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AIDS EDUCATION:  
A SOCIAL CONSTRUCTIONIST APPROACH

by

Julie M. Fraser  
B.A., University of Waterloo, 1990

A Thesis  
Submitted to the Faculty of Graduate Studies  
through the Department of Psychology in Partial  
Fulfilment of the Requirements for  
the degree of Master of Arts at  
The University of Windsor

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## Abstract

AIDS and HIV is a constantly growing concern in North American society. Adolescents and youth are considered to be groups in particular risk because of their unsafe sexual practices. Previous positivist research efforts attempted to understand adolescent risk as a function of their knowledge and a variety of attitudinal variables. While this research provided valuable findings, an understanding of adolescent unsafe behaviour remained fragmentary. The present study utilized a social constructionist approach to investigate this problem. Open-ended interviews were conducted with youth and adolescents in the Windsor area. Participants were encouraged to provide their constructions regarding a number of topics pertinent to safe sex. The themes of trust, responsibility, risk, pressure and states of consciousness emerged as primary in participants' accounts. Themes were interpreted in terms of how they reflected the social context, such as their role in maintaining societal power differentials and as reflecting current ideological thought in Western society. Recommendations were made as to how safe sex education might be made more effective for adolescents and youth.

### Acknowledgements

There are many people who are deserving of great thanks for their role in the development and completion of this research. I would like to thank my chair, Prof. Henry L. Minton, for his unswerving support and patience through many re-writes and tight deadlines, as well as the rest of my committee, Prof. Charlene Senn, Prof. Alan Sears and Prof. Barry Adam for their insightful comments and their flexibility. The staff of the Teen Health Centre, the AIDS Committee of Windsor and New Beginnings were also vital for their assistance and their willingness to grant me access to participants. Although it goes without saying, all the participants whose voices are contained herein were also completely invaluable and deserving of great thanks. Finally, to my friends, family and fellow students, your caring, your time and your probing questions helped keep this project alive, especially in the wee, sleepless hours. Special thanks to Darryl Hill, Linda Reinstein and Kevin Smith.



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## Chapter 1

### Introduction

AIDS. In a relatively short period of time, this single acronym has become imbued with many meanings, meanings which are personalized by, and distinctive to each individual. Whether we view AIDS as somebody else's problem, a personal battle, a gay disease, a source of jokes, a scourge on the amoral of society, or a fascinating new challenge to the medical community, AIDS has meaning for each of us. The concept of individual meanings becomes paramount if one considers the possible link between meaning and behaviour. That is, if one's personal construction of AIDS is seen as directly influencing one's sexual practices.

#### Youth and Adolescents at Risk

Given the serious consequences of contracting HIV, much effort has gone into determining which groups are most at risk and hence, most in need of education. The US Surgeon General (US Public Health Service, 1987) stated that adolescents and preadolescents are especially vulnerable to AIDS because they tend to experiment with sexuality and drugs. Other studies (Coates, 1990) target young gay men as being a particularly high risk group in need of attention. More current statistics from the Ontario Ministry of Health (1992), paint a fearful picture of teen safe sex practices

with more than half of the 16 to 24 year olds surveyed reporting never using condoms to protect against sexually transmitted diseases. Furthermore, female teens aged 15 to 19 suffer the highest rate of contracting STD's with more than 4,995 reported cases of chlamydia, gonorrhoea and syphilis. While males appeared to be less affected with only 951 reported cases of these STD's, there is some suspicion within the medical community that this is more of a reflection of male attitudes towards health care, than differential infection rates. One study (Kelly & Murphy, 1991), even went as far as to suggest that adolescents may be at the greatest risk because their behaviours may be most resistant to change.

#### Situating the Researcher in the Discourse

Although epidemiological statistics alone could provide a rationale for the necessity of studying adolescent's views of safe sex, my initial interest stemmed from my own questions about HIV and sexual practices. As a heterosexual female, despite my connections with the gay community, AIDS seemed to have little personal significance. With a burgeoning awareness of the heterosexual transmission of AIDS however, my meaning began to change. I became increasingly cognizant of a confusing paradox. People I knew, including myself, who were well versed in the specifics of AIDS and the transmission of HIV, who had close

friends battling the virus, nonetheless continued to practice risky sexual behaviour. Thus, my focus became the answer to the question of what is allowing people to disregard what they know about AIDS and continue to practice unsafe sex.

### Review of Relevant Literature

By virtue of there being a problem, it seemed obvious that educational campaigns were somewhat ineffective. A content analysis of pamphlets on AIDS submitted by six health care agencies in the state of Ohio, yielded some potentially suggestive results (Prewitt, 1989). According to the Prewitt study, not only did the literature not present information on sexual behaviour in a clear and specific manner, but the limitations imposed on the literature did not promote either education or personal preventive health behaviours. The question of what might promote safe sex behaviour led researchers to investigate factors predictive of safe or unsafe sexual behaviour. Those factors that will be reviewed in the following discussion include knowledge of AIDS, attitudes towards AIDS, safe sex and condoms, perceived risk, motivation, and coercion to engage in unsafe sex.

Knowledge. Despite this apparent limitation in quality educative material, studies have shown that youth do appear

to be learning more about AIDS. Many studies have shown a general increase in AIDS awareness (DiClemente, Forrest & Mickler, 1990; see also Fisher & Misovich, 1990 for a discussion of university students increase in knowledge from 1986 to 1988). From personal experience however, it still seemed that what people knew was not affecting how they behaved, knowledge of AIDS risk was not promoting safe sex behaviour. The literature readily supplied empirical support for this observation using a wide variety of subject populations.

Within American university settings many researchers (e.g., Baldwin & Baldwin, 1988; Burnette, Redmon & Poling, 1990; Carroll, 1991; Katzman, Mulholland & Sutherland, 1988) noted this discrepancy between knowledge and behaviour. Studies of Yugoslavian University students (Ajdukovic & Ajdukovic, 1991) provided some cross-cultural support as well. Work with adolescents, (Rickert, Jay, Gottlieb & Bridges, 1989; Roscoe & Kruger, 1990; Skurnick, Johnson, Quinones, Foster et al., 1991) similarly found that teens with a high degree of knowledge about AIDS were no more likely than their less knowledgeable counterparts to engage in safe sex behaviours. The same findings were indicated in other studies using Hispanic, Black, gay and bisexual adolescents (Rotheram-Borus & Koopman, 1991), as well as runaway adolescents (Koopman, Rotheram-Borus, Henderson, Bradley et al., 1990). Many of the health-care

professionals with whom I spoke prior to reviewing the existing literature also noted this discrepancy in their younger clientele.

Attitudes Towards AIDS. As the process of inquiry proceeded, many researchers began to de-emphasize knowledge of AIDS as an important factor in understanding sexual behaviour and looked to more fluid concepts. Vast amounts of research, aimed at the eventual prediction and control of behaviour, seized on attitudes towards AIDS as a possible mediating factor.

Attitudes towards AIDS alone held nebulous predictive value (e.g., Rotheram-Borus & Koopman, 1991). Researchers however, attempted to expand this idea by fleshing out the relationship between attitudes towards AIDS and such varied constructs as belief in a just world (Ambrosio & Sheehan, 1991), indices of religious and moral judgements (Clift & Stears, 1988), authoritarianism (Witt, 1989), formal operational reasoning (Peterson & Murphy, 1990) and liberalism versus conservatism (Paez, Echebarria, Valencia, Romo et al., 1991). Gradually more and more predictors became incorporated in an attempt to explain unwanted variance. One study attempted to show a link between attitudes towards AIDS and education, political preference, age, interpersonal communication and geographic region (Kraft & Rise, 1988), a wide range of factors to say

the least.

