their counterpart earned at least 1% higher. The findings of other scholars were consistent with the findings of Hersch and claimed that skin-tone prejudice is prevalent in the United States.

Hannon and DeFina (2014) explained in their study that colorism is more difficult to document than racism because the rarity of scholars who have the interest to collect data and propose instruments that measures skin tone as a form of discrimination. Hannon and DeFina explored the validity of skin tone scale including the graphically designed color guide to enhance the consistency of raters. The authors used logistic regression analysis in analyzing the National Longitudinal Survey of Youth and General Social Survey. The results of the study revealed that race of the interviewer influences the assessment of skin tone of the respondents. The authors found that Caucasian interviewer assesses the African-American respondents three times darker than the African-American interviewer does.

Hannon and DeFina (2014) recommended the need to determine the effects of interviewer's racial biases to address potential impacts in the colorism study findings. The researchers further recommended an additional color scale to resolve issues of inter-racial skin color confusion.

Byrd, Brunn-Bevel, & Sexton, (2014) examined the academic performance of African-American students in elite colleges and universities. Byrd et al., explored the differences between native African-Americans, Blacks from Caribbean, Latin America,

and Africa, and Blacks from other countries to determine the possible disparities these students encountered in college. The study revealed that although these students share similar shades of skin color, they differ significantly in terms of academic performance, social views, and camaraderie with Caucasians, and college preparation. Byrd et al., was among the scholars who argued that colorism should not be associated with racism.

Summary

Two significant public health concerns that threaten the health and welfare of the African American community are intimate partner violence and HIV/AIDS; at the center of the conundrum are the women. Heterosexual African-American women outnumber all other ethnicities regarding HIV infection incidence and the prevalence of violence. Although, poverty, drug and alcohol addiction, low self-esteem, low educational levels are not restricted to African Americans, certain types of racism and discrimination is inherent in the American society and remains. For example, two separate studies Krieger, (1990) and Krieger & Sidney (1996) examined the impact of racial and gender discrimination on health. The findings suggested that elevation in a person's blood pressure was an internalized response to unfair/racial discrimination.

Because of the overlapping nature of HIV and Intimate Partner Violence Risk factors regardless of the prevention program each should be taught in tandem and within the scope of cultural diversity that includes colorism.

Chapter 3: Methodology

Introduction

The purpose of this study was to assess the relationships among colorism, IPV, and high-risk sexual behaviors among AAW over the age of 18. Additionally, this study examined the potential confounding variables role in the relationships between IPV, high-risk sexual behaviors, as well as colorism among AAW. The participants of this study self-identified as AAW with previous experience of relationship violence and were residents within the southern region of the U.S. The focus of recruitment efforts involved public health departments and or clinics, domestic violence agencies, public libraries, community wellness clinics, churches, as well as social media. The subsequent completion of the participant interview process was through an integrated survey, comprised of four major questionnaires. This study utilized the following questionnaires to gather data, the Sexual Coercion in Intimate Relationships Scale, the In-Group Colorism Scale, the Modified Abuse Assessment Survey, and HIV Screening Tool. The Sexual Coercion in Intimate Relationships Scale and the modified abuse scale gathered information regarding the level of IPV among AAW, while the In-Group Colorism Scale gathered data about colorism among AAW. The HIV Screening Tool gathered information regarding the high-risk sexual behaviors among AAW in terms of their risks of obtaining HIV. The demographic questionnaire focused on information related to income, marital status, age, location, employment, and the educational background of the selected participants. The total time to complete the survey was 10 minutes (testing five

women, ranging in age from 18-52, their times were as follows: 10, 8, 10, 12, and 9 minutes respectively). Overall, the average time to complete a paper-pencil version of the survey was 9.8 minutes. None of the women who participated in the timing of the survey participated in the actual study, as destruction of the surveys took place upon completion. February 2016 marked the acquisition of the Institutional Review Board's (IRB) approval for this study. Data collection commenced immediately thereafter with an initial response rate of 1.3% (Chapter 4 presents the discussion of the relative changes in the respondent recruitment to include an addendum made by the IRB). Linear regression and correlation statistics were the tools used to analyze the data to address the purpose of the study.

The detailed methodological outline of the study execution is provided in this chapter. Also discussed in this chapter were the research design and approach, the setting and population sample. Presentation of the data collection methods and operationalization of the variables along with the data analysis, and instrumentation is also included.

Restatement of Research Questions

The following are the research questions and hypotheses that guided the study.

Research Question 1

What is the association between IPV and High-risk sexual behaviors among AAW who are residents of the southern region, after adjusting for potential confounders (age, marital status, employment, education, and income)?

$H_0$1: There is no association between IPV and high-risk sexual behaviors among AAW who are residents of the southern region, after adjusting for potential confounders (age, marital status, employment, education, and income).

H_a1: There is an association between IPV and high risk sexual behaviors who are residents of the states within the southern region, after adjusting for potential confounders (age, marital status, employment, education, and income).

Research Question 2

What is the association between colorism and IPV among AAW who are residents within the southern region, after controlling for potential confounders (age, marital status, employment, education, and income).

$H_0$2: There is no association between colorism and IPV among AAWn who reside within the Southern Region, after controlling for potential confounders (age, marital status, education, employment, and income).

H_a2: There is an association between colorism and IPV among AAW who reside within the southern region, after controlling for potential confounders (age, marital status, education, employment, and income).

Research Question 3

What is the association between colorism and high-risk sexual behaviors among AAW who reside in the southern region of the U.S., after controlling for potential confounders (age, marital status, employment, education, and income).

$H_0$3: There is no association between colorism and high-risk sexual behaviors among AAW who reside within the southern region, after controlling for potential confounders (age, marital status, employment, education, and income).

H_a3*:* There is an association between colorism and high-risk sexual behaviors among AAW who reside within the southern region, after controlling for potential confounders (age, employment, marital status, education, and income).

Research Question 4

Does colorism mediate the relationship between IPV and HIV sexual risk behaviors among AAW who are residents of the states within the southern region, after adjusting for potential confounders (e.g. age, employment, education, marital status, and income).

$H_0$4: Colorism does not have a mediating effect on the relationship between IPV and HIV sexual risk behaviors among AAW who are resident of the southern region (after adjusting for potential confounders, such as age, education, employment, income, and marital status).

H_a4: Colorism is a mediator, which affects the relationship between IPV and HIV sexual risk behavior among AAW who are residents within the southern region (after adjusting for potential confounders, such as age, education, employment, income, and marital status). Table 1, below represents how the research questions are aligned with the survey scales used in this study.

Table 1

Alignment of Research Questions with Survey Scales

Research Question	Corresponding Scale (variable)/ # ?s
RQ 1	Sexual Coercion scale (IPV)/12 Modified Abuse Scale (IPV)/9 HIV Risk Assessment Tool (SR)/7
RQ 2	Colorism Scale (Colorism)/12 Sexual Coercion scale (IPV)/12 Modified Abuse Scale (IPV)/9
RQ3	Colorism Scale (Colorism)/12 HIV Risk Assessment Tool (SR)/7
RQ4	Colorism Scale (Colorism)/12 HIV Risk Assessment Tool (SR)/7 Sexual Coercion scale (IPV)/12 Modified Abuse Scale (IPV)/9

Research Design and Its Appropriateness

This study utilized a quantitative correlational research design. This design allowed for the examination of the existence or lack of association and causation between sets of variables—colorism and IPV with HIV risk while controlling for age, marital status, and socioeconomic status of AAW. Utilizing a quantitative method allowed me to assign numerical values to the variables quantitatively. By assigning numerical values to variables, the identification of association and causation between the variables was measurable using different statistical methods (Hoe & Hoare, 2012). A quantitative method allowed the assessment of a direct relationship between sets of variables through the collection of quantitative data from questionnaires in which this study adhered to as

opposed to a qualitative study. Responses from interviews obtained from qualitative studies need to be interpreted and coded to identify trends or themes that is hard to use for determining statistical relationships. Moreover, qualitative research addresses different questions, such as the how and why questions of research (Tacq, 2011), which was not the purpose of this study. In contrast to qualitative research in which variables emerge from the data, all of the study's factors were known in advance and predictive relationships among them were allowed for designation as independent and dependent variables, with possible causal connections. Qualitative research has a focus on in-depth information from a small population, seeking a detailed understanding and is useful when the variables are not defined (Yilmaz, 2013). Therefore, it was not applicable since this study's aim was to generate conclusions from a large sample size.

Furthermore, correlational design generally concerns with the determination whether there is a significant positive or negative relationship between variables (Newman & Hitchcock, 2011). A correlation design is appropriate for predictive analysis regarding relationships among and between variables (Nimon & Reio, 2011). The purpose of this study was not only determining if association exists among variables but also determining if causation exists among the independent and dependent variables.

In summary, since no manipulation of the study variables occurred the research methodology used the quantitative correlational design allowing for effective prevention guidelines, programs, and policy initiatives.

Target Population and Sample Size

The target population for this study was African-American women with previous domestic violence and who were residents within the southern region. These African-American women had be over the age of 18 years and could be either married or single but must have had relationship experience. The selection of an inclusion criterion based on belonging to the African-American population and being an adult woman over the age of 18 allowed selection of individuals with the greatest risk potential while excluding special groups such as minors. Furthermore, the study participants self-identified as heterosexual and belonging to African-American ethnicity. The location was chosen based on the increased incidence of HIV infection among women within the population with female-to-female transmission rare (hence, this category excluded). Other categories excluded from the study included: non-English speaking individuals, girls under the age of 18, mentally or emotionally challenged individuals, men, and homosexuals. Nonprobability convenience sampling was a technique employed to recruit research participants for obtaining study data and it provided the researcher with potential respondents that were readily accessible and within close proximity (Leedy & Ormond, 2010). Nonprobability sampling allowed me to select a sample of the population that was more representative, a sample with prior experience with abusive relationships, and it was less time consuming, less expensive when compared to probability sampling techniques. Therefore, nonprobability convenience sampling, selection of the study population was nonrandom based on unique characteristics that helped answer specific study questions

(Laerd Statistics, 2012). Moreover, convenience sampling was the preferred method for this study due to the subject matter as well as the inability to access a population list, which would enable the researcher to conduct randomized sampling techniques (Laerd Statistics 2012a).

Conducting a power analysis allowed for the determination of the effective sample size needed for the study, which allowed for the likely anticipation that the study would yield a significant effect (Power & Precision, 2015). In the computation of the sample size three factors were under consideration, these included the effect size, the power of the test, and the level of significance. The effect size refers to the magnitude of the relationship between the variables (independent and dependent) (Berger, Bayarri, & Pericchi, 2013). Effect sizes are categorized according to small, medium, and large, and usually a medium effect size is used (Kumar, 2012). Meanwhile, the level of significance involves the probability of the rejecting a null hypothesis that is, in fact, true. The level of significance denotes the alpha level and is commonly set at 0.05 or 95% confidence interval (Haas, 2012). On the other hand, the power of the study represents the probability of rejecting a false null hypothesis.

The sample size and power analysis for this study was calculated using G*Power software v.3.1.3, developed by Faul, Erdfelder, Buchner, & Lang, (2009). The calculation used a logistic regression formula (the statistical technique for data analysis) and required data entry of the proportion of outcome of the exposed population. Stockman, Lucea, Draughon, Sabri, Anderson, Bertand,… Campbell, (2013) and

Stockman, Lucea, Bolyard, Bertand, Callwood, Sharp,…Campbell, (2014) reports that 47% of the American women who experienced IPV engaged in sexually risky behavior (causal and exchange sexual partners), with 76% of the women reporting that they did not use condoms during their last sexual encounter. The sample size calculation using the G*Power software determined with a 0.05 or 5% alpha level and a 95% power level to detect medium effect size or an odds ratio of 2.3333 using a two-tailed test (after correcting for the influence of covariates) and Z-score of 1.96 would be 104 respondents. Adding 50% to the G*Power calculation yielded an overall number of 156 respondents instead of the original 104 (Table 2 provides a summary of the sample size calculations with percent overage estimations). Increasing the sample size by 50% allowed for potential losses during the data collection phase as well as incomplete or missing data (helping to maintain data reliability). However, due to the number of qualified participants, the actual sample size used for this study was 143.

Table 2
Sample Size Calculation with Pecent Overage Estimation

OR	α err prob	Power (1-β err prob)	Sample Size	Critical z	30%	50%
2.333333	0.05	0.95	104	1.969964	135	156
2.333333	0.1	0.9	69	1.644854	90	104
2.333333	0.1	0.9	52	1.281552	68	78
2.333333	0.05	0.9	86	1.959964	112	129
2.333333	0.04	0.9	91	2.053749	118	137
2.333333	0.1	0.95	85	1.644854	111	126
2.333333	0.1	0.8	52	1.644854	68	78
2.333333	0.05	0.8	67	1.959964	88	101

* Perecent Overage Estimation is the amount added to the sample size as an a priori determination to account for possible losses due to participant drop-outs, and missing data.

Recruitment Strategies

To participate in the study there was a need for non-probability convenience samples of 156 women who self-identified as heterosexual, African-American, over the age of 18, and were living in one of the states belonging to the Southern Region. Recruitment efforts were conducted via advertisement (flyers) placement in a variety of venues to include domestic violence agencies seeking women with the research characteristics to include local public venues such as the libraries, community centers, churches, and state health department bulletin boards. In addition to bulletin boards, potential respondent recruitment utilized online social media.

Interested potential respondents were required to read the consent thoroughly prior to completing the survey. The consent served to educate the participants regarding the study and how I would ensure identities and other personal information would remain confidential.

Data Collection

I focused my data collection on a sample of adult AAW who were residents within the southern region and who experienced intimate partner violence in the past. Recruitment measures consisted of online social media and posting of flyers. Location of the flyers included libraries, clinics, local health departments, community centers, and church bulletin boards.

There was a requirement that all potential respondents read the consent form prior to survey completion. The consent form served to educate about the research and assured

the potential participants that their identities and information would remain confidential. Prior to the data collection phase, I obtained an IRB approval letter from Walden University. The instruments used to gather information on the study variables (colorism, IPV, and High risk sexual behaviors/HIV risk) were Sexual Coercion in Intimate Relationships Scale, In-Group Colorism Scale, HIV Screening Tool, and the Abuse Assessment Screen. The use of the demographic survey provided further screening and information about the age, marital status, and the socio-economic status of the participants.