Attitudes towards safe sex and condoms. Other research examined attitudes towards safe sex and condoms in an effort to better understand the problem. Regarding attitudes towards safe sex, it was found that many adolescents feel that safe sex is a good avenue for preventing the spread of HIV (Harrison, Wambach, Byers, Imershein et al., 1991). Unfortunately, work by Rotheram-Borus and Koopman (1991) found that for their sample of adolescents, high levels of unsafe behaviour were found to co-exist with moderately high levels of knowledge and positive beliefs about preventing AIDS. Other studies (Fisher & Misovich, 1990; Katzman, Mulholland & Sutherland, 1988) also suggested that while youth and adolescents may possess a high level of knowledge about AIDS and express concern about the spread of HIV, change in their own behaviour is inconclusive. Thus, attitudes towards safe sex do not seem to be predictive of safe behaviour.

Attitudes towards condoms were also investigated by many researchers. In one study (Sheeran, Abraham, Abrams, Spears et al., 1990), university aged students viewed condoms as offensive and unattractive to use, and women felt them to be more offensive than men. Further, many high school students have reported finding condoms difficult to use (Malavaud, Dumay, & Malavaud, 1990). That condoms are



viewed as offensive by some adolescents was also supported in a study carried out by Barling and Moore (1990), however, the results of this study were less than consistent as many students also reported favourable attitudes towards condoms. Attitudes towards condoms in samples of gay men were found to be somewhat mixed (Ross, 1988). In general, Ross cautions that beliefs and attitudes toward condom use in homosexually active men differ substantially from those in heterosexual individuals. What seemed consistent across both groups however, was that favourable attitudes towards condoms were related to reports of previous condom use and intent to use condoms in the future (Moore & Barling, 1991).

Perception of risk. Personal perception of risk was another factor that was investigated as a potential predictor of behaviour. Malavaud, Dumay and Malavaud (1990) presented information suggesting that condom use appeared to be more likely if students felt personally at risk. Perception of vulnerability to HIV was also found to be critical in influencing behaviour in a review of 10 studies published in the UK (Memon, 1990).

Other studies however, provided contradictory information. Brown (1991), using a university population found a weak link between beliefs about AIDS and personal concern, as well as little indication that either of these factors necessarily promote AIDS preventative behaviours.

Other work by Montgomery, Joseph, Becker, and Ostrow, et al. (1989), suggested that measures of perceived susceptibility to HIV had little value in the prediction of behaviour.

A further criticism of studies attempting to find connections between perceived risk and safe sex behaviour in adolescents, is the assumption that adolescents consider themselves to be at risk. Because adolescents themselves are becoming more concerned about HIV, as was previously stated, one might expect that a general perception of personal risk would be reported. However, research by Harrison, Wambach, Byers, Imershein et al., (1991) suggests that while individuals may be concerned about HIV in general, they do not necessarily see themselves at risk for contracting HIV, despite reported unsafe practices. This was also given support through personal communication with numerous health professionals, all of whom indicated that their adolescent clientele did not really believe that they were at risk.

Perceived motives for engaging in unsafe sex. With little useful information accruing from studies of attitudes, research attention became focused on understanding motivations for engaging in unsafe sex. Work by Catania, Coates, Greenblatt, Colcini et al. (1989) suggest that educational interventions with adolescents should address motivational issues for practising safe sex.

Cleary (1988) also cautions health care workers to be sensitive to the many psychological factors that motivate behaviour. Suggestions as to what these motivations to practice safe sex might be however, were somewhat scarce.

Some speculations as to adolescent's perceived motivation for having unsafe sex was gleaned from preliminary interviews carried out with professionals working in youth health care. The most common explanations offered to these professionals by adolescents, regarding their unsafe sexual activity, was that they got caught up in "the heat of the moment", or that their "hormones took over". While interesting, these descriptions did little to answer the question of what was motivating adolescent's unsafe behaviour.

Coercion to engage in unsafe sex. One variable that may influence adolescents' choices about safe sex behaviour is pressure to have unsafe sex. Although this was not spelled out specifically, the findings of one study indicated that this may well be a factor. Confidence in the ability to say "no" to sex was found to be a predictor of safer sexual behaviour with one group of adolescents (Rosenthal, Moore, & Flynn, 1991). To extrapolate, the inability to refuse pressure to have unsafe sex, may well be a predictor of unsafe behaviour.

That coercion to engage in unsafe sex is important to

understanding adolescent risky behaviour was also suggested from other, non-academic sources. A spokesperson for Toronto's Hassle-Free clinic, Carol Camper, describes her clients: "a lot of these women don't have the power in the relationship to insist on condom use" ("Sexually-transmitted", 1993). Although subtle, the exertion of power within a relationship should still be considered coercive, and in this case, a coercion directly related to unsafe behaviour.

Substance Use. That drug and alcohol use is related to unsafe sexual practices has been suggested in numerous studies. Work with largely heterosexual samples indicates that the use of alcohol and other drugs greatly increases the chances of partaking in risky sexual behaviour (Clapper & Lipsitt, 1991; Pulford, 1991; Robertson & Plant, 1988; Stall, 1987). Similarly, work with homosexual males found that drug and alcohol abuse were related to high risk behaviour (McKirnan & Peterson, 1989).

Applied Findings. As research continued, the number of potentially significant factors became more and more unwieldy. Of greater concern, however, was the growing suspicion that there seemed to be no clear indication that any factors identified thus far were particularly useful in promoting behaviour change. Even with the prospect of

"significant" links, practitioners were faced with the virtually impossible task of applying this plethora of knowledge to the real world, a world in which differences between groups (e.g., men and women, gays and straights, different ethnic groups) made the widespread application of these findings problematic.

While many researchers relied on a more traditional approach to the problem, more recent research, largely accruing from more applied settings, was heading in a different direction. Most notably, a paper by Fisher and Fisher (1992), pointed to what was being missed in past research. These authors had succeeded in developing a generalizable model for promoting and evaluating AIDS risk behaviour change which was applicable to any population. In brief, they viewed AIDS risk reduction as a joint function of knowledge about AIDS, behavioural skills for performing specific acts involved in AIDS prevention, and motivation to reduce AIDS risk. Further, because these skills vary depending upon the population of interest, they advocated assessing client groups to establish their needs in each of these regards. This, in essence, allows educators to tailor interventions to the needs of their clients.

While compelling, this was not a completely novel idea. Manning, Balson, Barenberg and Moore (1989) spoke of the need for college health education programs to be attuned to the needs and deficiencies of the particular student body.

They also recommended tailoring AIDS prevention to the specific campus audience. In another study, Moore (1988) underscored the necessity for educators to try different teaching methods that addressed the emotions and attitudes of their specific audience participants.

While not completely lacking in the Manning et al. and Moore studies, Fisher and Fisher (1992) made further suggestions as to how needs assessment might be best undertaken. Central to their proposal was a reliance on open-ended elicitation research. For example, it was suggested that open-ended interviews might be a better way to evaluate the level of knowledge since questionnaires often allowed participants to appear to "know more" than they actually did and were not necessarily representative of how they might respond in a more natural setting. Further, standard focus groups (Krueger, 1988) were also advocated to allow for the self-assessment of current behavioural skills.

To a large extent, this addressed some of the problems with previous research projects and contradictory information accruing from disparate populations. For much of the preceding research, it was assumed that deviations introduced by subject differences were, at best, a barrier to be overcome. In the eyes of many researchers, certain fundamental, universal truths about behaviour must exist and furthermore, exist across individuals. For these researchers, to understand these fundamental truths is to

solve the puzzle, to permit prediction and therefore, control of behaviour. What the Fisher and Fisher study pointed to however, was that the differences that inevitably exist between populations are not a hindrance, rather, they are the key to the educative process. Instead of dismissing difference, it needed to be understood and incorporated into education.

The question then became one of how to incorporate "difference" between subjects into a useful theoretical framework. That such an adjustment is warranted has been suggested by other researchers. One Dutch study dealing with adolescent condom use underscored the necessity of distinguishing between groups, both in terms of monogamy and gender (Richard & VanderPligt, 1991). Establishing the presence or absence of traditional sexual roles in the Black community was also implicated as an important differentiating factor (Fullilove, Fullilove, Haynes, & Gross, 1990). Further, research on AIDS and women by Bell (1989) emphasized the need for preventive education to take into account the cultural, economic and social realities of the communities at risk.