I completed the NIH-sponsored Human Research Protections Training in 2013, the certificate number is 1049946 (see Appendix K). After securing all required permissions, the actual data collection began. The recruitment strategy involved identifying locations and agencies that had participants who met the research criteria. Respondent identification did not rely on the use of lists or randomized sampling techniques; therefore, convenience sampling was the method for selecting the women from the various venues. The consent contained a brief background of the study and the risks and benefits involved. However, due to the nature of study, and the personal nature of the questions, modification of the consent was necessary; the change was from the typical informed consent to an implied consent format. The same background information remained to include the risks and benefits; however, no signature or affirmation was required. By completing the survey, the participants were giving their consent (implied).

The implied consent followed a similar format to informed consent. According to Creswell (2013), it is crucial to advise study participants of all the measures to maintain data security, which includes storage, analysis, and publication. For the study, the participant briefing will serve as notice for data security measures. Since the consent used in this study involves implied consent and computer-assistance, therefore, voiding the need for confirmatory signatures. The collection of personal identifiable information was not part of the data collection process. As with informed consents, there is the requirement to secure the consent forms or to have them remain confidential in a stored locked cabinet and only accessible by me for five (5) years then, destroyed. Given that during this study, the collection of no personal identifiable information did not take place, is viewed without any foreseeable risk, therefore, presentation of the research findings as discussed in this dissertation would not divulge the identity of the participants. Moreover, sharing of the results would be within the forum of conferences, summaries to instrument authors and or academic journals.

Potential participants were informed through recruitment flyers as well information posters (see Appendices I & J). Both the recruitment flyer and the information posters gave the potential participants information regarding the study description. The poster served to inform the participants that, the survey's purpose was to collect information regarding their relationship experiences, which included previous experiences with abuse, the potential impact skin tone had on their relationships, and sexual risk. Part of the study notification included a statement that participation is strictly

voluntary. Lack of participation did not affect the support services of cooperating agencies and no names, or other identifying information was a part of the survey questionnaires. Furthermore, no surveys were distributed at any point during or after agency meetings.

Keeping personal information private and under protection is critical in eliminating risk. Therefore, collection of the participant's personal information to include location (except state of residence) was not required; this helped eliminate the potential risk associated with the study such as uneasiness/temporary psychological stress of answering personal questions (as evidenced by increased anxiety, sadness, depression, or feelings of loss). Additional potential risks included embarrassment and reprisal from the perpetrator. An explanation provided prior to the administration of the survey indicated that participation was voluntary; furthermore, any question that caused discomfort did not require an answer (the data analysis did not include incomplete surveys). To mitigate, the uneasiness paper and pencil surveys may generate, placement of completed surveys would be in an envelope and sealed by the participant to help protect privacy. However, this study only generated computer-assisted surveys. As a cross-sectional study without interventions or manipulation of variables, the ability to foresee any short-term or long-term benefits from participating in this study was not available. The reason such information was not available was due to the nature of the cross-sectional study, it only captured data at a specific point in time without manipulating the environment. Therefore, I could not know definitively if the abused

women had high-risk sexual behaviors before the abuse. Explanations given to the participants outlined how the study would benefit others through provisions of baseline data that assists in designing more culturally diverse programs. Participation in the study did not include compensation.

Study debriefing did include reiteration of confidentiality procedures, their rights as research participants, and cross-referencing of consent (informed) and questionnaires would not be done (completed questionnaires required immediate sealing and each participant would seal their questionnaire prior to submission, if paper format used).

Participant recruitment did not begin until IRB approval. Agencies identified for participant recruitment in the metro Atlanta area were The Women's Resource Center in Decatur, Georgia, and the Partnership Against Domestic Violence located in Fulton and Gwinnett County Georgia, and online social media served other areas within the Southern Region of the United States. These agencies serve the metro Atlanta area by providing victims of domestic violence with safe housing, emergency shelters, volunteer services, free attorney fees, financial workshops, and community-based advocacy. Due to changes in administration and in policies at the time of IRB approval, there was a restriction on posting information flyers. Therefore, the recruitment efforts continued outside these agencies. The potential participants if interested were granted access to secure online site with included username and password. Once on the site, the respondents would read the implied consent and complete the survey as indicted. After obtaining the necessary data, I encoded the data from the survey using Microsoft Excel and then transferred the Excel

worksheet into SPSS. SPSS is the statistical program used to analyze the data, specifically SPSS Version 23.

Measures

A self-administered questionnaire was used to collect data on the possible mediating factors that may affect African-American women's HIV sexual risk. The present study adapted and utilized instruments that were previously developed and examined psychometrically. Permissions for the use of these measures not found within the public domain were obtained via email (Appendix B). The demographic survey, was the prelude questionnaire as it contains socioeconomic status information for example, age, location, income, marital status, educational level.

Predictor Variable-Intimate Partner Violence

The Sexual Coercion in Intimate Relationships Scale (SCIRS).

The full 34-item, 6-point scale serves to measure conflict within relationships; more specifically, it assesses communication tactics, hinting, subtle manipulations, and the use of force. It assesses sexual coercion among adult intimate relationships to force or threaten through psychology, behavioral terror, and or withholding resources. According to Shackelford & Goetz, 2004 and Goetz & Shackelford, 2011 the SCIRS scored alpha reliabilities on the three subscales, .91, .95, .96 respectively. Furthermore, when observed against nonsexual violence and control, the SCIRS produced measure behaviors that were uniformly positive without sharing more than 20% response variance,

thus, indicating evidence of convergent and discriminative validity (Goetz & Shackelford, 2011).

Modified Abuse Assessment Screen

Developed by McFarlane et al., (1992), the abuse assessment screen is a tool for assessing the frequency, the severity of physical abuse, and perpetrator and uses body mapping for injury documentation. The original study participants were 691 African American, Hispanic, and Caucasian pregnant and non-pregnant women. Answering yes to questions 2, 4, and 5 is an indication of abuse (McFarlane et al., 1992). In terms of agreement, test/re-test reliability scoring across the same population (same trimester) was 83% (Basile et al., 2007). Since total scores for the screen were not calculated for the AAS, individual responses were evaluated against nationally tested research instruments (McFarlane et al., 1992; Soken et al.,1998). These were: 1) the Conflict Tactics Scale, which measures the self-reported frequency of violent attacks within relationships when compared to the CTS the internal consistency reliability or alpha coefficient for the AAS was .80. 2) The AAS when evaluated against the Index of Spouse Abuse (ISA), the alpha coefficient was .89 and .93 for physical and non-physical subscales respectively and 3) the Danger Assessment Screen, examines the potential danger of homicide within the relationship with one's partner when the AAS comparison completed, the reliability was .84 (McFarlane et al., 1992; Soeken et al.,1998).

Hazzard Subscale of Powerlessness

Finkelhor and Browne (1986) postulated using a traumagenic dynamics model that sexual abuse alters the cognitive and affective orientation of the victim's environment along four dimensions. The four dimensions are self-blame/stigmatization, betrayal, powerlessness, and traumatic sexualization (Hazzard, 1998). The development of the Trauma-Related Belief Questionnaire (TRBQ) by Hazard (1993) followed the traumagenic dynamics model of Finkelhor and Browne. The TRQB served as a measure to test traumatic sequelae in abuse survivors, Hazzard used a sample of 56 adult female sexual abuse survivors to pilot test the scale. The TRBQ consist of 56-items, each on a 5-point Likert-type scale ranging from 0 (absolutely untrue) to 4 (absolutely true). The total TRB scale scored .93 for internal reliability (alpha coefficient). According to Hazzard (1998) the alpha coefficients for the subscales self-blame/stigmatization (29 items), betrayal (10 items), powerlessness (10 items), and traumatic sexualization (7 items) were; .89, .86, .78, and .87, respectively. For the purpose of this study, the powerlessness scale is the sole scale used from the TRQB. Multiple regression analysis as employed by Hazzard was the methodology to assess the TRB measure's validity. The regression analysis examined the relationship between the four subscales and the psychological and behavior attributes of the participants. Powerlessness beliefs predicted low self-esteem, depression, and an external locus of control, which accounted for 30% of the variance (Hazzard, 1998).

Colorism Scale

From a macro or structural-political level colorism serves to place individuals of color within a social stratification, a hierarchy based on skin tone. The colorism scale as developed has the intent of engaging colorism from the perspective of the individual, how each believes that skin color variations matter (Harvey et al., 2014). The perception persists that, colorism has strong meaning and significance in the areas of self-concept, impression formation, attraction/affiliation, and upward mobility.

Development, review, and editing of the colorism scale involved subject matter experts. Testing of the scale involved a national sample of 500 male and females of various socioeconomic statuses, ages, and educational levels. The scale is a 20 question 7-point Likert-like survey with five subscales, self-concept, attraction, affiliation, impression formation and upward mobility. According to Harvey, Banks, & Tennial, (2014) the total instrument and the subscales scored high in reliability and structural validity, thus proving high psychometric quality.

Outcome Variable-STD (HIV) Risk Behaviors

Modified HIV-Risk Screening Instrument

Gerbert, Bronstone, McPhee, Pantilat, Allerton, (1998) developed a self-administered HIV-risk assessment screening instrument to assess the number of reported HIV-risk behaviors. Each item on the scale is dichotomous with a score of either 1 or 0; 1 indicates that the participant has engaged in risky behavior and 0 that the participant has not engaged in risky behavior.

The final measure, a 10-item survey omitted questions regarding vaginal, oral sex, sex with a hemophiliac, sex with an HIV-positive partner, and HIV–test result. The omission of these items facilitated the maintenance of instrument reliability and content validity.

The reintegration of the oral and vaginal sex questions to the measure allows for the capturing of data that was not possible in the original heterogeneous sample. The measure demonstrates good internal reliability and content validity, as evidenced by Kuder-Richardson-20 coefficient consistency of .73, which is considered moderately high for a brief instrument measuring multiple risk factors (Gerbert et al., 1998). Content validity of the HSI measure was through its ability to differentiate between high and low-risk individuals. As well as through its ability to consistently measure like responses when compared to those from other studies using similar HIV risk questions (Gerbert et al., 1998).

Data Analysis

This study used both descriptive statistics and inferential statistics. Frequency distribution and measures of central tendency provided a summary of the data collected in terms of descriptive statistics. The frequency (number) and percentages of occurrence of the study variable outline the frequency distribution. Hoe and Hoare (2012) differentiated descriptive statistics over inferential statistics in that the former simply describes what the dataset displays whereas the latter draws conclusions about the population from the sample statistics.

Linear regression and correlation are two inferential techniques used for this study. Linear regression will help determine whether colorism influences IPV and subsequently HIV risk among AAW. Regression analysis serves three purposes: description, control, and prediction (Hilbe, 2011). In this study, the analysis will describe the relationship colorism between IPV; and whether this relationship has an effect on the vulnerability of AAW related to HIV risk.

Likewise, the analysis will also describe the possible relationship and or influences IPV has on high-risk sexual behaviors, and thus the vulnerability of AAW on HIV risk. Secondary analysis explores the effects of the significance of two independent variables after controlling for the age, marital status, and socio-economic status of the AAW.

This study aimed to know if any significant relationship exists between the independent variable (i.e., IPV), primary mediator variable (i.e., colorism), and dependent variable (i.e., HIV risk) after controlling for the presence of confounding variables (i.e., age, marital status and socio-economic status). Furthermore, controlling for the confounding variables early in the analysis phase will help mitigate any bias or confusion, thus allowing for accurate measurement and interpretation of the variable relationships.

Standard statistical analysis for simple linear regression combined with either the Pearson's or Spearman's Correlation and after the performance of linear multiple regression tests, Coefficient will further explain any relationships between variables,

more specifically the magnitude and the direction of the correlation and or relationship between the dependent and independent variables.

Likewise, Pearson's Correlation Coefficient (r) is the most widely used type of correlation coefficient (Denzin & Lincoln, 2011), also called linear or product-moment correlation. Pearson's correlation reflects the degree of linear relationship between two variables. It ranges from +1 to -1, a correlation of +1 means that there is a perfect positive linear relationship between variables. On the other hand, a correlation of -1 means that there is a perfect negative linear relationship between variables. Typically, the expression of correlation results is in terms of a scatter plot diagram, which describes the relationship between the variables under study, Chapter 4 will include this diagram.

Summary

The purpose of this quantitative correlational research was to examine the impact of intimate partner violence (IPV) and colorism on the high-risk sexual behaviors among AAW. In addition, this study examined the mediating role of colorism on the relationship between IPV-HIV-risk while manipulating other relationship variables, such as income and education. Recruited for this study were one hundred and forty-three (143) AAW domestically abused and who are residents of the 17 states of the southern region of the United States.

Data was subjected to descriptive and inferential analysis that included linear regression and Pearson's/Spearman correlation analysis to identify whether significant association and causation exist among the independent and dependent variables. The

chapter included detail about the research questions and corresponding hypothesis, population, sample size, data collection procedures, and data analysis procedures. Chapter 4 presents the findings of the possible relationships between variables.

Chapter 4

Introductory Overview

The purpose of this study was to assess the relationships between colorism, IPV and high-risk sexual behaviors among African-American women residing in the southern region of the United States. The data submitted by the study respondents was through the online survey service, Survey Monkey. Completed survey information was downloaded from the Survey Monkey database into a Microsoft Excel spreadsheet. Upon downloading, the raw data were reviewed, coded, cleaned, and imported in SPSS for analysis. The analysis of the data included descriptive statistics, correlation, univariate, and bivariate regression (linear regression). This chapter begins with a description of the demographics of the target population, followed by descriptive statistics of the major variables in the study. Before performing the descriptive statistical analysis, Coefficient Alpha or Cronbach's Alpha was used as a measure to test the internal consistency of survey's subscales before the process of variable transformation and composite variable development. The Statistical Package for the Social Sciences version 23 was the software utilized for these and other inferential and regression techniques. Chapter 4 concludes with a review of the study's key findings.

Data Collection

Recruitment for this study was according to the parameters outlined in Chapter 3. However, the initial response rate in February 2016 was 1.2%. In evaluating the low response rate, it was determined that a couple of factors were at play, the first being a

limitation on geographic area, limited agency support (from the larger IPV agencies), and possible survey taking fatigue (there were too many questions causing incomplete survey responses). The study survey with the demographic questions totaled over 98 questions. To alleviate the possibility of survey taking fatigue, the addition of visual clues aided the respondents; signals added helped the participants in knowing the percent completed, and the number of questions per page was limited to five.

Due to the recruitment limitations within the state of Georgia, IRB approval was sought to expand recruitment to the southern region of the United States. According to the U.S. Census Bureau (2015a) the states belonging to the southern region are Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia. The amended IRB approval was in May 2016 with commencement of expanded recruitment.

In addition to expanding the recruitment efforts beyond the borders of Georgia, recruitment efforts included local agency referrals, social media, and the other public venues. Besides having an expanded geographic region and the inclusion criteria of having a prior history of relationship violence a qualifier question was embedded within the survey: Have you ever been exposed to domestic violence, as defined as physical, mental, emotional, financial, or sexual abuse in your relationships? The target population for this research study was AAW who experienced some type of IPV, therefore, the qualifier question was added to capture this population.

The total number enrolled in this study was 143 AAW; data collection occurred from February to June 2016.

Demographics of the Respondents

This study utilized a cross-sectional survey design, inwhich 260 AAW responded. Only 143 of the 260 AAW were utilized in this study based on incomplete information and not meeting the inclusion criteria. Nine hundred and twenty-five women replied to the survey, 665 were excluded based on demographics (residing in states outside the southern region). Moreover, 76% were excluded based on race/ethnicity, Caucasian women; the other 1% were Hispanic women. Of the 143 AAW, 42.7% self-reported using a 5-point color chart with corresponding word descriptions as having medium brown skin tone, those with light brown skin tone were self-reported at 25.2%, and very dark brown skin tones were self-reported at 2.8%. Table 3 details the self-reported skin tones of the study respondents.

Table 3

Self-Reported Skin Tone of Respondents with Percentage

Skin Tone	Frequency	Percent	Cum. Percent
Very light Brown	13	9.1	9.1
Light Brown	36	25.2	34.3
Medium Brown	61	42.7	76.9
Dark Brown	29	20.3	97.2
Very Dark Brown	4	2.8	100

The ages of the respondents were categorized into seven groups for analysis. The majority of the survey respondents were between the ages of 25 and 31 (23.1%); 16.1%

were between the ages of 46 and 52 years of age, 11.9% were between 53 and 59 years of age, with the remaining 48.9% distributed among the other four age groups (see Table 4. for the complete education, income, age, and marital status of the study respondents).

A large number of the participants (36.9%) reported currently living in the states of Georgia, Florida, and Texas; 17.3%, 15.8%, 13.5% respectively. The remaining women resided in states scattered throughout the southern region with Delaware, West Virginia, Kentucky, and Oklahoma having the least respondents with n=4. Table 5 visually represents the respondents by state.

Table 4
Socioeconomic Demographics

	Frequency	Percent	Percent Cumulative
MARITIAL STATUS			
Married	30	21	21
Widowed	7	4.9	25.9
Divorced	26	18.2	44.1
Separated	8	5.6	49.7
In Domestic Partnership	6	4.2	53.8
Single, but living with SO	22	15.4	69.2
Single never married	44	30.8	100
EDUCATION			
Less than High School	7	4.9	4.9
High School Diploma	28	19.6	24.5
Some College but no degree	43	30.1	54.5
Associate Degree	25	17.5	72
Bachelor Degree	29	20.3	92.3
Masters Degree	9	6.3	98.6
Doctoral Degree	2	1.3	100
INCOME			
$ 0- $ 9,999	20	14	14
$10,000 - $ 24,999	31	21.7	35.7
$ 25,999 - $ 49,999	46	32.2	67.8
$ 50,000 - $ 74,999	26	18.2	86
$ 75,999 - $ 99,999	13	9.1	95.1
$100,000 - $ 124,000	4	2.8	97.9
More than $125,000	3	2.1	100
AGE			
18 -24	15	10.5	10.5
25- 31	33	23.1	33.6
32- 38	15	10.5	44.1
39- 45	19	13.3	57.3
46- 52	23	16.1	73.4
53- 59	17	11.9	85.3
60 or older	21	14.7	100
EMPLOYMENT STATUS			
Full-time	66	46.2	46.2
Part-time	15	10.5	56.2
Unemployed and seeking work	17	11.9	68.5
Unemployed and not seeking work	3	2.1	70.6
Retired	20	14	84.6
Disabled, Not able to work	14	9.8	94.4
Full-time student	8	5.6	100

Table 5
Demographics of Respondents by State

State	Frequency	Percent	Cum Percent
DELAWARE	1	0.7	0.7
FLORIDA	22	15.4	16.1
GEORGIA	26	18.2	34.3
MARYLAND	8	5.6	39.9
N. CAROLINA	11	7.7	47.6
W. VIRGINIA	1	0.7	48.3
VIRGINIA	9	6.3	54.5
ALABAMA	6	4.2	58.7
KENTUCKY	0	0	0
TENNESSE	5	3.5	62.2
MISSISSIPPI	9	6.3	68.5
ARKANSAS	5	3.5	72
LOUSIANA	3	2.1	74.1
OKLAHOMA	1	0.7	74.8
TEXAS	21	14.7	89.5
S. CAROLINA	10	7	96.5
D. OF COLUMBIA	5	3.5	100

From a socioeconomic perspective, the single largest category of respondents were among the single, never married group, 30.8%, followed by women who self-reported as married, 21%. In terms of education, 30.1% reported having some college without a degree, the next largest group of respondents were women with only a high school education, 19.6% of the sample. Approximately 32.2% of the respondents' self-reported an average annual income for the range between $25,000 to $49,000. Table 5 represents the visual summary of the data.

Colorism

The majority of the respondents surveyed reported that their skin tone was a major component of their identity, 27.3%; 29.4%; agree and strongly agree, respectively. Twenty-five percent could not determine if skin tone was a factor in whom they were. Of the 143 respondents, 42 % believed that there was no difference between light-skinned people; however, 35% of the women that there was an inherent difference between light-skinned and dark-skinned individuals. Over half the respondents, 51% believed from an economic point of view skin color does not matter, yet, there were those participants who believed no matter how hard one worked, the color of the person's skin mattered more, 22.4%. Table 6 summarizes colorism data from the respondents.

Table 6

Colorism

		Frequency	Percent
Skin tone important component of who I am	Disagree	26	18.2
	Neutral	36	25.2
	Agree	81	56.6
There are real differences between light-skinned and dark-skinned people	Disagree	60	42
	Neutral	33	23.1
	Agree	50	35
Most of my friends tend to be the same skin tone	Disagree	109	76.2
	Neutral	17	11.9
	Agree	17	11.9
I choose who I am going to be friends with by their skin tone	Disagree	123	86
	Neutral	7	4.9
	Agree	13	9.09
The majority of my friends are the same skin tone as me	Disagree	110	76.9
	Neutral	13	9.09
	Agree	20	14
I am primarily attracted to people of a certain skin tone	Disagree	82	57.3
	Neutral	21	14.7
	Agree	40	28
I prefer a romantic partner who is the same skin tone as me	Disagree	91	63.6
	Neutral	32	22.4
	Agree	20	14
I prefer light skin over dark complexion skin when choosing romantic interests	Disagree	94	65.7
	Neutral	27	18.9
	Agree	36	25.2

Table 6

Colorism

		Frequency	Percent
Lighter skin make others more attractive	Disagree	100	69.9
	Neutral	26	18.2
	Agree	17	11.9
Even if you really work hard, your skin tone matters most	Disagree	73	51
	Neutral	38	26.6
	Agree	32	22.4
Skin tone plays a big part in determining how far you can make it	Disagree	67	46.9
	Neutral	34	23.8
	Agree	42	29.4
If you want to get ahead, you have to be the right skin tone	Disagree	75	52.4
	Neutral	39	27.3
	Agree	29	20.3

Intimate Partner Violence

Inclusion criteria included being an African-American woman over the age of 18 with a history of IPV. Approximately, 36.4% of the respondents reported being hit, kicked or slapped at least once in the last year. Nine percent reported being physically abused more than six times; four women or 2.8% reported being hit between 11 and 20 times, while 7% reported physical violence more than 20 times during the past month. The largest number reported, *n*=63 or 44.1% suffered other forms of intimate partner

violence. Approximately 44.8% of the AAW women surveyed remained in the relationships out of necessity: money, food, clothing, childcare, a place to live, or companionship. The women who reported physical violence, 18.2% reported being threatened if they did not engage in sexual activities with their partner, 42% reported they were made to feel obligated by their partners to force them to have sex, and 29.4% of the surveyed women reported being forced to participate in unprotected sex. Thirteen (9.1%) of the women thought that their skin color played a part in their abuse while 14.7% of the respondents believed that if their skin color could change the emotional and physical abuse would also change (Table 7, colorism as a factor of abuse and Table 8, Intimate partner violence statistics provides a summation of the key findings).

Table 7
Colorism as a Factor of Abuse

		Frequency	**Percent**
Do you feel your skin color played a part in your abuse?	Yes	13	9.1
If your skin color were changed, do you feel the emotional and physical abuse would also change?	Yes	21	14.7

Table 8
Intimate Partner Violence Statistics

Number of times hit	Frequency	Percent
1 to 5 times	52	36.4
6 to 10 times	14	9.8
11 to 20 times	4	2.8
More than 20 times	10	7
No bodily injury/other forms of abuse	63	44.1
Dependence on abuser for assistance	**Frequency**	**Percent**
Financial	64	44.8
Child care	64	44.8
Food	29	20.3
Lodging	23	16.1
Clothing	17	11.9
Companionship	24	16.8
Nothing	50	34.9
Coercion by abuser to illicit sexual contact from respondent		
My Partner threatened physical force if did not have sex at least 1 time in past month	9	6.3
My Partner threatened physical force if did not have sex at least 2 times in past month	4	2.8
My Partner threatened physical force if did not have sex at least 3-5 times in past month	6	4.2
My Partner threatened physical force if did not have sex at least 6-10 times in past month	5	3.5

Table 8

Intimate Partner Violence Statistics

Coercion by abuser to illicit sexual contact from respondent

	Frequency	Percent		Frequency	Percent
My Partner threatened physical force if did not have sex more than 11 times in past month	2	1.4	My Partner physical forced me to have sex with him more than 11 times in past month	6	1.9
My Partner physical forced me to have sex with him at least 1 time in past month	10	7	My partner threatened violence against someone/something I cared about to force my to have sex with him at least 1 time in the	3	2.1
My Partner physical forced me to have sex with him at least 2 times in past month	4	2.8	My partner threatened violence against someone/something I cared about to force my to have sex with him at least 2 times in	2	1.4
My Partner physical forced me to have sex with him at least 3-5 times in past month	4	2.8	My partner threatened violence against someone/something I cared about to force my to have sex with him at least 3-5 times in	3	2.1
My partner threatened violence against me if I did not have sex with him at least 1 time in the past month	7	5	My partner threatened violence against someone/something I cared about to force my to have sex with him more than 11 times in the past month	4	3
My partner threatened violence against me if I did not have sex with him at least 2 times in the past month	6	4	My partner threatened violence against someone/something I cared about to force my to have sex with him at least 6-10 times in the past month	5	4

Table 8
Intimate Partner Violence Statistics

Coercion by abuser to illicit sexual contact from respondent					
	Frequency	Percent		Frequency	Percent
My partner threatened violence against me if I did not have sex with him at least 3-5 times in the past month	3	2	My partner made me feel obligated to have sex with him at least 1 time in the past month	24	17
My partner threatened violence against me if I did not have sex with him at least 6-10 times in the past month	4	3	My partner made me feel obligated to have sex with him at least 2 times in the past month	15	11
My partner threatened violence against me if I did not have sex with him at least 3-5 times in the past month	3	2	My partner told me if I loved him I would have sex with him this occurred at least 2 times in the past month	14	10
My partner told me if I loved him I would have sex with him this occurred at least 1 time in the past month	10	7	My partner told me if I loved him I would have sex with him this occurred at least 3-5 times in the past month	5	4
My partner told me if I loved him I would have sex with him this occurred at least 2 times in the past month	3	2	My partner threatened to have sex with other women if I did not have sex with him at least 1 time in the past month	17	12
My partner told me if I loved him I would have sex with him this occurred at least 1 time in the past month	10	7	My partner threatened to have sex with other women if I did not have sex with him at least 2 times in the past month	9	6
My partner told me if I loved him I would have sex with him this occurred at least 6-10 times in the past month	9	6	My partner threatened to have sex with other women if I did not have sex with him at least 3-5 times in the past month	6	4
My partner told me if I loved him I would have sex with him this occurred more than 11 times in the past month	3	2	My partner threatened to have sex with other women if I did not have sex with him more than 11 times in the past month	4	3

Table 8
Intimate Partner Violence Statistics

Coercion by abuser to illicit sexual contact from respondent		
	Frequency	Percent
My partner made me feel obligated to have sex with him at least 3-5 times in the past month	11	8
My partner made me feel obligated to have sex with him at least 6-10 times in the past month	6	4
My partner made me feel obligated to have sex with him more than 11 times in the past month	3	2

High-Risk Sexual Behaviors

As indicated in previous research, this study explored the correlation between having a history of intimate partner violence and engaging in behaviors that lead to sexually transmitted diseases, such as HIV, the difference, however, this study utilized a homogenous population of AAW. Multiple items captured data related to high-risk sexual behaviors. These indicators were condom use, intravenous drug use, and sexually transmitted infections (STIs).

At the time the survey was administered 2.1% of the women reported that they knowingly had sex with a man who had sex with other men (MSM), while 11.9% disclosed that they did not know if their sexual partners were engaging in sexual activities with other men. Twenty-two women (15.4%) indicated they had more than one sexual partner; 88 of the sexually active women (61.5%) reported during the last six months they never used a condom when engaging in vaginal sex. Approximately, 44.8% of the women reported having been diagnosed with a sexually transmitted infection within the past year before the survey administration. This data is consistent with the CDC (2014a) which states that women who have been exposed to both physical and sexual violence are more prone to contracting sexually transmitted diseases than women exposed to physical abuse alone. Less than 3% of the women indicated previous use of intravenous drugs. More than 18% of the study respondents reported having sex in exchange for money or drugs; 11.2% of the women were not aware if their partner had a history of intravenous drug use. Finally, 11.9% of the women disclosed that their sexual partners' within the past six months had a sexually transmitted infection such as gonorrhea, chlamydia, genital warts or genital herpes; approximately, 10.5% of the women indicated that they did not know of their partner's infection history (Table 9 denotes the visual summary for the high-risk sexual behaviors).