While understanding and accommodating individual differences seemed to have intuitive appeal, incorporating difference into the standard positivist models of research remained problematic. Although changing methodological procedures was a beginning, it became apparent that what

this new emphasis suggested was not merely an interesting new twist on methodology, but a complete paradigmatic shift.

#### Positivist Versus Non-positivist Inquiry

The vast bulk of the literature regarding HIV was carried out from a logical positivist perspective. As the preceding research review suggests however, the results of utilizing this approach have been less than encouraging. This is not surprising since the logical positivist perspective operates under numerous assumptions that could serve to obscure inquiry into such a complex phenomenon as human sexual behaviour. Guba and Lincoln (1985) contrast the assumptions of positivist and naturalist paradigms in an argument for the value of a non-positivist approach. Specifically, they evaluate both approaches based on their assumptions regarding the nature of reality (ontology); the relationship of knower to known (epistemology); the possibility of generalization; the possibility of causal linkages; and the role of values in inquiry (axiology). Of these criticisms, two seemed most central to my arguments regarding limitations of past research pertaining to AIDS and HIV.

Firstly, regarding the nature of reality, Guba and Lincoln (1985), describe the stance of positivism in the following manner:

There is a single, tangible reality 'out there'  
fragmentable into independent variables and



processes, any of which can be studied independently of the others; inquiry can converge onto that reality until, finally, it can be predicted and controlled. (p.37)

A review of the attitudes towards AIDS literature perhaps speaks most eloquently about the problems associated with this approach. The fragmentation of variables associated with attitudes towards AIDS yielded a vast number of ostensibly inter-related factors yet did little to provide an understanding of the larger issues. Furthermore, the identification of the need to take into account individual differences in the construction of AIDS education programs suggests that the concept of a single tangible reality may be problematic.

Furthermore, positivism assumes the possibility of generalization and actively works toward that goal. Guba and Lincoln (1985) describe this in the following fashion:

The aim of inquiry is to develop a nomothetic body of knowledge in the form of generalizations that are truth statements free from both time and context (they will hold anywhere and at any time). (p.38)

Once again, positivist goals of generalization deny the importance of individual difference in the research process and sit in opposition to the methodology proposed by Fisher and Fisher.

### Social Constructionism

It became apparent that an alternative, post-positivist paradigm would seem to be more congruent with the findings

of the more recent AIDS literature. However, within the naturalistic paradigm, there exist many competing schools of thought. For the purposes of the present study, the approach that was chosen was that of social constructionism. Although it is difficult to untangle social constructionism from closely related domains such as labelling theory, phenomenology, ethnomethodology and symbolic interactionism (Kitzinger, 1987), certain basic tenets can be delineated. It is important to note however, that the boundaries between many of these areas remain cloudy and exact distinctions are difficult to make.

In broad terms, social constructionism views individual reality as a construction derived from the social influences that impinge upon the individual. Thus, the unique social context in which the individual finds him- or herself is the primary vehicle which serves to inform their own reality and by extension, guide their actions within that reality. In short, reality (and behaviour) is historically and culturally determined (Kitzinger, 1987). Within this paradigm, knowledge itself is viewed as socially constructed. Berger and Luckmann (1967) state this idea most cogently:

commonsense "knowledge" rather than "ideas" must be the central focus for the sociology of knowledge. It is precisely this "knowledge" that constitutes the fabric of meanings without which society could not exist. The sociology of knowledge, therefore, must concern itself with the social construction of reality. (p.10)

As a method of inquiry, social constructionism is primarily concerned with explicating the processes by which people come to describe, explain or otherwise account for the world (including themselves) in which they live (Gergen, 1985). Because social constructionism considers reality to be the individual's understanding of their own experience, a methodological shift is inevitable with the adoption of a social constructionist epistemology. The focus shifts from imposing an experimenter-based reality upon the participant to allowing the participant to speak for him/herself and as such, the participant's reality begins to inform theory.

The adoption of a social constructionist framework not only incorporates the methodological approach advocated by Fisher and Fisher and others, but also places this methodology squarely in the middle of a more congruent epistemology. As such, in order to better understand adolescent sexual behaviour, this research project sought answers directly from the population of interest. Using open-ended interviews, adolescents and young adults from the Windsor area were asked about their views on safe sex and a variety of topics related to safe sex behaviour. Participants were given the opportunity to present their views and constructions of safe sex in a non-judgemental atmosphere and encouraged to provide their understanding of what is motivating their behaviour.

Although formal hypotheses were not generated prior to

the interview process, certain expectations of what might be found, given trends in the literature, can be stated.

General expectations were as follows:

- most participants would describe favourable attitudes towards safe sex
- interviews would yield a variety of opinions regarding condoms, but negative evaluations would be strongly represented
- gay male participants would have somewhat different attitudes towards condoms than heterosexual participants
- favourable attitudes towards condoms would be related to reports of previous condom use and intent to use condoms in the future
- participants would not view themselves personally at great risk of contracting HIV
- participants' descriptions of high risk groups would include promiscuity as a defining characteristic
- participants in the present study would offer explanations for their unsafe sexual behaviour similar to those described by health-care professionals
- respondents would indicate that substance usage does in fact increase the chances of engaging in risky behaviour
- female participants would be likely to describe having been pressured to have unsafe sex by their male partners
- male participants may also describe pressure from their female partners to refrain from using condoms

As stated before, adolescents appear to be a group in need of education regarding safe sex and HIV. To date, studies attempting to understand adolescents' unsafe sexual behaviour have been inconclusive. Limitations of prior research may be due to a reliance on positivist research paradigms, while a naturalistic or post-positivist approach may be a more effective way of fostering understanding of the issue. Using a social constructionist approach, the

present study attempted to gain a more in-depth understanding of adolescents' constructions of HIV and safe sex. It is hoped that the information obtained from this investigation will serve to better the understanding of adolescent sexual behaviour and as such, can be fed back into the AIDS education programs accessible to the target population.

## Chapter 2

### Method

#### Participants

Selection Criteria Because the research focused on the experience of adolescents and youth, participation was limited to those individuals between the ages of 16 and 24. While it would have been educative to include participants under the age of 16 in the study, it was ethically impossible to do so. Although no other selection criteria were involved, an attempt was made by the researcher to include both males and females, as well as heterosexual, and gay and lesbian identified participants. Further, sampling from a variety of locations also increased the likelihood of obtaining participants with diverse opinions and experiences.

#### Recruitment Procedures

Numerous organizations in the Windsor area that service adolescents and youth could have been used for this study. However, recruitment was limited to three organizations: The Teen Health Centre, The AIDS Committee of Windsor, and an open facility for young offenders. These organizations were chosen because they offered access to adolescents and youth and were willing to allow the researcher entrance into their facility. Each will be described more fully in the following discussion.

The Teen Health Centre. The Teen Health Centre (THC) is a multi-disciplinary health care facility in the Windsor area which specializes in confidential youth-oriented services. The THC was approached by the researcher to aid in the recruitment of participants. Walk-in clients or those with standing appointments with nursing staff were briefly apprised of the study and were asked if they would like to receive more information and possibly participate. Interested participants were then referred to the researcher. All interviews with THC clientele were carried out within the THC itself.

New Beginnings. By referral from the THC, the researcher was also able to seek participants from New Beginnings, an open facility for male juvenile offenders located in Windsor. This residential centre houses young offenders after their first involvements with the legal system. The maximum time of incarceration in this facility is six months. Its designation as an open facility refers to the fact that participants are free to leave on weekends or at other times provided they have just cause. In order to solicit volunteers, the researcher presented the study to a group within this organization and potential participants were encouraged to sign a sheet indicating their interest. Interviews were then carried out on the organization's premises when convenient for the participants. Ethical restraints prevent the researcher from identifying any of

the respondents as young offenders.