Table 9

Respondents Answers to High-Risk Sexual BehaviorsQuestions

	Frequency	Percent
Have you had more than 2 sexual partners in the last 6 months	22	15.4
Have you ever had a Diagnosed with STD such as gonorrhea, syphillis, chlamydia, genital warts, or genital herpes?	64	44.8
Have you ever had sex with someone for money or drugs	26	18.2
Have you ever Injected Drugs with a needle	4	2.8
Have any sex partners within the last 6 months injected drugs with a needle*	21	14.7
Have any of your sex Partners in the past 6 months had sex with men (MSM)*	20	14
Have any of your sex partners in the past 6 months ever had a STD such as gonorrhea, syphillis, chlamydia, genital warts, or genital herpes? *	32	22.4
How often have you had vaginal sex without a condom during the last 6 months: Always	55	38.5
Vaginal sex w/o condoms: Sometimes	36	25.2
Never had vaginal sex	21	14.7
Never had vaginal sex w/o condom	31	21.7

*Denotes positive and don't know responses

Composite Variables

As a means of facilitating the data analysis, composite variables were developed

from the survey subscales based on the constructs of sexual risk, violence, and colorism (Table 10, displays the summary).

The composite sexual risk score (HIVRiskV) was comprised of the frequency of specific high-risk sexual behaviors to include unprotected sexual intercourse, multiple sexual partners, exposure to sexually transmitted infections, trading sex for drugs of money, or knowing engaging with a partner with high-risk behaviors (men having sex with men and intravenous drug use). These indicators served as the basis for the scores and the calculations. Each question and the subsequent answers were assigned values based on a point scale (1 point was given for each high-risk behavior). The scores ranged from 0 to 34, with a mean of 5.77 and a standard deviation of 5.71 (n=143).

The composite of the colorism variable (ColScore) was assessed through individual perceptions of skin tone and the influences skin tone has on the selections of friends, societal norms, the choice of partners, self-image, and socioeconomic issues. The scoring as in the sexual risk composite utilized a one-point scale; the maximum each respondent could score was 60. The mean for this composite was 28.5 with a standard deviation of 8.38. The final, composite developed was the intimate partner violence composite (InPVio2). The maximum score each respondent could score was 51, the mean score for this item was 9.74, and the standard deviation was 9.14.

Table 10

Mean, SD, and Percentile of Composite Varianble Scores

Variable	Mean	SD	75 tn Percentile Score
InPVio2	9.74	9.18	11.5
ColScore	28.5	8.38	32
HIVRiskV	5.77	5.71	7

Reliability of Study Measures

In an effort to improve the completion rate, minimalize survey fatigue the questions were reduced to 50 and reliability testing confirmed prior to dissemination (reliability results are discussed later). The HIV-Risk Screening Instrument (Gerbert et al, 1998), was originally performed on a heterogeneous sample of women, and scored an internal reliability rating of .73; unfortunately, the study was never conducted on a homogenous sample of AAW. Therefore, it was difficult to conclude that the instrument was a reliable measure for use in this population. Subsequently, a reliability analysis of the study's modified instrument was performed. The Coefficient Alpha or Cronbach's Alpha for this modified instrument was .76, this result compared favorably with Gerbert et al., (1998) internal consistency measurement (Table 11 displays the visual representation of the internal reliability ratings for the instruments used in this study).

The construct of intimate partner violence was measured through the combined use of two instruments, the Sexual Coercion in Intimate Relationships Scale and the Modified Abuse Screen; the Hazzard Powerless Screen was omitted from the construct

due to reduced internal consistency scoring. The Sexual Coercion in Intimate Relationships Scale as originally presented had three subscales psychology, behavior terror, and withholding resources, the internal consistency for these subscales were .91, .95 and .96 (Goetz & Shackelford, 2011). The Modified Abuse Screen was utilized in a study of heterogeneous women comprised of 691African-American, Hispanic and Caucasian; the internal consistency score for this measure was .80 (McFarlane et al., 1992; Soeken et al., 1998). The transformed variable, InPVio2, was generated for measuring the internal consistency of the Intimate Partner for Violence variable for use with the study's population of AAW. Thus, the new construct/variable had a good internal consistency with a score of .89.

The final construct or measure was that of colorism; according to Harvey et al., (2014), the colorism scale displayed high psychometric properties and possessed good internal consistency. A reliability analysis of the modified colorism scale for this study's population revealed a good internal consistency of .81.

Table 11

Coefficient Alpha - Reliability Analyis

Measure	Alpha
High-Risk Sexual Behavior n = 7	0.76
Intimate Partner Violence n = 21	0.89
Colorism n = 12	0.81

Bivariate correlations using Spearman rho were performed prior to assessing the research questions; the correlations were between the covariates (age, income, education, employment, and marital status) and the dependent variable, high-risk sexual behaviors (Table 12 illustrates the bivariate correlations). The correlations between the covariates and high-risk sexual behaviors indicated non-significant associations; therefore, the covariates were not used in the subsequent regression analysis.

Table 12

Bivariate Correlations between Covariables and HRSB

Demographic	High-Risk Sexual Behaviors
Age	-0.34
Education	-0.133
Income	0.856
Employment	-0.121
Marital Status	0.12

Note. ∗ $p < .05$. ** $p < .01$; Used Spearman Coefficient

Analysis of Research Question 1 (RQ1)

RQ1: Is there an association between IPV and High-risk sexual behaviors (HRSBs) among AAW residing within the southern region of the United States, after adjusting for potential confounders (age, marital status, education, and income)? Research question 1 was analyzed using linear regression. The dependent or criterion variable was HIV-Risk and or High-Risk Sexual Behaviors, and the predictor or independent variable was Intimate Partner Violence. The parameters for high-risk sexual behaviors were measured using a combination of dichotomous as well as ordinal questions in the form of Likert-like responses. Before the data analysis, the parametric assumptions for the statistical test were assessed; the first assumption requiring an examination was the test for linearity. A scatterplot of the HIV-risk scores was plotted

against the scores of intimate partner violence. Visual inspection of this scatterplot (Figure 2) indicated a linear relationship between the variables (intimate partner violence and HRSB). Thus, this assumption was not violated.

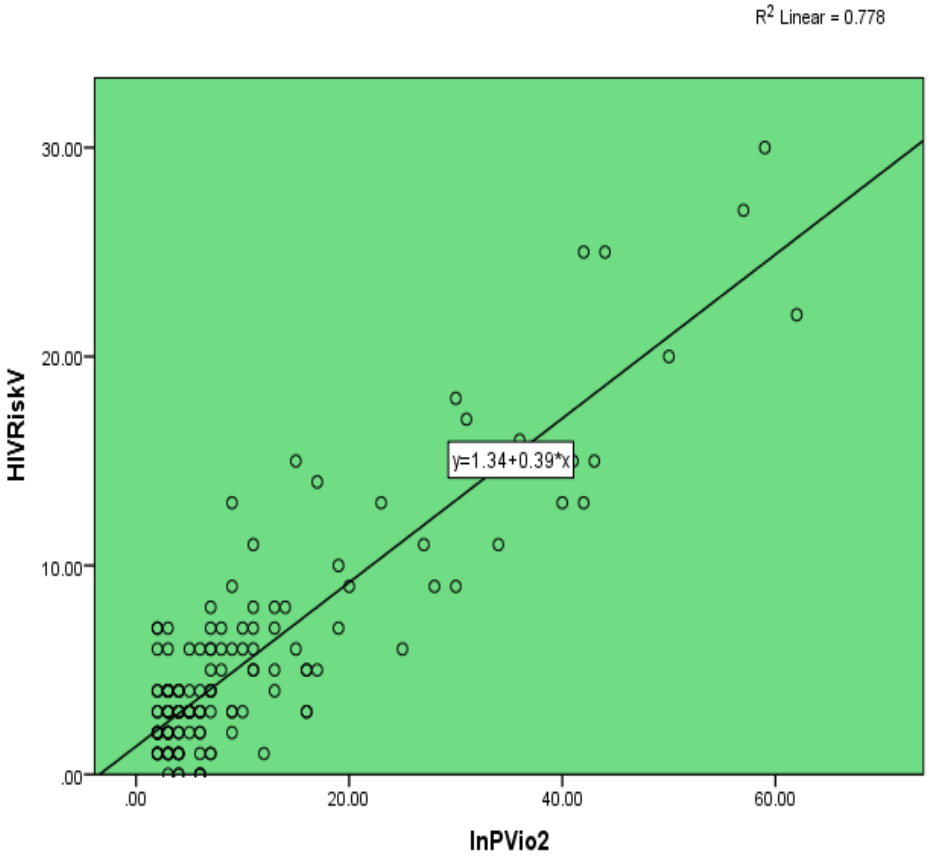

Figure 2. Scatterplot of Linear relationship between high-risk sexual behaviors and intimate partner violence.

Visual inspection of the normal probability plot indicated that the residuals were normally distributed; thus, fulfilling the assumption of normality (see figures 3 and 4). The remaining assumptions were the independence of observations, outliers, and homoscedasticity.

In evaluating the assumption of independence of observation, there was independence of residuals, as determined by the Durbin-Watson statistic of 2.049.

In testing the assumption of outliers, there was only one outlier, presented in case number 56. After a full evaluation of the data to include potential data entry errors, these outliers remained for the final analysis; consideration of this case was on the basis of it being an unusual legitimate value and necessary (see Table 13 for the regression data).

Violation of the assumption of homoscedasticity did not occur. Through the visual inspection of a plot of standardized residuals versus standardized predicted values, homoscedasticity was present (Figure 3.).

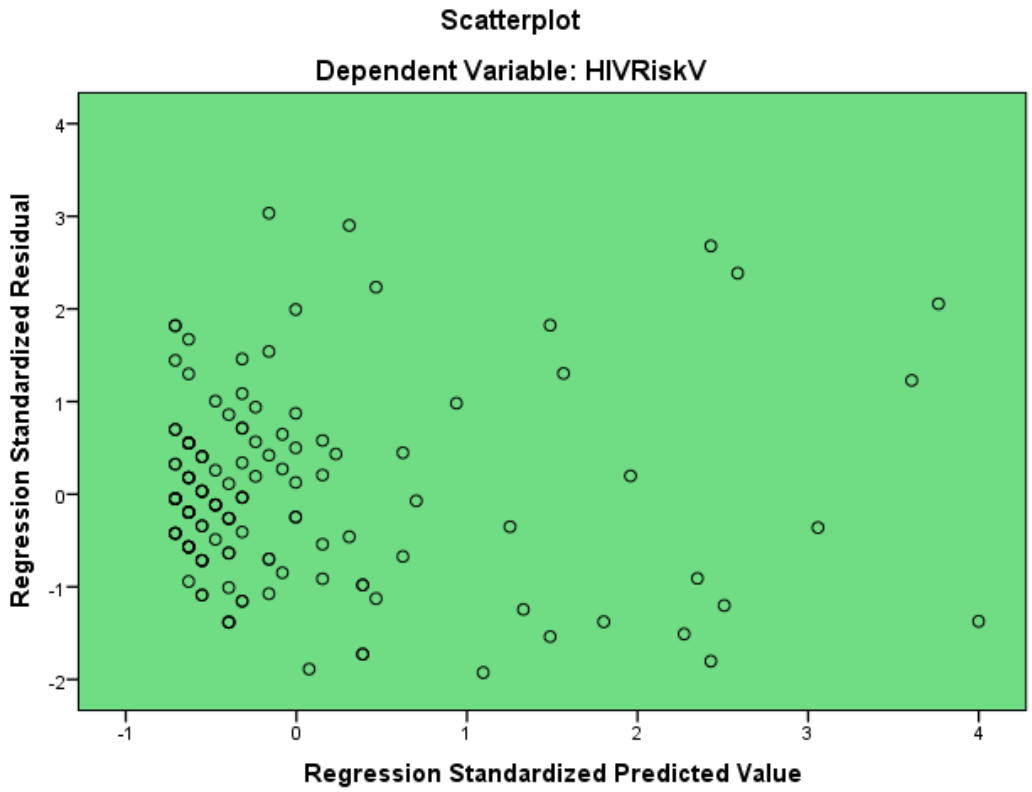

Figure 3. Scatterplot of the DV Standardized residuals versus predicted values

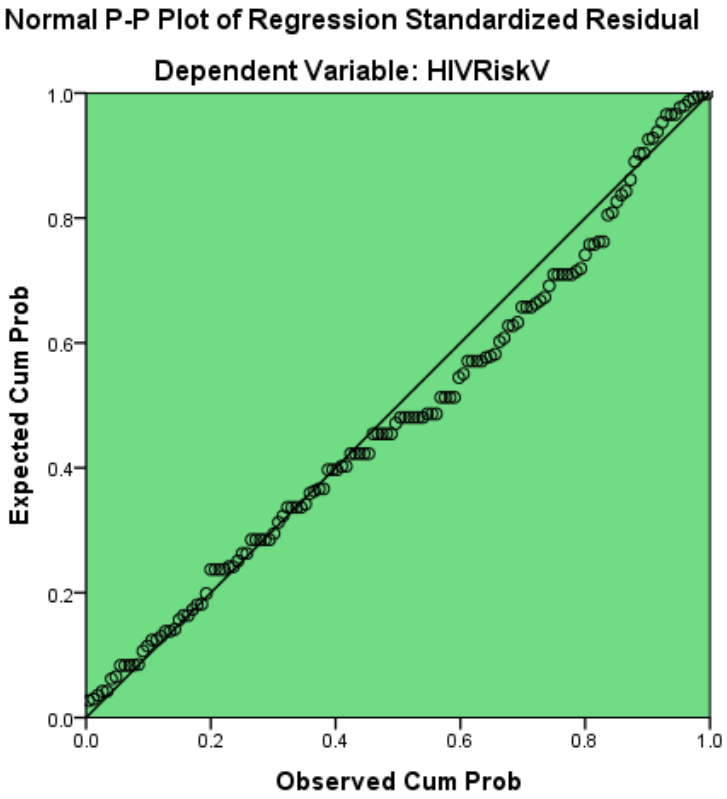

Figure 4. Normal Probability Plot Of High-Risk Sexual Behaviors

After determining that none of the assumptions related to linear regression were violated, data interpretation began with an estimation of a good fit. Three values were assessed r, R^2, and the adjusted R^2; where r= .882, R^2 = .778 and the adjusted R^2 = .777 (see Table 13 for summation of the regression analysis). The r-value of .882 denoted that there was a strong positive correlation between intimate partner violence and high-risk sexual behaviors. The value of R^2 signified that there was a 77.8% variance in high-risk sexual behaviors, which the independent variable explains, intimate partner violence among AAW. Overall, participants with high-risk sexual behaviors tend to be in relationships involving intimate partner violence.