AIDS Committee of Windsor. The AIDS Committee of Windsor (ACW) is an organization dedicated to the education of the general public regarding HIV and its transmission as well as providing support services for those individuals directly affected by AIDS. With the support of the ACW, the researcher was able to publicize the study to a group of individuals attending an ACW volunteer training meeting. Interested parties signed a contact sheet and were approached directly by the interviewer to receive more information. If interested, meetings were arranged for interviews to take place at locations convenient for the participants.

Word of Mouth Solicitation. A number of participants were also solicited by word of mouth. These were individuals who were either referred by previous participants as being good people to contact by virtue of their divergent opinions or had heard of the study from past participants and volunteered their time. Because diversity of opinion was important, the individuals who were referred by word of mouth for their diverse views were vital to the research process. These interviews also took place at various locations convenient for the participants.

Sample Characteristics In total, 24 individuals participated in the study. Of those 24, 12 were male and 12



were female. The average age of males was 19.8 years and the average age of females was 19.4 years. The average age of all participants was 19.6. Age of participants ranged from 16 to 24 years. A breakdown of participants by age and sex can be found in Appendix A. According to the demographic information, 2 males identified as gay and 2 women identified as lesbian. The remainder of the sample identified as heterosexual. Three females and one male considered themselves to be people of colour.

The Teen Health Centre provided 8 of the participants who took part in the study. Of these 8 participants, 2 were students involved with the Teen Health Centre on a volunteer basis. The remainder of the participants were users of the Teen Health Centre's medical facilities and were referred by the nursing staff. The open facility for male juvenile offenders provided 6 participants. The AIDS Committee of Windsor provided 3 participants from amongst their volunteer training group. Lastly, 7 of the participants were referred by word of mouth from a variety of sources.

#### Methods of Data Collection

Two primary methods of data collection were utilized in this study to ensure that all relevant information was obtained. This included a background questionnaire and the interview itself.

### Background Questionnaire

A modified form of a questionnaire used by Senn & Dzinis (1988), was used to ensure that certain basic information about participants was collected without having to be directly addressed during the interview. The information obtained dealt with educational status, age, marital status, current relationships, sexual orientation, living arrangements, ethnicity and religious affiliation. The complete questionnaire can be found in Appendix B.

### Interviews

During the initial stages of the research process, each interview was conducted by one of two interviewers, one of whom was the author (the principle researcher). A second researcher carried out interviews in fulfilment of a Senior Honours Thesis and discontinued interviewing when her work was complete.<sup>1</sup> A comparison of the interviews carried out by the two researchers did not yield any significant differences in content thus, for the purposes of this research, all interviews were combined and analyzed by the principle researcher. For the purpose of simplification all reference to researchers or interviewers in this paper will be made in the singular (i.e., researcher or interviewer).

Interviews were conducted in an open-ended, semi-structured format to obtain each participant's opinions regarding a number of areas pertinent to safe sex. The

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<sup>1</sup> Lizanne Valiquette was the second researcher.

content of the interviews was drawn from prominent themes in the literature. These areas included attitudes toward safe sex, perception of risk, behavioural motivators, perceived coercion to engage in unsafe sex, possible effects of substance use, perceptions of others attitudes regarding safe sex, and sources of knowledge (see Appendix C for interview schedule).

Because of the epistemological imperative of allowing respondents to define their own reality, the interview questions were open-ended. To impose a fixed structure, in the form of firmly set questions, would have forced an experimenter-based reality on the participant rather than attempting to understand the participant's reality. However, the interview schedule also includes examples of more specific questions that were asked in order to encourage participants to relate experiences and opinions relevant to the aforementioned content areas.

Participants were also encouraged to bring up any topic they saw as relevant to the subject area in question and were given the opportunity to add topics to the interview that they felt had been neglected. This flexibility served the dual purpose of empowering the participants to speak about their reality in whatever way they saw fit as well as "guarding against premature closure by supposing that we know all the questions and are just looking for answers" (Dexter, 1970, cited in Kitzinger 1987, p.73).

### Procedure

All potential participants were informed that a researcher from the University of Windsor was looking for people who wished to be interviewed and were willing to discuss their personal opinions and views of safe sex. This information was either communicated by members of the recruiting organizations or by the researcher herself. Interested participants either contacted the researcher directly or signed a sheet giving the researcher permission to contact them. Participants were also told that they were under no obligation to identify themselves.

After the initial contacts were made, interested participants met with the researcher. The researcher explained the procedures involved more fully and gained verbal assent from the volunteers. The consent form (Appendix D) was then explained and the participants were encouraged to read it themselves. Any questions about the study were handled by the interviewer at that time. Participants were asked to sign two copies of the consent form and were given one of those copies to take with them. The remaining copy was retained by the researcher. With informed consent obtained, participants were then asked to pick a pseudonym. It was emphasized that their pseudonym was the only name by which they would be identified throughout the study and therefore ensured anonymity.

After a short introduction to the study (Appendix E),

the interviews were carried out. All interviews were audio-taped for the purpose of transcription by the researcher. Tapes were erased upon completion of the written transcription. The interview was intended to solicit information from participants on the topics delineated in the interview schedule.

After the completion of the interview, participants were probed about their reactions to the interview and given a chance to discuss this. It was assumed that the rapport built up between the interviewer and the participant during the interview would facilitate such discussion, particularly if participants experienced any unease with the subject matter. In order to promote reflection, participants were encouraged to voice any feelings they might have over dealing with an emotionally laden topic like sexual behaviour. While there was some potential for participants to be distressed, it was not evident during any of the interviews. This is not surprising as it was the participant him or herself who largely dictated the content and direction of the interview. Participants seemed to refrain from discussing details with which they were not wholly comfortable. A copy of questions used to probe for participant distress can be found in Appendix F.

Following this phase, participants were introduced to the Background Questionnaire and asked to complete it. The researcher remained with the participant while he or she

filled out the questionnaire in the event that they required clarification of any items.

After the completion of the questionnaire a final debriefing was undertaken. This took the form of a brief instructional work explaining the reasons behind the choice of methodology as well as some educational material related to safe sex behaviour and a list of community resources (Appendix G). The interviewer briefly summarized the content of the feedback sheet orally and encouraged participants to read along. Any further concerns that were raised by the interview were also probed and dealt with at this time.

Before ending the session, participants were queried as to their interest in obtaining a copy of the final report and/or being contacted for possible additional research. Participants also had the option of having no further contact with the researcher. Lists of participants interested in being called back or receiving a copy of the results were kept separately from all other documentation and were destroyed after subsequent use. Finally, participants were encouraged to contact the principle researcher if they had any further questions.

## Chapter 3

### Results

#### Analysis

It is difficult to discuss analysis in the typical sense when adopting a perspective that situates the "results" in process. In many ways, it is more accurate to consider the act of analysing qualitative data as the process itself. Utilizing Marshall & Rossman's (1989) approach to qualitative analysis, the preliminary phase involved two steps, organizing data and generating categories, themes and patterns. Each of these will be dealt with separately, although it must be understood that these dimensions overlap considerably.

Organizing Data. After the completion of each interview, the researcher made notes pertaining to the interview. Themes that had been stressed by the respondent, behavioural observations of the participant and the researcher's reaction to the interview were all noted. Subsequently, each interview was transcribed by the researcher and written notes were appended to the verbatim transcripts.

With the overwhelming amount of information accruing from open-ended data gathering, constant immersion in the data was vital. Reading and re-reading existing material was a useful way of fostering clarity of thought. This also assisted the researcher in situating herself more accurately

in the context of the interviews and in the participants' reality.

As themes became apparent, the researcher directly challenged subsequent participants with these emerging themes and allowed the participants to validate or invalidate them. Not only did what was discussed in the interviews change as new themes emerged, but the predominant themes were altered by the critical examination of these themes by participant and researcher. Consistent with Guba and Lincoln's (1989) description of hermeneutic circles, bringing emerging themes into subsequent dialogues for participant comment also helped to foster the credibility of accounts. At the completion of data collection, all transcripts and accompanying notes were re-read.

Generating Categories, Themes and Patterns. As has been stated, the identification of themes was, to a large extent, inseparable from the process of data gathering itself. That is, themes emerged throughout the process of data gathering. In general, the identification of themes required recurring ideas or language, and patterns of belief that linked people and settings together; a sort of congruence of realities.

With themes identified, the researcher was then able to group themes into broader categories based on "recurring regularities" in themes, or what Guba refers to as convergence (cited in Patton, 1980). Establishing



convergence further involves examining the extent to which categories meet the two criteria of "internal homogeneity" and "external heterogeneity". Internal homogeneity refers to the extent to which the data that belong to a certain category hold together. External heterogeneity refers to the extent to which differences among categories are bold and clear. It was necessary for both criteria to be met in order to validate the generated categories. Having examined categories for both internal homogeneity and external heterogeneity, analysis then addressed the question of divergence.

According to Patton (1980), divergence of categories involves the "flesh[ing] out" of the categories. He further suggests that this is carried out through:

processes of extension (building on items of information already known), bridging (making connections among different items), and surfacing (proposing new information that ought to fit and then verifying its existence). (p.312)

At the completion of this step, five major categories remained. The themes within each category were then interpreted. A useful tool during the interpretation of themes was the concept of function in language. Potter and Wetherell (1987) stress the importance of language as a tool for doing; people use language "to order and request, persuade and accuse". Thus, close attention was given to the function of participant's discourse. Moreover, themes were also interpreted in terms of how they reflected the

social context, such as their role in maintaining societal power differentials and as reflecting current ideological thought in Western society.

The five categories that emerged from participants accounts were Trust, Responsibility, Risk, Pressure, and States of Consciousness. Each of these categories and their accompanying themes will be dealt with separately. It should be noted, that during the discussion of themes, direct quotations from the participants are utilized. The researcher attempted to be as faithful as possible to participants accounts and hence, all facets of participant discourse will be reflected in the quotes. If pauses were a prominent part of a participants account they are noted in the following manner: [pause]. The utilization of three dots (e.g.,...) denotes the researcher having edited out parts of the discourse. This was done as sparingly as possible. Blank lines in respondents accounts indicate identifying information that was removed to protect the anonymity of respondents.

### Themes and Interpretation

#### Trust

The concept of trust emerged very quickly as central to many participants accounts, although it was discussed in many different ways. Respondents described trust within a relationship as the end product of the process of coming to

know a partner. Participants also discussed trust as a fundamental component of a good relationship. Trust was also viewed as influential regarding decisions to have unsafe sex. The main focus of this section is understanding each of these discussions of trust and their inter-relationship to decisions about sexual practices.

As was stated, participants often spoke of getting to know one's partner, with the assumption that the process of getting to know one's partner is synonymous with coming to trust one's partner. Participants described the process of coming to know a partner in many different ways. When Kait was pressed to explain how one gets to know their partner, she gave the following exhaustive list:

o.k., get to know their um, personality per se, their likes or dislikes, their background, um, we're talking to their youth, get to know their whole family history, background...everything about that person, what that person did before with other girlfriends or you could say boyfriends, how they react in their lifestyle, um, on a social basis how they react within a group, how they act singly, ah, what they understand about myself, if they know anything about me, how they um, um, perceive me as a person, my family, that kind of thing, like sharing the same things, um, let me see, financial backgrounds are very good, personal goals um, what they want to do in life, what they want to do with their life like later on down the line um, what things they've accomplished throughout their life, the things they've, um, what mistakes they've made, whether it be anything at all, there's so many things you can learn about a person

Kait, age 19

Sharon, on the other hand, described getting to know her partner in terms of the amount of time that she spent with

that partner. When asked to describe how long it would take her to judge that she really knew a partner she said:

it would also probably depend on how often I saw them, like if I saw them every night of the week maybe about a month, like, you know, if I saw them like maybe three times a week it would probably be about two, three months kind of thing

Sharon, age 16

Regardless of how participants described the process of coming to know and therefore, trust a partner, trust was viewed as a fundamental part of being involved in a good relationship. That a relationship could not even exist without trust was suggested by Lance:

oh yeah, like, trust is all over the place, you trust them that they're not gonna do this, and that they're gonna do this and then they're, you know you have to have constant trust in a relationship and if you're in a relationship you should make sure that you're in it long enough that you can be 100% sure

Lance, age 18

Trust was also related to participant's decisions regarding safe sex. More specifically, trust was used as a rationale for why participants had unsafe sex. Respondents justified their unsafe sexual behaviour by saying that they had unprotected sex because they trusted their partner. One respondent said of her unsafe behaviour:

I guess to a certain point I trusted him too, you know, he started giving me all these statistics...he told me that, you know, like what I told you before, like about you know, he jacks off a lot and his sperm is a lot less potent and you know lesser chance to...maybe because he seemed confident that it wouldn't, like he seemed confident that the chances were really, weren't that great so...I guess I kinda thought that, well o.k., because I consider him smart, like I don't

know, I thought maybe he would know something  
Ariel, age 21

Thus, trusting a partner was related to both being in a good relationship, and having unprotected sex.

In regards to participant's constructions of the relationship between these concepts in terms of directionality or causality two themes emerged. Firstly, some participants who considered themselves to be in a trusting, and therefore, a good relationship seemed to indicate that having unsafe sex was a way of affirming the trust and goodness of the relationship. In short, a good relationship was seen to involve trust and the ultimate show of trust was having unprotected sex. This assumes that judgements regarding both the trust and the quality of the relationship precede the decision to have unsafe sex.

This construction is risky due to the over-riding assumption that you can know another individual completely, and that trust is a product of complete knowledge. The presupposition that complete knowledge can be obtained about one's partner does not take into consideration that one's partner could conceivably lie or at the very least, be unaware of certain things about themselves (e.g., prior exposure to an STD) which could pose a threat to their partner. It also appears that the ways in which participants describe getting to know their partner (e.g., Kait) do not include asking about information pertinent to risk (e.g., Have you been tested before?).

To question the honesty or awareness of one's partner poses a direct challenge to the assumption that knowing, and therefore trusting one's partner is always possible or warranted. When directly challenged by the observation that knowing and trusting are not necessarily fool-proof ways of ensuring that one is not at risk, almost all respondents had difficulty addressing this issue. In a particularly interesting dialogue between a male participant (P:) and the interviewer (I:), the respondent avoided dealing with criticisms pertaining to the feasibility of trust as a rationale for having unprotected sex.

P: well, that's why I said you should both go and get checked out, like, if you know someone for like you know, just for a couple of weeks or whatever you know, why not wait until it means something, get checked out and do it safely instead of, you know what I mean

I: right, what about after that though?

P: after that, what like, if they're sleeping around or something?

I: yeah

P: well, there's nothing you can do about that because if you trust that person and she gets something, well, there's nothing you can do about that

Star, age 17

An alternate understanding of the connections between trust, unsafe sex and a good relationship, is that participants could decide to have unsafe sex in order to create a trusting, good relationship. This assumes that the decision to have unsafe sex precedes feelings of trust and

quality in a relationship.

Although it is somewhat unclear, this seems to be what Sharon is talking about when she describes her reason for having unprotected sex. She said:

Probably because I trust him and I wanted to spend, like I wanted to spend a while with this guy, like, um, I wanted to have a very good relationship with him and all that, you know, I wanted to stay with him for a while like, it wasn't like, it was basically trust, like I trusted him that I basically knew that he didn't have AIDS and all that or any other diseases

Sharon, age 16

What Sharon's account suggests is that her decision to have unprotected sex with her partner was a way of "making" this relationship into a good one. In essence she said that she had unprotected sex because she "wanted to have a very good relationship". Thus, having unprotected sex was viewed as a way of ensuring the relationship would be good.