Table 13

Regression Analysis between IPV and HRSB

Variable	B coefficient	r	R^2	Adjusted R^2	β	sig	Durbin-Watson	t
Intimate Partner Violence	0.392	0.882	0.778	0.777	0.882	0.001	2.049	21.8

Analysis of Research Question 2 (RQ2)

RQ2: What is the association between colorism and IPV among AAW who are residents of states within the southern region of the United States, after controlling for potential confounders (age, marital status, education, and income)? The statistical test used to analyze the potential relationship between the two independent variables was Spearman's coefficient. Utilization of Spearman's correlation was appropriate in the evaluation of these the two variables because they failed to satisfy the assumption of continuous variables necessary for Pearson's correlation. Spearman's correlation has three assumptions that require satisfaction; the first deals with the variable being at the continuous or ordinal level. The second assumption is concerned with the variables having paired observations and the final assumption relates to the variables being monotonic, which means as on increases the other also increases or as one increases the other decreases (Laerd Statistics, 2015). None of the assumptions for Spearman's correlation occured. Spearman's correlation calculation for the variables of intimate

partner violence and colorism yielded, $r_s = .371$, $p = .001$. This calculation demonstrated a moderate positive correlation between the two independent variables. Indicating a statistically significant relationship, implying that as colorism scores increased this will lead to a medium level increase in intimate partner violence scores. Furthermore, since there was a medium but significant relationship there was acceptance of the alternative hypothesis.

Analysis of Research Question 3 (RQ3)

RQ3: What is the association between colorism and high-risk sexual behaviors among African American women who reside in the Southern region of the United States, after controlling for potential confounders (age, marital status, education, and income)? As in the analysis between intimate partner violence and high-risk sexual behaviors, assessment of the assumptions related to linear regression required satisfaction before data analysis.

None of the assumptions were violated, the test of independent (Durbin-Watson) equaled 2.052. The case wise diagnostics revealed one (1) outlier. This outlier remained in the dataset for final analysis based on its empiric value to the study and analysis of the residual values did not reveal any data points that were significantly out of range when compared to the others. Further, analysis of the data displayed a moderate positive correlation between the colorism variable and the high-risk sexual behavior variable that was statistically significant ($r = .337$, $p = .001$). Fourteen percent (14%) of the variance

in high-risk sexual behaviors among the women in this study was due to colorism with an adjusted R^2 of 13.6% (Table 14, has the summary of the regression analysis).

Table 14
Regression Analysis between Colorism and HRSB

Variable	B coefficient	r	R^2	Adjusted R^2	β	sig
Colorism	0.257	0.377	0.142	0.136	0.377	0.001

Analysis of Research Question 4 (RQ4)

RQ4: Does colorism mediate the relationship between IPV and HIV sexual risk behaviors among AAW who were residing in the southern region of the United Stated, after adjusting for potential confounders (e.g. age, education, marital status)?

Four conditions must be met before the variable could be considered a true mediator. These conditions were: 1) the IV must be related to the DV, 2) the IV must be related to the mediator, 3) the mediator should remain a significant predictor of the DV, and 4) the IV should no longer be a significant predictor of the DV. If all four of these conditions are met, there is full mediation (Statistic Solutions, 2015).

Sequential regression was the technique used to determine if mediation existed, the initial step involved running a linear regression analysis between the IV and the DV. The results were r = .882, β for IVP = .882, p = .001. Based on this data the IV, intimate partner violence and the DV, high-risk sexual risk behavior had a strong positive

correlation that was statistically significant. The final step in sequential regression involves adding the second IV (colorism) or the potential mediator variable to the equation. After conducting the linear regression analysis with the addition of colorism, the following results were: IVP: previous r = .882 new r= .882; previous β = .882 new β = 887; the significance level for intimate partner violence remained at p = .001. Colorism: r = 321; β = -.009, p = .680. Since the independent variable, IVP did not negatively react by adding the second IV, the relationship between the IVP and HRSB remained statistically significant. The study results indicated no mediation. Table 15 details the findings of the regression analysis for mediation between the study variables.

Table 15
Regression Analysis between IPV-HRSB with Mediation Variable

Variable	B coefficient	r	Adjusted R^2	β	sig	Partial Correlation	Durbin-Watson	t
Intimate Partner Violence	0.392	0.882	0.777	0.882	0.001		2.049	21.8
Intimate Partner Violence after mediation	0.39	0.882	0.775	0.877	0.001	0.858	2.052	19.4
Colorism	0.008	0.882		0.012	0.787	0.023		0.271

Summary of Findings

Significant associations were determined between IPV and high-risk sexual behaviors, colorism and IPV, and colorism and high-risk sexual behaviors among AAW residing within the southern region of the United States. The association between IPV

and HRSB remained strong despite the insertion of the mediator variable; colorism did not have an influence on the relationship. Therefore, the null hypothesis was be accepted. Colorism was found not to mediate the relationship between IPV and HIV sexual risk behaviors among AAW.

In Chapter 5, the results and findings will be further discussed to include the conclusion, recommendations, and suggestions for further research.

Chapter 5: Discussion, Conclusion, and Recommendations

The purpose of this study was to (a) examine the relationships among colorism, IPV, and high-risk sexual behaviors that could lead to infectious disease, such as HIV in AAW and (b) to investigate whether colorism had a mediating effect on the relationship between intimate partner violence and high-risk sexual behaviors. Convenience samples of 143 AAW were utilized to respond to online questionnaires that measured the variables of colorism, IPV, and high-risk sexual behaviors. A combination of correlation statistics and linear regressions were conducted to determine the relationships between the study variables while controlling for the effect of income, age, employment, education, and marital status. The first relationship under investigation in this study was between IPV and HRSBs; results indicated that among this population of AAW intimate partner violence relates to high-risk sexual behaviors. The second relationship was between colorism and IPV; results, although not as strong as the relationship between IPV and HRSBs, the association between colorism and IPV was statistically significant. The association between colorism and HRSBs was the third relationship explored in this study; based on the findings colorism correlated with high-risk sexual behaviors. The exploration of colorism's mediating role in the relationship between IPV and HRSB was the final association investigated during this study. The evaluation of this last relationship involved the use of sequential linear regression, and the results indicated that colorism did not contribute to the relationship between IPV and HRSB; hence, colorism did not provide any mediation value.

Interpretation of Findings

The results of this study showed that the asscociations were statistically significant as it relates to the relationships between IPV → HRSB, colorism → HRSB, and Colorism → IPV (p = ,001). However, during the assessment of colorism's mediating role in the relationship between IPV and HRSB, colorism had a nonsignificant effect (p = .787). Thus, the strength of the relationship between IPV and HRSB remained significant (p= .001). From the composite scoring of the individual subscales, intimate partner violence had a mean score of 9.74 and the composite score of 11.5 fell within the 75^{th} percentile; this indicated that women scoring greater than the mean had high IPV scores and there were 75% of women with scores of 11.5 or greater. High scores for colorism were greater than the mean of 28.5 with 75% of the scores higher than 32. Lastly, the mean high-risk sexual behavior scores for this study was 5.77 indicating scores above this were considered high; 75% of the study population had scores greater than 7. Thus, the high scores among the women in this study provide evidence that increased levels of IPV increases sexual risk. This finding is supported by previous research (Campbell 2013; Cohen et al., 2000; Kalichman & Kelly, 2000; Zierler et al., 2000) that established a correlation between the incidence of IPV and increased sexual risk, especially risk associated with the transmission of HIV. Moreover, the high levels of colorism indicated that the women were more susceptible to both IPV and high-risk sexual behaviors. The highest rate of abuse that occurred among these AAW was in the age range of 25-31(comprising 23.1%) with the age range of 18-24 representing 10.5% of

the targeted population. Surprisingly, a larger percentage of the women were over the age of 40; 39-45 (13.3%), 46-52 (16.1%), 53-59 (11.9%), and over 60 (14.7%), the cumulative percentage for the women over the age of 40 is 56%. This indicates that these older women were in the abusive relationships despite their relationship experience.

As stated by Cohen et al., (2000); Kalichman & Kelly, (2000); Zierler et al., (2000), CDC (2015a), Maman et al., (2000) Wingood & Diclemente (2000), and El-Bassel et al., (2009), there is a shared epidemiology between IPV and HIV. The shared epidemiology or risk factors for HIV and IPV exposure are the socioeconomic determinants of income, education, and employment. The lack of adequate income and employment has a collective influence on the associated risk as it relates to access to care, the ability to pay for care and the ability to pay for related treatments. Not only are the socioeconomic determinants contributing risk factors for both HIV and IPV, but IPV increases HIV risk through unsafe sexual practices (lack of condom use) and high-risk behaviors (multiple sexual partners, sex while intoxicated, and sex for money or drugs). This study confirmed the findings of previous research as it relates to poverty. The income range with the largest reported numbers in this study was between $25,999 - $49,999 (32.2%) annually; the income range of $10,000 - $24,999 was 21.7%; followed by the income range of $0 – $9, 999 (14%). Combined these income ranges were 67.9% of the study's population and represented an earning potential of less than $50,000 anually. Detailed information from the study participants was not reported regarding the number of people supported by the annual incomes or if they had adequate access to

health care, which would infringe upon the income total. However, based on data from the U.S. Census Bureau (2015b) the threshold for a family four is $24,447. Nonetheless, not being able to care for oneself or minor children could lead to compromising situations. For example, the results of the study indicated that 46% of the women remained under full-time employment, yet, 44.8% stayed in the relationship for financial reasons, 44.8% for assistance with child care, other reasons that may answer why the women over 40 remain in abusive relationships, include help with a place to live (16.1 %) and the need for companionship (16.8%). The dependence on the abuser fosters a relationship of dysfunction and increases the grip the abuser has over the life of the woman.

Previous studies (Campbell 2013; Cohen et al., 2000; Kalichman & Kelly, 2000; Zierler et al., 2000) reported that victims of abuse and women at risk for HIV come from backgrounds of low education; in contrast to the results of the current study—the educational levels among the study population were inconsistent regarding HIV risk. Only 4.9% of this study's population reported less than a high school education and their high-risk sexual scores were 28% above the study mean of 5.77. Nearly 20% of the women reported having obtained a high school diploma with 42.8% having high-risk scores greater than the mean of 5.77; of the 30.1% of women with some college, 44.2% had elevated high-risk scores, which were greater than the study mean. Women with a bachelors' degree was 20.3% with 38% of these women possessing high-risk scores above the mean. The bivariate analysis with HRSB before the regression assessment

indicated that education among this group of AAW was not significant (p = -.133). Despite the determination of insignificance, the amount of variance above the mean score suggests that among this population of AAW education remains a pivotal component and driving force toward an increased level of understanding and general awareness.

The study results demonstrated that colorism was related to both IPV and HRSB/HIV-Risk, however, the results also found that colorism was not a mediator in the relationship between IPV and high-risk sexual behaviors. Despite the lack of mediation, it was clear that colorism, through its racial and class undertones, contributes in destroying the self-esteem, self-image, and the psyche of the woman; thus having a low self-esteem relates to having unprotected sex and failure to advocate in a self-protective manner as previously observed by (Kennedy & Limmer, 2007; El-Bassel et al., 2009) and were in agreement with the present study findings.

As discussed in Chapter 2, the theory of power and gender and the social cognitive theory was used as the conceptual framework guiding this study; this study increased awareness related to the role/influence colorism could play on the physical and mental health and welfare of the individual. Connell (1987) postulated at the societal level through the sexual division of labor that the economic role of women was marginalized. Although, no inquiry was made into what types of jobs these women performed, for example, gender specific or uncompensated tasks related to childrearing or house cleaning, it was evident in this study the women were paid less and some remained in the abusive relationships out of necessity (childcare, a place to live, support,

food, clothing or companionship). For this study's population whose age was significantly below 30 (23.1%), had an income less than $25,999 per year (21.7%) they had double the marginalization when compared to white, older more affluent women (Bueno, 2015).

Also emanating from the societal level, the sexual division of power culture views power in terms of strength, where power is a condition of masculinity (Connell, 1987). The role of the women is to nurture, to take care of the man and to be subservient to his wants and needs, and to be unquestioning. This was corroborated within this study's findings as 44.1% of the women reported various acts of coercion and intimidation to force the male's will over the woman.

Cathexis as the third construct of the theory of power and gender and emanating from the level of society as postulated by Connell (1987), cathexis structuring assigns cultural gender specific roles that marginalize women in heterosexual relationships. This is accomplished through social norms and affective attachments as it relates to sexual behaviors (Connell, 2012; Wingood & DiClemente, 2002). This study confirmed vulnerability to disease, limited control over condom use, lack of concern regarding partner STI history, and partner sexual risk. The reported STI rate of the study's population (44.8%), noncondom use during vaginal sex (38.5%), having sex with a partner with a known STI history (22.4%), and engaging in sexual activities with a partner openly has MSM (14%).

According to Bandura (1986) as a component of the SCT, each individual has the power to harness self-efficacy as a trait by successfully completing tasks. When there is distortion of the power of self-efficacy, there is also distortion in the ability to achieve goals and maintain a balanced healthy life. Both colorism and IPV have the ability to negatively obscure perceptions and hinder self-efficacy; there were clear cases of study individuals who did not master the concept of self-efficacy, who continued to be manipulated and did not seek avenues to change detrimental behaviors. This confirmed the findings of Seth et al (2014) that AAW experiencing IPV were unable to successfully navigate behavioral tasks or practice preventative health care measures. Moreover, Finfgeld-Connett (2014) postulated that the higher prevalence of violence among AAW was related to life circumstances, which include racism, discrimination, poverty, and antisocial roles. For example, study results indicated 9.1% of the respondents believed that their skin color played a part in their abuse, and 14.7% of the women believed that changing their skin color would also change their circumstance related to their intimate partner abuse.

These study findings indicated that AAW, from an epidemiologic viewpoint, had risks that were similar to the general population as it relates to IPV and HRSB. However, there were unique cultural differences that should not be overlooked, one of which was colorism. Colorism was related to both IPV and high-risk sexual behaviors and if left unfiltered can negatively affect the health the individual.

Limitations

Limitations of this study include:

- Findings from this population may not be generalizable to other AAW or other women of color due to homogeneity and a relatively small sample size, $N = 143$.
- This study utilized linear regression to analysis mediation, the predictive value of linear regression could be used to predict risk relative to IPV scores.
- The reliability coefficient, .766 for the High-risk sexual behavior screen used for this population was minimally acceptable. The numbers of questions were reduced to eliminate fatigue and disinterest. Therefore, the screen would require follow-up testing on various populations.
- Because of nonprobability sampling, there is the possibility of selection bias. The respondents may form atypical or undesirable characteristics, or may omit characteristics out of fear being judged or criticized. This may be evidence by the fact there is limited research comprised solely of African-American women, and this study had to be expanded from the state of Georgia to the southern region to gain the necessary sample size; 925 women responded of which 76% were Caucasian women, 260 AAW responded, only 55% met the inclusion criteria.