The risks associated with Sharon's account are obvious. While one could criticize basing sexual decisions on potentially faulty knowledge, participants sharing Sharon's view are perhaps at even greater risk by virtue of having next to no knowledge about their sexual partners.

Although the nature of this discourse allows only for a limited extrapolation from respondents accounts, work by Hollway (1989) seems to capture what respondents in the present study may be alluding to in the trust discourse. In a discussion of sex without contraception, Hollway uses structural linguistics' distinction between the 'signifier'

and the 'signified' in order to better understand the meaning of her participants accounts. The signifier, in this case making love without contraception, is "the sound or written image" (p. 51), whereas the signified, is "the meaning" inherent in the signifier. In Hollway's discussion the signified or the meaning behind making love without contraception, is securing commitment to the relationship. Thus, it may be that in the case of this study's respondents, the signifier, having unsafe sex (or making love without contraception) also contains the signified (securing commitment to the relationship). Regardless of how it is interpreted, understanding how individuals construct a link between trust and unsafe sex is an integral part of understanding risk behaviour.

### Responsibility

When discussing safe sex, many participants spoke of the responsibility for practising safe sex. In general, many women and men in the study indicated that they felt it was the woman's responsibility to make sure that safe sex was practised. While discussing her opinion that safe sex is something that you have to do for yourself, one respondent said:

speaking from a female perspective, I mean the woman has more to lose than the guy...[guys] don't really think of the consequences whereas the girl has to deal with the consequences in the end

D., age 21



Another woman, when asked about differences between men and women and their attitudes towards safe sex said the following:

I think that women have a, more of a responsibility I'd say, and they think it's more of their responsibility to use a condom...probably because it's associated with um, with um, pregnancy, like being protected against pregnancy and so, because we've had to look over, we've had to look after that for so many years that oh, we have to protect ourselves against something else so, of course it's the woman's job to do that  
Esther, age 23

A male respondent, when asked if men and women differ in their attitudes towards safe sex, also suggested that women were in a position of needing to be more responsible for ensuring that safe sex occurs. In his words:

I think girls are probably more serious about [safe sex] than guys, it's probably easier for guys not to take responsibility and to avoid taking responsibility for it...part of it is like I said, is that, you know that, the physical repercussions like for, you know, if a girl gets pregnant she can't run away from it, you know, but the guy can

James, age 21

Perhaps not surprisingly, for both men and women, the view of women as more responsible for safe sex is an extension of pre-existing views that hold women responsible for preventing pregnancy and even resisting unwanted sex (Laws & Schwartz, 1977). In fact, when participants were talking about women having responsibility for safe sex, it was often difficult to determine whether this referred to responsibility for contraception alone or for both contraception and the prevention of STD's.

Many participants identified social forces or institutions which they felt conferred the responsibility for contraception on women. In commenting on the current state of sex education in the schools, one woman said:

I know that was true for when I was in elementary school and when I was in high school with the way sex ed was handled it was the girls ended up with the two or three day session on all the different methods of birth control and the guys end up with a period, a film and that's it and back to playing the next formal sport on the curriculum

Anastasia, age 22

In Anastasia's view, the way in which the sex education was carried out, with its emphasis on teaching women about how to prevent pregnancy, served to communicate to women that contraception was their responsibility. Similarly, the corresponding lack of contraceptive information in men's sex education classes also communicated that contraception is fundamentally a woman's problem and therefore a woman's responsibility.

Another respondent also highlighted ways in which the medical community, as well as males, in general, also conferred responsibility for contraception on women. Blaze commented on the common assumption that women should be on the pill:

girls should always be on the pill, they should always be on the pill, that's the thing from the guys...and plus another bad thing is a lot of doctors they automatically put the kid on the pill

Blaze, age 21

Men's assumptions that women should be on the pill and the medical communities willingness to prescribe the pill to

young women is another way in which the responsibility for contraception is placed on women. Since, condom use could be viewed as both a form of contraception and as a safe sex practice, it is not surprising that the message that is communicated to women is that safe sex, in the form of condom use, is their responsibility by virtue of it being a form of contraception as well as a preventive measure for STD's.

What is painfully ironic about this state of affairs is that while these institutions represent structures that place women in a lower position of power, they also place the responsibility for contraception on women. In short, they place women in a position of relative dis-empowerment yet assume that women have sufficient power to negotiate the use of contraception and safe sex with their male partners.

While it was evident that women were perceived as responsible for practising safe sex, many accounts also expressed sentiments that men may be viewed as outrightly irresponsible regarding safe sex practices. In fact, many female respondents quite openly lamented their view of men as largely irresponsible about the use of safe sex and where sex is concerned in a broader sense. One respondent had particularly vocal opinion on this topic:

when the show's done and gone and everybody's went home, who's stuck with it, like, who's always stuck with it, you're always left dripping and slimy and gross while they get to just go to the sink, wash their dick off and go home, and you get stuck with all the shit, and to me it comes down

to, like, cause I never had a same sex problem that way, it comes down to responsibility, it's always the woman's business to keep everything under control cause 9 times out of 10, it's not the guy that's going to say, oh, oh, oh, because they're so used to always being, used to picking up, so they get somebody knocked up, picking up and going away or changing ? , but women are left with a larger responsibility always...I find that men have it easier...men have far more responsibility than they ever live up to

Anastasia, age 22

Although respondents did suggest that males may indeed be irresponsible regarding their safe sex behaviour, there seemed to be a tendency to lessen the severity of this criticism or at least justify its existence as acceptable or logical. For example, some male and female participants down played male irresponsibility by virtue of men adopting differential responsibility depending upon their emotional ties with their partners. In describing why he was more conscientious about condom use with his girlfriend than he had been with his previous casual partners, one respondent said:

just the difference between sex and making love...making love to me is a whole lot different and I think that can be a crucial point too, making love you know, you care, you care about yourself, you care about the other person...personally, in my relationship I try to take care of it [safe sex], always...[but] if you're having sex it's like, let's do it...I don't care, you're just there for fun, you know, we're gonna have fun with each other and that's gonna be it, I don't give a fuck whether you live, die, breath, whatever, you know, I don't care what the hell you do with the rest of your life, I'm gonna have my fun, you're gonna have yours, who cares, I don't care about you

Lance, age 18

Thus, while not denying that he might be irresponsible with regards to safe sex with some partners, Lance seemed to emphasize his responsible behaviour with partners with whom he felt an emotional tie.

Another common account cited to explain why men may not be remiss in their irresponsibility brought in recent medical "evidence" disseminated by local health authorities, suggesting that women are more at risk of contracting HIV from men than vice versa. One respondent explained differences in the amount of responsibility assumed by men and women by saying:

well, I think the guys have less of a worry, because they don't get pregnant, like they can get AIDS but, it's, I don't know, I've heard that AIDS is transferable more from a guy to a girl than from a girl to a guy so I don't know, I think they have less worries about that, I don't know, most guys are so, oh, it won't happen to me, and I think it's more guys that don't take the precautions than girls

Ashley, age 16

A male respondent who had never practised safe sex, also brought this up in response to being questioned about males sexual practices. He said:

[the health nurse] said it's not likely, she said it's a low risk that you can get AIDS from your girlfriend um, because, um, I don't know what she said, she said she can get it very easily from you if you've got it but if she doesn't have it, I mean if she has it and you don't, the chances are a lot less...if they were really worried about it, they would use a condom right but uh, since they're not worried about it...then I guess that's true, they don't think that they can get it

Dave, age 18

What appears to be happening in these accounts is that men

and women are rationalizing men's irresponsibility by virtue of men being at less risk of contracting HIV from women. Therefore, men need not be responsible. Obviously, this does not address men's responsibility to protect their partners who are, according to the statistics, more at risk of contracting HIV from them. Responsibility falls to those who are perceived to be more at risk of contracting disease. Since, according to these "statistics" women do seem to be more at risk, the responsibility for safe sex is on women. Because women are using this rationale to explain why it is acceptable for men to not assume responsibility for safe sex, they are also supporting a system which places responsibility on them.