- Potential bias may exist, although, the survey was completely anonymous and the collection of personal identifiable information was not part of the study's process, however, due to the sensitive nature of the questions, the participants may not have been totally forthcoming with the information they provided.
- As a cross-sectional study, the ability to make inferences about causality is limited and thus the interpretation of the research findings relative to cause and effect relationships between the variables are restricted. Therefore, a longitudinal study would be beneficial in addressing not only the relationships between variables but mediation. Advocating for longitudinal studies does not negate this study, but this study would serve as the basis for such longitudinal studies.

The findings made significant contributions to the body of knowledge regarding IPV and high-risk sexual behaviors as it related to colorism among AAW. The results demonstrated the need for further research related to colorism's role in the relationship between IPV and HRSB, in order to develop and implement programs geared toward culturally sensitive prevention measures.

Implications for Social Change

More than thirty years have passed since the virus responsible for infection (HIV) made public headlines. We have learned much regarding its' spread and due to advances in medical research lives are being saved, they are living longer but the number of AAW

exposed to the virus is increasing despite medical advances. There remains speculation regarding why AAW disparagingly have higher numbers when compared to women from other racial/ethnicities. One notation relates to African-American women's mate selection, while others deal with the socioeconomic factors, such as poverty, young age, and lack of education; which are the same factors that predispose these women to intimate partner violence. Although the risk factors related to HIV and IPV could be applied to any woman, certain types of racism and discrimination as described by Kreiger (1990) and Kreiger and Sidney (1996) remains endemic to American society. As such colorism, which is a subset of racism can have detrimental effects on the emotional and physical well-being of the individual. The information garnered from this study could be utilized to modify existing programs aimed at reducing the incidence IPV and HIV transmission; while simultaneously, teaching skills related to improving self-efficacy as well as those needed to enhance self-advocacy (thus reducing the negative effects of colorism).

This study has as an underlining goal of expanding the clinical insight regarding IPV and HIV-risk unique to AAW. The literature review did not ascertain any study that explored the relationship between colorism, IPV, and HIV-risk among AAW. Following this premise, the results from this study will be shared with the copyright holders of the instruments used in this study.

Furthermore, the results of this study could be used as a basis for larger studies and program evaluations. From the perspective of social change, having an increased

awareness of colorism's role within the structure of IPV and HRSB can facilitate better program development and foster better self-awareness.

Recommendations for Future Research

There is evidence in the literature that establishes an intersection between IPV and HIV. However, in the search for research regarding this intersection among homogenous samples of AAW and the influence of colorism; observations of studies within the U.S. has been qualitative, meta-analyses or comprised of racially or ethnically mixed populations. None of these studies were able to highlight findings that would significantly change the way programs were to be developed, evaluated or even how interventions initiated. As a community African Americans have been marginalized and relegated to a secondary and at times inferior role in society they have faced both economic and health disparities, yet the fact remains that the burdens related disease are increasing. The current study could serve as the foundation for future research with the following recommendations:

- Future studies will need replication with different subsets of the population, for example, different regions, and different ethnicities or a combination of ethnicities for comparison.
- More detailed study within the African-American community to include males and/or the abuser will provide a more diverse perspective and insight regarding prevention services.

- Future studies are required to explore the relationship of colorism on violence from both the female and the male perspective, as a means of developing prevention programs.
- Future studies that explore the predictive value of linear regression, for example, longitudinal studies that follows a sample of women over time and retrospective studies that follow women with HIV to see if they would have scores that indicate high risk.
- Future studies are needed to explore not only the relationship of colorism on IPV and HRSB but also the psychological ramifications.
- To improve external validity and extend the overall understanding of the phenomenon, a mixed methods study is recommended. The use of qualitative, as well as quantitative methods would provide valuable insight and deeper explanations to behaviors that epidemiologic studies alone could not answer.

Recommendations for Action

We have an understanding of what works, the public service announcements have relayed their intended message regarding safe sex; some communities hard hit by drug abuse have opted for needle exchange programs, clinics provide free condoms and free HIV testing; and there is domestic violence awareness initiatives, yet, the problems remain—with the women in the African-American communities suffering.

The results of this study have highlighted the fact that there is a positive intersection between IPV and HIV. It also demonstrated that colorism has a negative influence on violence as well as the potential of increasing high-risk sexual behaviors among AAW.

To meet the needs of this population and reduce the prevalence of both IPV and HIV, more public health funding is required. When it comes to the health of the nation less government is not necessarily a viable option. It is imperative that Public Health Policymakers seek avenues for increased public health funding for the development of new or modified programs. Some of these programs would include:

- Educational programs for increased awareness regarding the myths of IPV and HIV (for example, it's not possible to get HIV if I only have one partner).
- Development of programs that are culturally sensitive; programs that would provide information on colorism as a risk factor. If psychological components were present, mental health offerings would be available.
- Modification prevention programs related to IPV and HIV to include colorism, the main principles related to the theory of gender and power and that of self-efficacy.
- Overall, the programs developed should include evaluation tools, while one of the key goals should include breaking the dysfunctional relationship between the abuser and the victim.

Conclusion

Two public health concerns that are of epidemic proportions within the African-American community are intimate partner violence and human immunodeficiency virus. Research on mixed populations or homogenous populations of Caucasian women has determined that women exposed to IPV are more likely to engage in high-risk sexual behaviors leading to HIV infections. There has been limited research in the area of HIV and IPV that involves a homogenous sample of AAW. This study bridges that gap. Therefore, the purpose of this quantitative cross-sectional study was to assess the relationships of colorism, IPV, and high-risk sexual behaviors among AAW.

Four research questions helped guide this study. Three of the research questions indicated statistically significant relationships, the IPV→High-risk sexual behaviors relationship, the colorism →IPV relationship, and the colorism → high-risk sexual behavior relationship. The significance found in these relationships led to the extrapolation that IPV exposure increased a woman's involvement in high-risk sexual behaviors. The negative internalized feelings associated with colorism, such as low-esteem, and low self-efficacy there was an increase in the woman's engagement in high-risk behaviors. The colorism → IPV relationship, displayed a moderate correlation, the significance indicated that AAW experiencing the negative effects of colorism, through the lack of self-esteem and self-advocacy are at an increased risk for being in a violent relationship. Colorism was not a significant contributing factor in the relationship between IPV and high-risk sexual behaviors.

Although colorism was not a factor, the effects of colorism and IPV can have long-lasting implications on the life of the woman, particularly when there is an increase in high-risk sexual behaviors leading to HIV infections. Reversal of the effects of colorism and IPV on high-risk sexual behaviors among AAW is possible; however, this will require changes within various levels of society. The changes that deter domestic violence should through culturally sensitive prevention initiatives aimed at reducing and eliminating the transmission of HIV infections among AAW. It is important to note that despite the establishment of this study's target population as AAW, other women of color are susceptible to the ills of colorism and the negative ramifications. Therefore, research findings and interventions developed from this study and future studies should include a blueprint to assist other women of color.

Public health actions must go beyond just stating abstinence, encouraging condom use or telling the victim of abuse she deserves better, that she has a choice. From an intellectual point of view these interventions are well-intentioned but hey do nothing to change long-term behaviors. Program success must find what motivates the individual toward lasting and sustained change. There is a multitude of reasons why a person will incorporate or fail to include change, none the less the actions employed should utilize a multifaceted approach, which adds colorism from the psychological well-being perspective. Future research should explore the relationships presented in this study on a larger scale using the predictive value of linear or logistic regression.

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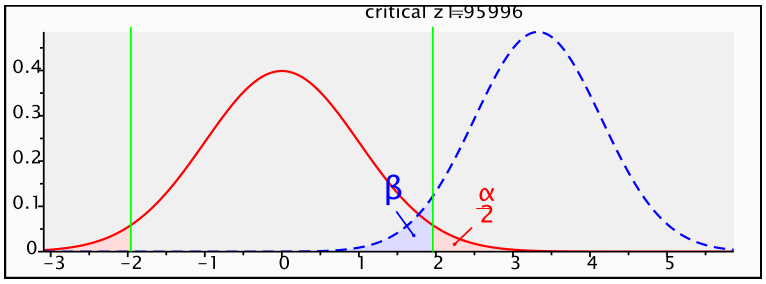
Appendix A1: Sample Size Computation

Tail(s)	α	Power	OR	Critical z	Sample size	30%	50%

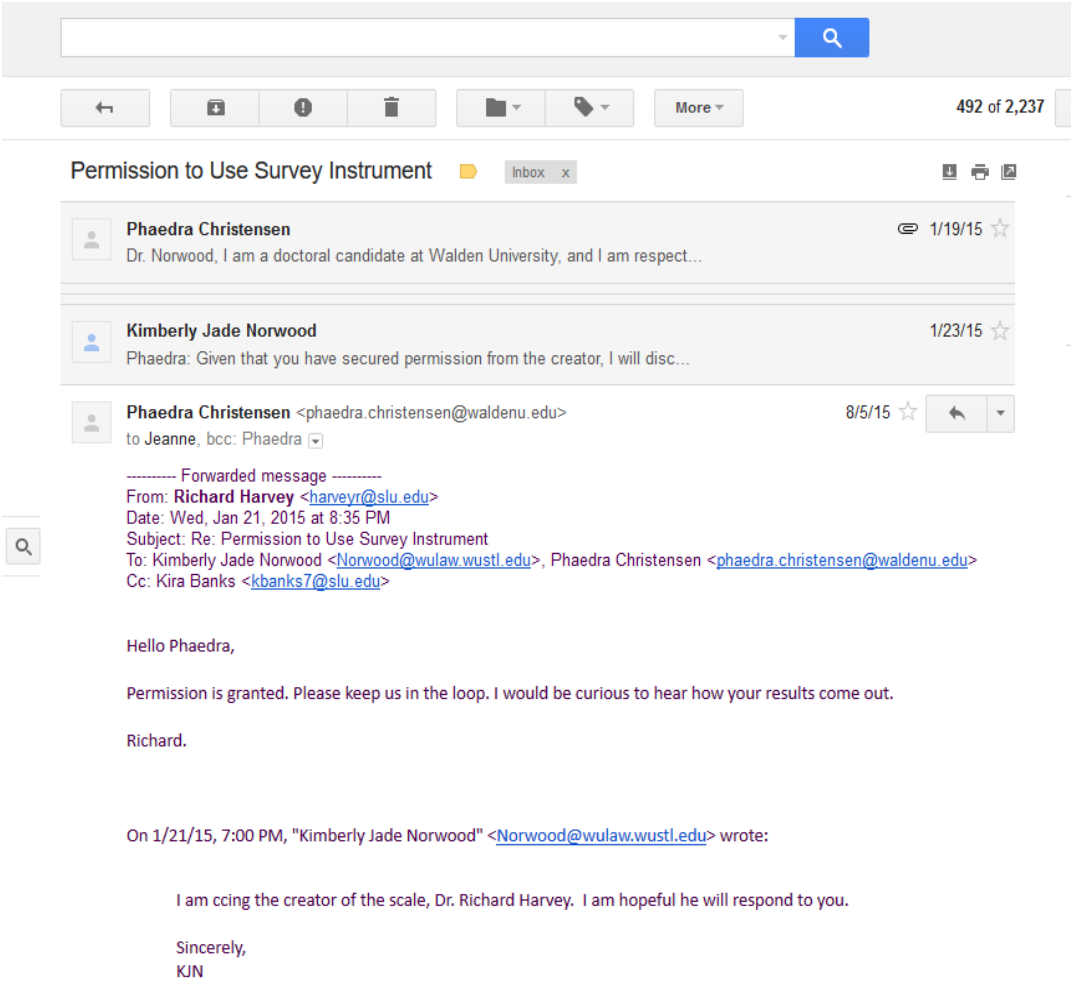


Options:	Large sample z-Test, Demidenko (2009) with var corr		
Analysis:	A priori: Compute required sample size		
Input:	Tail(s)	=	Two
	Odds ratio	=	2.333333
	Pr(Y=1|X=	=	0.3
	α err prob	=	0.05
	Power (1-β	=	0.95
	R² other X	=	0
	X distributi	=	Normal
	X parm μ	=	0
	X parm σ	=	1
Output:	Critical z	=	1.959964
	Total sampl	=	104
	Actual pow	=	0.951523

Figure. A1. Sample Size Computation

Appendix B: Permissions to Use Study Instruments

Colorism Scale/Creator: Harvey



492 of 2,237

Permission to Use Survey Instrument

Inbox x

Phaedra Christensen 1/19/15
Dr. Norwood, I am a doctoral candidate at Walden University, and I am respect...

Kimberly Jade Norwood 1/23/15
Phaedra: Given that you have secured permission from the creator, I will disc...

Phaedra Christensen <phaedra.christensen@waldenu.edu> 8/5/15
to Jeanne, bcc: Phaedra

---------- Forwarded message ----------
From: **Richard Harvey** <harveyr@slu.edu>
Date: Wed, Jan 21, 2015 at 8:35 PM
Subject: Re: Permission to Use Survey Instrument
To: Kimberly Jade Norwood <Norwood@wulaw.wustl.edu>, Phaedra Christensen <phaedra.christensen@waldenu.edu>
Cc: Kira Banks <kbanks7@slu.edu>

Hello Phaedra,

Permission is granted. Please keep us in the loop. I would be curious to hear how your results come out.

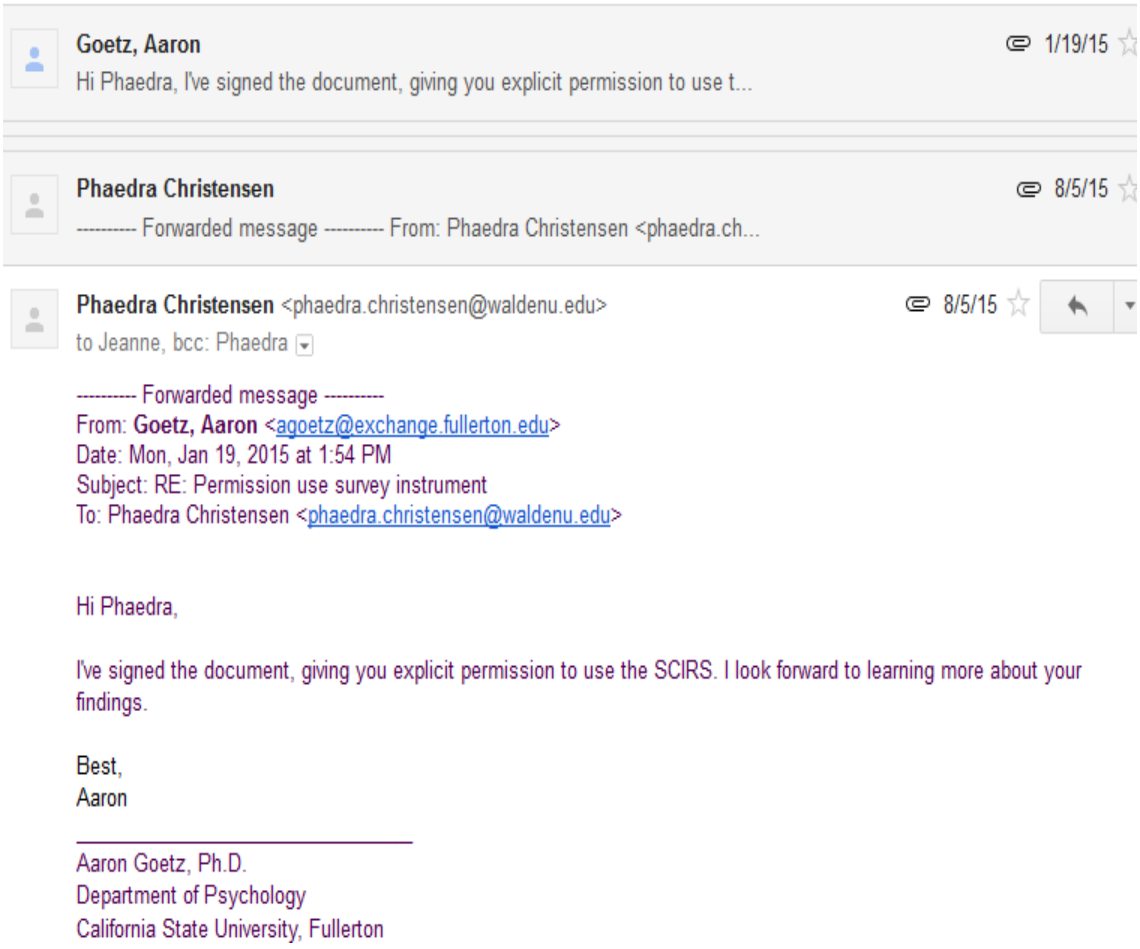
Richard.

On 1/21/15, 7:00 PM, "Kimberly Jade Norwood" <Norwood@wulaw.wustl.edu> wrote:

I am ccing the creator of the scale, Dr. Richard Harvey. I am hopeful he will respond to you.

Sincerely,
KJN

SCIRS/ Creator: Geotz



Goetz, Aaron 1/19/15
Hi Phaedra, I've signed the document, giving you explicit permission to use t...

Phaedra Christensen 8/5/15
---------- Forwarded message ---------- From: Phaedra Christensen <phaedra.ch...

Phaedra Christensen <phaedra.christensen@waldenu.edu> 8/5/15
to Jeanne, bcc: Phaedra

---------- Forwarded message ----------
From: **Goetz, Aaron** <agoetz@exchange.fullerton.edu>
Date: Mon, Jan 19, 2015 at 1:54 PM
Subject: RE: Permission use survey instrument
To: Phaedra Christensen <phaedra.christensen@waldenu.edu>

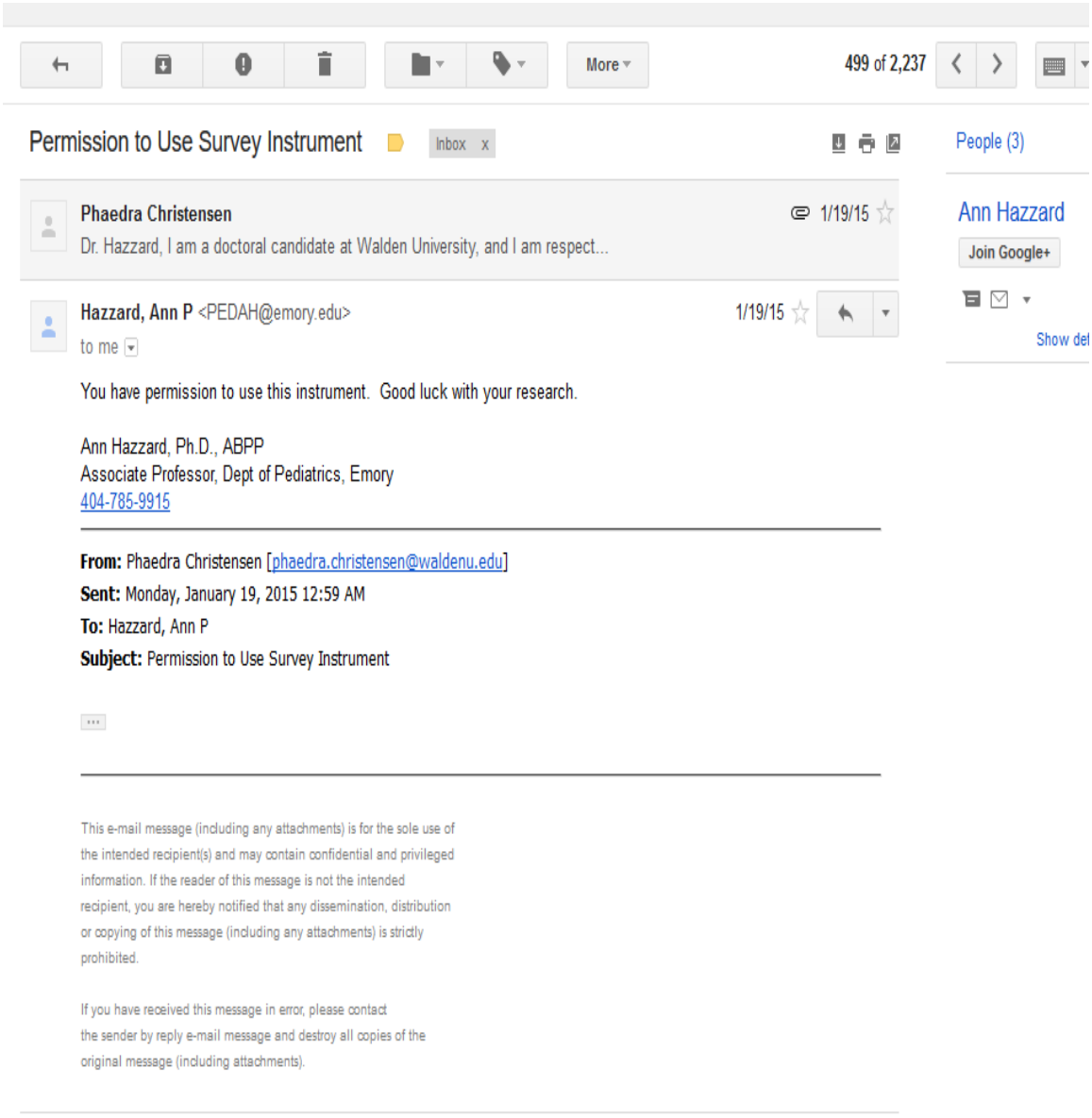
Hi Phaedra,

I've signed the document, giving you explicit permission to use the SCIRS. I look forward to learning more about your findings.

Best,
Aaron

Aaron Goetz, Ph.D.
Department of Psychology
California State University, Fullerton

Trauma Related Belief Scale/ Creator: Hazzard



Permission to Use Survey Instrument

Inbox x

Phaedra Christensen 1/19/15

Dr. Hazzard, I am a doctoral candidate at Walden University, and I am respect...

Hazzard, Ann P <PEDAH@emory.edu> 1/19/15

to me

You have permission to use this instrument. Good luck with your research.

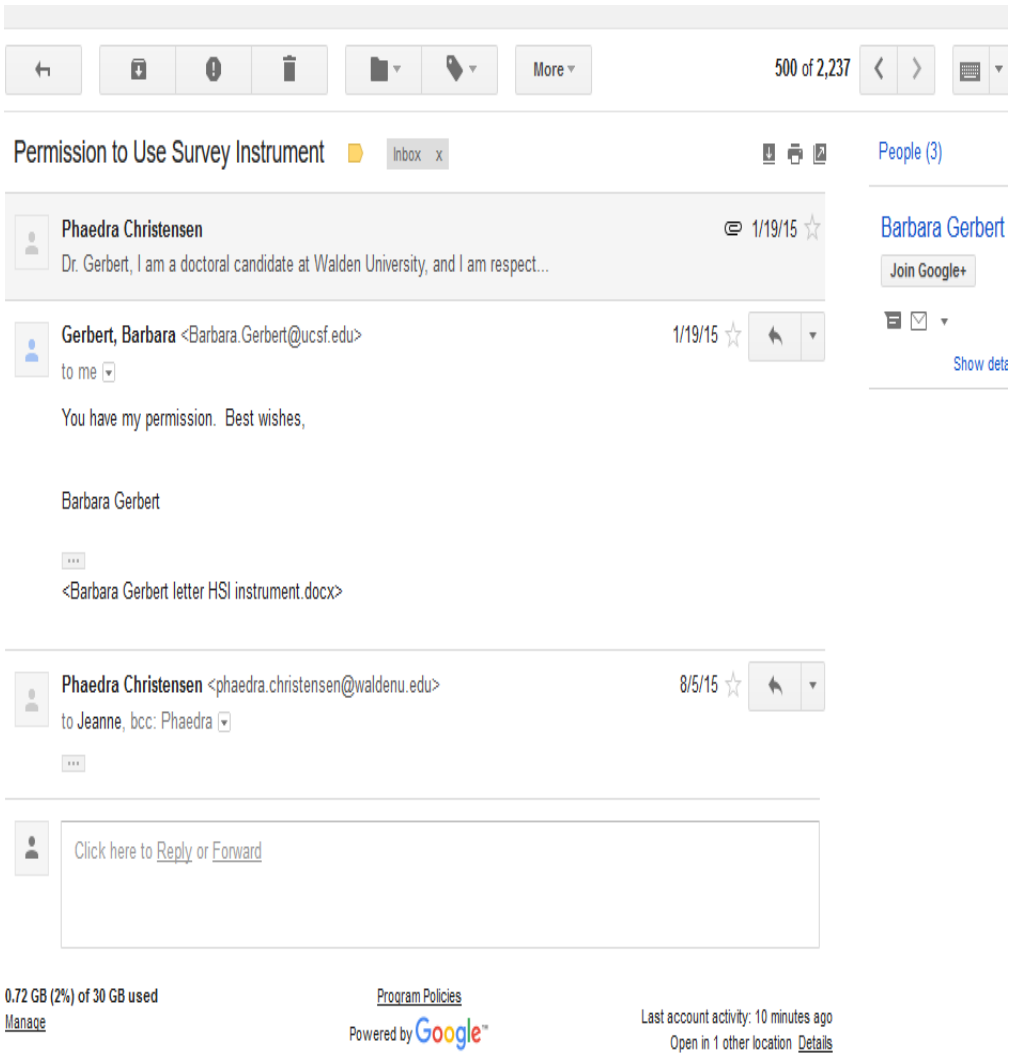
Ann Hazzard, Ph.D., ABPP
Associate Professor, Dept of Pediatrics, Emory
404-785-9915

From: Phaedra Christensen [phaedra.christensen@waldenu.edu]
Sent: Monday, January 19, 2015 12:59 AM
To: Hazzard, Ann P
Subject: Permission to Use Survey Instrument

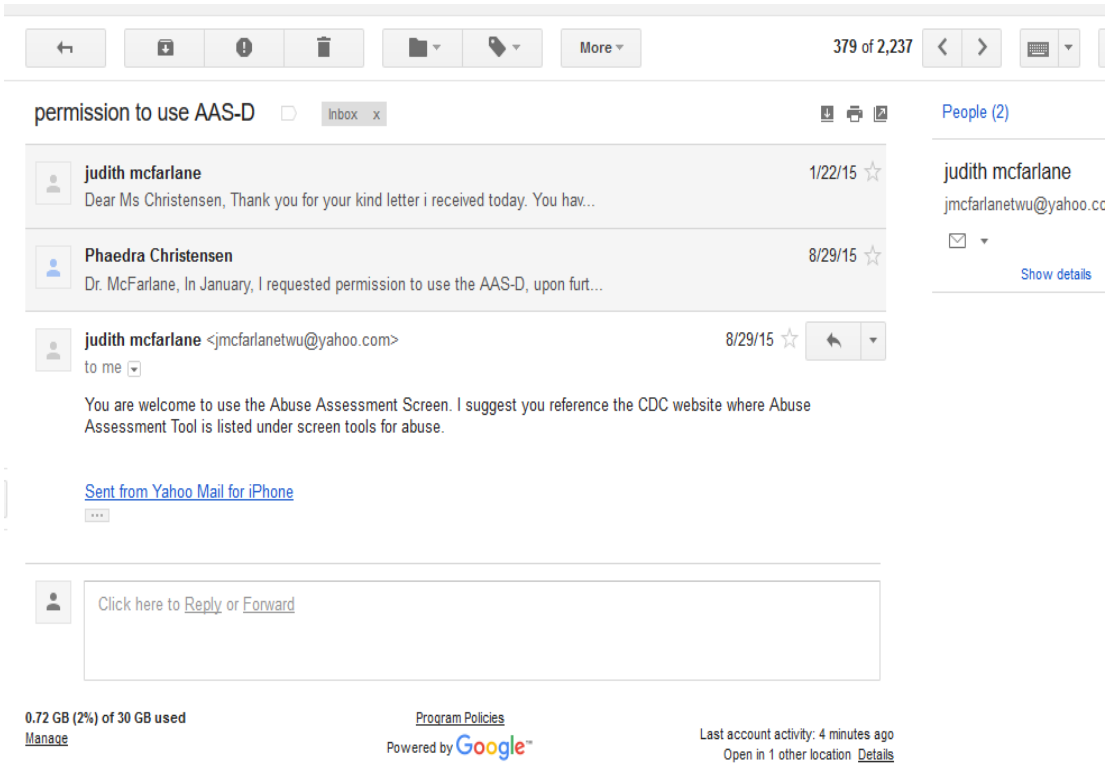
This e-mail message (including any attachments) is for the sole use of the intended recipient(s) and may contain confidential and privileged information. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this message (including any attachments) is strictly prohibited.

If you have received this message in error, please contact the sender by reply e-mail message and destroy all copies of the original message (including attachments).