This tendency for women to support lines of reasoning that serve to further confer responsibility on them is also evident when women are asked about how they feel the educational system should be changed. More specifically, although many of the women complained about their having responsibility foisted on them, and were dissatisfied with male's not taking responsibility, they were unable to step outside of that system when it came to making suggestions regarding improvements in the educational system. By and large, female respondents made suggestions that education should provide ways to foster behaviour change in women. One woman's suggestions for education were the following:

make sure that the children understand attitudes  
that women, that men have about women and give

them reasons to protect themselves because they have lives that they may not be able to live, so first of all, they need a motivation to protect themselves, second of all, they have to understand what they're up against, they're up against the coercion of men not wanting to use them, so what you have to do is, you have to instill values and ideas in their mind that's going to make them

Esther, age 23

Thus, while feeling uncomfortable with their responsibility for safe sex, women still indicated that education should provide strategies that allow them to assume that very responsibility more easily. No consideration was given to the possibility that education might address strategies aimed at making men more responsible for their sexual practices. That these types of educational strategies were not mentioned by women, may reflect women's feelings of hopelessness that these strategies could be effective given the power imbalance which traditionally exists between men and women.

That men's behaviour is viewed as largely unchangeable was also evident in many women's accounts when they were asked to comment on how they felt about men's irresponsibility pertaining to sex. Many women said that "that's just the way men are" or "guys are just like that". This "boys will be boys" type attitude is indicative of the ways in which male sexual behaviour is viewed as natural and therefore unquestionable. Hollway (1989) talks about the discourse of male sexual drive which may be reflected in these women's statements. According to Hollway, "the

central proposition of this discourse is that men are driven by the biological necessity to seek out (heterosexual) sex" (p. 54). The extent to which male sexual activity is constructed as biologically determined or "natural" precludes any criticism of that behaviour. Laws and Schwartz (1977) also discuss the common construction of males as being "tormented by their polygamous nature [*italics added*]" (p.189). Despite a paucity of research supporting this view of the male sexual drive, it remains relatively fixed in our society (Laws & Schwartz, 1977). Thus, respondents' remarks may well be reflective of this view of male sexuality.

### Risk

As part of the interview process, participants were asked to comment on whether or not they felt that they were personally at risk of contracting HIV, if they felt there were such things as high risk groups, and if there were, what characterized groups at high risk of contracting HIV. Most participants made some statement as to everyone being at risk of HIV. Many participants also supported a belief in higher risks or high risk groups and described these in a number of ways. One participant described higher risk in terms of unsafe behaviours. He said, "What do I think a risk is? Doing it any time without protected sex, that's a risk" (Lance, age 18). Another respondent identified high



risk groups saying, "um, from what I've heard, I guess um, I'd probably say ah, the gays and intravenous drug users" (James, age 21). Still other respondents claimed that promiscuity was a prime indicator of risk. In the words of one woman:

sure there's still risk but probably not as much as people who, two people who've done it with like maybe five different people who were planning to do it together...probably they're higher risk

Alexandra, age 17

Still other participants considered people at risk to be people who don't care about themselves or people who don't care about others.

Other common explanations of characteristics of risk groups include ethnicity, geographical location, education, liberalism and socio-economic status. As one participant said when commenting on what people perceive to be less risky:

I know who she is and he's from a good family and they always try to say that it's not going to happen, this is Windsor, what happens in Windsor, you know, you go to Detroit or you go to New York but they won't have anything happen here and or, it's on the basis of colour too, well, he's white he's good...you're not going to catch anything because...you go to this high school or you're in this price bracket...I think as you transfer into a different form of education you know what I mean, cause sometimes the more liberal a place is, like um, the more liberal a place, like an education, a structured place that you go to is, the more you're going to learn...it usually depends on the type of men you date too for that, cause there's a lot of women that are totally liberal, they care and they just, they totally believe in it...

She also commented on groups that she perceived to be more

at risk:

and there's a lot of women, a lot of girls, I think, um, not a lower economic status but, maybe they, I don't know, they, you know, they go out with guys and have tons of babies, you know, maybe they don't care about that, but, I find that, it kinda depends on you yourself, if you're going somewhere in life, you know, if you have a direction...there's a lot of young adults that, you know, they don't really want to do anything with school and they want to party and they want to have lots of sex and babies and get mother's allowance and stuff like that"

Blaze, age 21

Blaze's account is interesting when one considers the groups which she suggests are considered to be at risk. People of colour, people of lower socio-economic status and those not associated with institutions representing the middle class (e.g., universities) are some of the most obvious groups. Further, each of these groups could rightly be considered marginalized groups within Western society. That disease has been considered to be a problem associated with marginalized and powerless groups is not a new idea. Foucault (1976) identified this discourse as rooted in the history of the medicalization of disease (including venereal disease) and sexuality, and the medical communities concomitant interest in eugenics and the betterment of the human (upper class) condition.

On a simpler level, Blaze's account is notable for identifying those at risk as being those that are unlike her, a white middle class heterosexual. In this way, Blaze defines herself 'out of' risk by virtue of not belonging to

the risk groups she discussed. Interestingly, many of the respondents who were quoted earlier similarly defined themselves 'out of' risk. Although they considered everyone to be at risk to a certain extent, they often detailed risk characteristics that did not seem to pertain to themselves. That people define themselves 'out of' risk groups, and hence out of being at risk was more obvious in some accounts. The two women in the study who identified as lesbian, limited their risk by virtue of the group to which they belonged. According to one participant:

in my mind, I've always considered women to be so clean, and I think that's probably part of it...I'm saying that as a lesbian, I don't consider myself to be at as much risk, and the fact I don't like the idea that I should have to protect myself against a woman

Katherine, age 22

That lesbians are a marginalized group in society makes these women's defining themselves 'out of' risk curious. If, as Foucault (1976) claims that marginalization and powerlessness are associated with disease risk, it may be that these participants are reasserting their power by virtue of denying their risk. In other words, they may not be denying their marginalization but may still be attempting to assert their power by denying being at risk. Another possible explanation however, is that the actual risk of transmission between women without a history of heterosexual contact, is relatively small, although few researchers will claim it is impossible (Haines, 1989; Holman, 1989). As

such, these respondent's denial of risk may be warranted.

Another common argument that people used to define themselves out of risk of contracting HIV is that within 'their' monogamous relationship, they have nothing to worry about. Being in a monogamous relationship does not necessarily mean that one is not at risk as was suggested in the discussion of trust in an earlier section of this paper. Many health professionals with whom I spoke emphasized that when people view monogamy as no risk, they don't consider the concept of 'serial monogamy'. That is, while one may be monogamous with a current partner, the possibility is not addressed that their partner could introduce an STD from a previous (monogamous) relationship.

Monogamy as an indicator of no risk is also problematic when one considers the inconsistencies in participants accounts. While one respondent, Julius, suggests that theoretically you can't be sure that your partner is monogamous, this did not extend to his own relationship. In this way, he was able to define himself 'out of' risk. Initially Julius, a gay male, said:

well, when you're involved in a monogamous relationship, you can't really be sure that your partner has been monogamous

This insinuates that belief in monogamy may still be a risky proposition. However, when speaking of himself and his own partner, assumptions about monogamy were no longer risky.