HIV Risk Screening Tool/ Creator: Gerbert



Abuse Assessment Scale/ Creator: McFarlane



Appendix C: Study Questionnaire/Demographics

Drections: Please read each item carefully. Circle the number that corresponds with the answer that BEST describes you. Please Answer every question.

1. What is your current age?

18-24……1	39-45……....4
25-31……..……..2	46-52……5
32-38……....3	53-59……....6
	Over 60……7

2. What is your skin tone? Choose the number that BEST matches your skin.

3. What is is martial status?

Single	1
Married	2
Divorced	3
Separated	4
Living with someone	5

4. What was the highest grade of school ever completed?

Less than high ……..1	Bachelor's Degree……4
High school diploma……..2	Master's Degree……5
Associate's degree…….3	Dororate……..6

Other (Please specify)_____

5. What is your total income before taxes ?

$0-$9,999……1
$10,000-$19,9999……2
$20,000-$29,999……3
$30,000-$39,999……4
$40,000-$49,999……5
$50,000-$59,999……6
$60,000-$69,999……7
$70,000-$79,999……8
$80,000-$89,999……9
$90,000-$99,999……10
$100,000 or more……11

6. What is your current employment status?

Unemployed ……1
Full-time employment……2
Part-time employment……3
Full-time student……4
Part-time student……5
Disabled……6
Other please specify _____

Appendix D: Modified Abused Assessment Screen

Directions: Please read the folowing questions carefully. Circling YES or NO for each question and as indicated.

1. Have you ever been emotionally or physically abused by your partner

YES NO

2. Within the past year, have you been hit, slapped, kicked, or otherwise physically hurt by your partner?

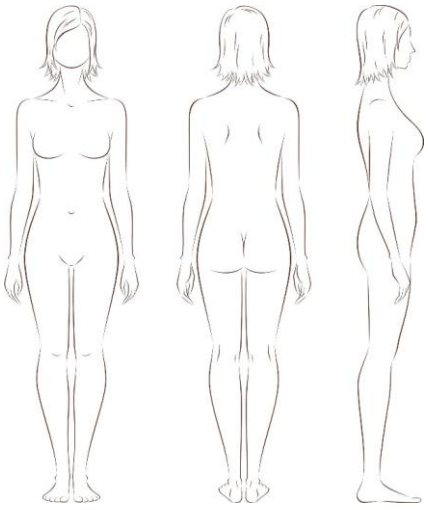
YES NO

If you answered YES to the above questions, by whom?
(Circle ALL that apply)

Husband, Ex-Husband, Boyfriend, Other

Total number of times were you hit by this person _____

Mark the area on the body below of where you were injuried. Score each incident based on the following scale. If any descriptions of the higher number apply, use the higher number.



1= Threats of abuse including use of weapons

2= Slapping, pushing, no cuts, and or lasting pain

3= Punching, kicking, bruises, cuts, and or continuing pain

4= Beating up, severe contusions,burns, broken bones

5= Head injury, internal injury, permanent injury

6= Use of a weapon, wound from a weapon

Incident Score _____ Incident Score _____ Incident Score _____
Incident Score _____ Incident Score _____ Incident Score _____

3. Within the last year,has anyone threatened physical harm if you did not have sex with them?

YES NO

If YES, by whom, Circle all that apply

Husband Ex-Husband Boyfriend Oher

4. Within the past year, has anyone forced you to have unprotected sex of any kind to include anal sex?

YES NO

If YES, by whom, Circle all that apply

Husband Ex-Husband Boyfriend Oher

5. Within the past year, has anyone force you to have sex with others against your will for money or drugs?

YES NO

If YES, by whom, Circle all that apply

Husband Ex-Husband Boyfriend Oher

6. Do you feel your skin color played a part in how you were treated sexually?

YES NO

7. If your skin tone were changed, do you feel that the emotional and physical abuse would also change?

YES NO

If YES, Circle One (1) to describe the direction of color change that would help improve your circumstances

Lighter Skin tone Darker Skin tone

8. Are you afraid of your partner or anyone listed above?

YES NO

Appendix E: Study Questionnaire/HIV-Risk Assessment Tool

Directions: Please read each of the following questions carefully. Then, circle the number that corresponds to your answer for the question. For example, if your answer is Yes, you would circle "1".

1. Have you had 2 or more sexual partners in the last 6 months?

YES	1
NO	0

2. Have you ever had vaginal sex (a man puts his penis into your vagina) with a condom during the last 6 months?

Never	1
Sometimes	2
Always	3
Have not had sex	4

3. Have you ever had vaginal sex (a man puts his penis into your vagina) without a condom during the last 6 months?

YES	1
NO	0

4. Have you had anal sex (when a man inserts his penis into your anus) with any of your sexual partners during the last 6 months?

YES	1
NO	0

5. How often have you used a condom when having anal sex in the past 6 months?

Never	1
Sometimes	2
Always	3
Have not had anal sex	4

6. Have you ever had a sexually transmitted disease such as gonorrhea, syphillis, chlamydia, genital warts, or genital herps?

YES	1
NO	0

7. At any time in the past 6 months, were you ever given money or drugs to have sex with you?

YES	1
NO	0

8. Have you ever had sex with someone so that they would give you money or drugs?

YES	1
NO	0

9. Have you ever injected street drugs, steroids, or vitamins with a needle?

YES	1
NO	0

10. Have any of your sex partners within the past 6 months ever injected street drugs, steroids, or vitamins with a needle?

YES	1
NO	0

11. Have any of your sex partners in the past 6 months been men who have sex with other men?

YES	1
NO	0

12. Have any of your sex partners in the past 6 months ever had a sexually transmitted disease such as gonorrhea, Chlamydia, genital warts, or gential herpes?

YES	1
NO	0
Don't Know	0

13. Have you ever had oral sex (a man puts his penis into your month) with a condom during the last 6 months?

Never	1
Sometimes	2
Always	3
Have not had anal sex	4

14. Have you ever had oral sex (a man puts his penis into your month) without a condom during the last 6 months?

YES	1
NO	0

Appendix F: Hazzard: Powerless Subscale

Directions: Below are statements of different thoughts and feelings. Some statements are about what happened in your past (your experiences). Other statements are about your views concerning different issues. For each statement, please circle the number to indicate how untrue or tue the statement is to you. There are no right or wrong answers. The rating is as follows:

0= Absolutely untrue 1= Mostly true 2= Partly true, Partly Untrue
3= Mostly true 4= Absolutely True

Most things in life can't be controlled	0	1	2	3	4
Something like this might happen to me	0	1	2	3	4
No matter what I do I can't stop bad things from happening	0	1	2	3	4
I often worry I will be abused again	0	1	2	3	4
I can protect myself in the future	0	1	2	3	4
I can't control what happens to me	0	1	2	3	4
More bad things happen to me thanto other people	0	1	2	3	4
I can usually achieve what I want in most situations	0	1	2	3	4
It doesn't pay to try hard because things never turn out right	0	1	2	3	4
People don't have much influence over the way things turn out.	0	1	2	3	4

Appendix G: Colorism Instrument

Directions: The below statements describe certain attitudes, feelings, or thoughts regarding skin tone. There are no right or wrong answers, only personal responses. For each item yu will be asked to indicate how much you agree or disagree with the statement listed. Use the following scale to provide your

(A) Strongly Disagree	(B) Disagree	(C) Neither Agree or Disagree	(D) Agree	(E) Strongly Agree

My skin tone is an inportant part of my self-concept.
A B C D E

My skin tone is an important component of who I am .
A B C D E

My skin tone affects my self-esteem.
A B C D E

My skin tone is a big part of my identity.
A B C D E

You can tell a lot about a person by their skin tone.
A B C D E

Blacks with lighter skin tone tend to be more pleasant people to deal with.
A B C D E

Dark-skinned people are more difficult to deal with.
A B C D E

There are real differences between light-skinned people and dark-skinned people.
A B C D E

I'm usually uncomfortable being around people who are a certain skin tone
A B C D E

Most of my friends tend to be the same skin tone.
A B C D E

I usually choose who I'm going to be friends with by their skin tone

A B C D E

The majority of my friends are the same skin tone as me

A B C D E

I am primarily attacted to people of a certain skin tone.

A B C D E

I perfer a romantic partner who is th same skin tone as me

A B C D E

I perfer light skin over dark complexion skin when choosing romantic interests

A B C D E

Lighter skin tone make others more attractive

A B C D E

Even if you really work hard, your skin tone matters most.

A B C D E

Skin tone plays a big part in determining how far you can make it

A B C D E

Skin tone affects how much money you can make

A B C D E

If you want to get ahead, you have to be the right skin tone.

A B C D E

Appendix H: Sexual Coercion in Intimate Relationships Scale

Directions: Sexuality is an important part of any intimate relationship and can sometimes be a source of conflict. Below are a list of acts that can occur in an intimate relationship. Please use the following scale to indicate how oftenin the past 6 months these acts occured. Write the number that best represents your response in the area provided.

0 = Act did NOT occur in the past month
1= Act occurred 1 time in the past month
2 = Act occurred 2 times in the past month
3 = Act occurred 3 to 5 times in the past month
4 = Act occurred 6 to 10 times in the past month
5 = Act occurred 11 or MORe times in the past month

My partner hinted that he would withhold benefits that I depend on if I did not have sex with him	
My partnerthreatened that he would withhold benefits that I depend on if I did not have sex with him	
My partner withheld benefits that I depend on to get me to have sex with him	
My partner hinted that he would give me a gift or other benfits if I had sex with him	
My partner gave me gifts or other benfits so that I would feel obligated to have sex with him.	
My partner reminded me of the gifts or other benfits he gave me so that I would havesex with him	
My partner pesisted in asking me to have sex with him, even though he knew I did not want to.	
My partner pressured me to have sex with him against my will.	
My partner initiated sex with me when I was unaware (for example, I was asleep, drunk or on medication) and continued against my will.	

My partner threatended to physicaly force me to have sex with him.	
My partner physically forced me to have sex with him.	
My partner made me feel obligated to have sex with him.	
My partner hinted that he would have sex with another women if I did not have sex with him.	
My partner threatened to have sex with another woman if I did not have sex with him.	
My partner told me that other couples have sex more than we do, to make me feel like I should have sex with him.	
My partner hinted that he might pursue a lont-term relationship with another woman if I did not have sex with him.	
My partner threatened to pursue a long-term relationship with another woman if I did not have sex with him.	
My partner hinted that if I were truly committed to him that I would have sex with him.	
My partner told me that if I were truly committed to him that I would have sex with him.	
My partner hinted that if I loved him I would have sex with him.	
My partner told me that if I loved him I would have sex with him.	
My partner threatened violence against someone or something I care about if I did not have sex with him.	
My partner threatened violence against me if I did not have sex with him.	

My partner hinted that other women were interested in a relationship wth him, so that I would have sex with him.	
My partner told me that other women were interested in a relationship with him, so that I would have sex with him.	

Appendix I: Recruitment Flyer

Be Heard: Fill out a Survey on Your Relationship Experience

Research: Women's Health Study. Exploring relationship experiences, skin tone, and sexual risk.

Are You? An African American Women? Over the Age of 18? Do you have a past history of relationship violence either emotional, physical, sexual, psychological, or financial? Do you live in a state within the Southern Region?

Contact: Phaedra Christensen, RN, MA, P.h.D. (c)

E-mail: phaedra.christensen@waldeun.edu

or

Directly Access Research Survey @

https://www.surveymonkey.com/r/MPKD7B7

Password: SMimacon07

Appendix J: Information Poster

Flyer-Information Poster

Dear Prospective Research Participant,

I am Phaedra Christensen; a Ph.D. candidate in Health Services at Walden University, conducting a research study related to women's health and I am investigating if skin tone has an impact on intimate relationships and high sexual risk behaviors.

I am seeking participants to take a survey, who speak English fluently, are women and are Black/ African-American and have a been in an intimate relationship with previous histories of violence (e.g. threats, physical, emotional, sexual, etc.). Participants of the age of 18 years old and older are welcomed.

The survey will take approximately 10-15 minutes to complete. At any time during the survey, the research participant may withdraw if she feels uncomfortable with the content the survey. However, only fully completed survey will be used.

This research is not affiliated with any organization; declining or discontinuing to participate by the volunteer will not impact their ability to receive services from agencies that assistance women with domestic violence. If the participant has determined that she requires assistance, she can contact the Georgia Coalition Against Domestic Violence at 1-800-33-HAVEN, for resources in their area.

If you are interested, please contact me via the below-listed information. This research utilizes a survey, which is completely anonymous. Online access is through the following secure link: https://www.surveymonkey.com/r/MPKD7B7
Password: SMimacon07.

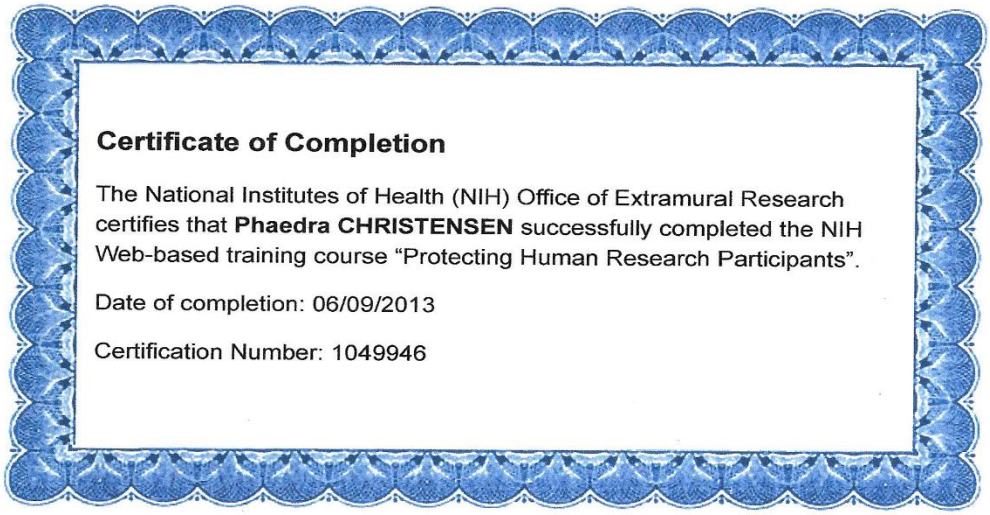
Sincerely,

Phaedra Christensen, MA, BSN, CPAN.

Ph.D. Public Health Candidate

phaedra.christensen@waldenu.edu

Appendix K: Certificate of Completion



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Phaedra CHRISTENSEN** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 06/09/2013

Certification Number: 1049946