He said:

I know him well enough that I would believe him to be safe. I know him well enough already to believe that he would be faithful...I know that he's been faithful since we've started dating

Julius, age 24

Katherine also suggests that she does not consider herself to be at risk by virtue of being in a monogamous relationship, yet if she were to be dating would consider herself at risk. She says of her own risk:

if I were to not be in a relationship and be out there and everything, for the most part, I think I would use dental dams

Katherine, age 22

The view that monogamy is a valid way of lessening one's risk of contracting HIV has been popularized by the media and educational campaigns. Some messages communicate that if you have more than one partner or multiple partners, you're at risk. This does not address the fact that having unsafe sex with one partner must still be considered risky. It may be that some participants have taken this type of information to mean that if more than one partner is a risk then only one partner means no risk, regardless of the presence of unsafe sexual practices.

Another theme which emerged, suggesting that people are defining themselves out of risk, dealt with the actual redefinition of language that is indicative of risk. The media has popularized the connection between being 'sexually active' and 'being at risk'. Thus, one would expect that people would construe the term sexually active in such a way as to not describe their own behaviour. In one

participant's discussion of how she felt her peers viewed the concepts of risk and being sexually active, she said the following:

they don't want to take the initiative about thinking that they're at risk, because if you're at risk that means you must be sexually active...they always classify, like the commercials and everything is, if you're sexually active...you're a risk and you're high risk and everyone doesn't want to take it on themselves, like me, think that they could actually be at risk, so, that's why people don't really acknowledge themselves as a risk...like, one of the questionnaire's for I think it is, is the AIDS thing, anonymous AIDS thing, I went there to overlook it, to help make mine, and the questions are like, well, do you consider yourself sexually active and most people, oh, of course not, and they consider well, if you have more than this partners, or if you have sex this many times then you're sexually active...and people are like, oh well, I can't be sexually active because I'm this person, and when you label sexually that's so negative, you know what I mean...you don't ever hear anybody say, hi, I'm sexually active, would you like to have sex with me

Blaze, age 21

What Blaze suggests is that people are unwilling to consider themselves to be at risk because they don't want to take that label "on themselves". She also suggests that to be labelled sexual or more correctly to be labelled sexually active is to be labelled negatively. It is likely that being labelled sexually active has negative connotations precisely because of its connections with the idea of risk. Thus, avoiding considering oneself as sexually active, is a way of avoiding considering oneself to be at risk.

While labelling oneself sexually active appears to be distasteful by virtue of its connection with risk, many

women also fight the label of sexually active because of its connotations of promiscuity. Many female respondents described the pressure of traditional views of female sexual behaviour as negative, "loose", or "slutty" while male sexual behaviour as socially sanctioned and expected. One respondent put it this way:

yeah well, if a girl goes out and sleeps with a guy then she's a slut but if the guy, the guy who she's sleeping with he's the stud, he's the big man, he got it and you know, that, that doesn't make any sense to me at all

Alexandra, age 17

This view was supported by many of the female respondents. The male respondents also supported this view, albeit in less overt ways. According to one male:

women who seek out sex, strange thing is when a guy seeks it out, he's a stud and when a woman does it she's a slut

yet of women that he has had one night stands with he comments:

I know what I wanted, both of us wanted it fine, it's done, uh, bye, I don't want to deal with you now, you know, it was fun but I don't have any respect for anybody who does that, I don't choose to associate with them afterwards

Lance, age 18

Thus, women in particular have been given the strong message that being sexually active is not only risky from a safe sex point of view, it is also socially undesirable. Once again, in reference to the discourse of male sexual drives, while male sexual urges are viewed as natural, female sexual drives are not. Female sexual behaviour is

sanctioned only when the goal of that activity is procreation (Hollway, 1989). Reiss (1960) looked at the expression of the "double standard" in society. Specifically, the asexual woman is considered good, and therefore marriageable, while the sexually available woman is labelled bad and ineligible for marriage. More current research suggests that this "double standard" is still very much with us (Laws & Schwartz, 1977; Maticka-Tyndale, 1992) and seems evident in these participants' accounts as well. In response to the pressure of the "double standard" and the pressure to avoid considering oneself at risk, women seem to have attempted to redefine what sexually active means to them in order to evade the double stigma of being labelled at risk and promiscuous.

Unfortunately, denial of one's sexual activity may also put many women at risk of not practising safe sex. In line with much of the contraception literature, many women do not obtain contraception because that represents being sexually active (see Whitley & Schofield, 1985 for a review). If this holds true where safe sex is concerned, it may be that women are not obtaining condoms in an attempt to deny that they are sexually active. Further, since the unavailability of condoms was cited by respondents as a reason for not practising safe sex, this may be an important facet of risk for female participants.



## Pressure

The concept of pressure was examined by the participants during the course of interviews. It seemed that participants made a distinction between pressures that they experienced at the inter-personal level and pressures they felt emanated from a societal level. Each of these will be dealt with separately although on an interpretive level, one could consider both of these pressures as societal pressures. The differentiation of the two merely reflects participant's separation of these two themes.

Inter-personal Pressure. Closely related to the theme of responsibility, was that of pressure or coercion by a partner to engage in unsafe sex. It was expected that women would report this pressure to engage in unsafe sex. Many respondents did so. According to one:

I only went out with one guy who said I refuse to use a condom...this guy had been with a number of people before I even met him and um, like, he was like, I'm not using a condom I don't like using them

Sharon, age 16

Another respondent experienced the pressure more overtly and when asked why she had had unprotected sex said the following:

[because] he might get mad...yeah, he would get, because he didn't like condoms if he had to wear a condom, he didn't like it, so the only alternative is to not wear it, but if I didn't want that then he'd say, oh, what are you good for, forget it

Ariel, age 21

Men in the study also reported that suggestions to not

use condoms were made to them by their female partners. Seldom did men refer to this as pressure, however. That men don't refer to this as pressure may be a reflection of the power differential between men and women. With women being in a dis-empowered position, they may be unable to exert pressure in any real sense. Men's lack of perception of pressure when requests were made to not use condoms is shown in the story related by the following participant:

um, well, I remember the first time see, it was that, I was concerned and I said well, like I don't have a condom and she said well, I don't care, I said o.k.,...and it was just like, if she didn't care, I didn't care so and then like, since then, um, if she doesn't care it doesn't matter right

Dave, age 18

Another respondent had a slightly more involved response to this topic yet still indicated that the request to wear a condom was not viewed as pressure. When asked what he would do if a woman asked him to not use a condom, he replied:

it depends on how she says it, if she says [in an angry whisper] "don't wear a condom", or if she says [in a calm voice] "you don't have to wear a condom if you don't want to", [in an angry whisper] "don't wear a condom", why you got something you wanna give me, a little more than what I'm gettin' here or if she said [in a calm voice] "you don't have to wear one if you don't want to", that's different o.k., sure, whatever

Lance, age 18

In general, men seemed much less likely to construe women asking them to refrain from using condoms as pressure. More often, females' requests that their male partners not use condoms seemed to be viewed as permission giving. One male

said, "it's not really pressure, it's just like, don't worry about it you know" (Star, age 17). This also supports the view that women are deemed to be fundamentally responsible for the use of condoms; not only must they ensure that they are used, they also seem to be able to dictate when they are not used with few objections from their male partners.

Another theme which emerged was that many younger women seemed to feel more concerned with the pressure to have sex rather than the pressure to have unsafe sex. One participant said:

so the next time I went down, he'd asked me, he'd just asked me and I said no, but the first time, like he'd actually pressured me, like come on have sex with me you know, it's not going to be any big deal, like that kind of thing, and I sat down back and I was like, how can you say that, I mean, it is a big deal

Kait, age 19

Often it was important to discern whether participants, particularly when speaking about pressure, were talking about the pressure to have sex or the pressure to have unsafe sex. If participants are not giving much thought to the question of safe sex because they're worrying about the decision to have sex itself, they may find themselves ill-prepared to handle decisions about safe sex once they have made a decision to be sexually active.

One last theme that became evident in discussions of pressure was related to having experienced some form of sexual assault. Many of the participants who expressed the strongest views regarding their discomfort with being

pressured, and their unwillingness to give in to it, also reported some form of sexual harassment or assault in their past which they viewed as causative to the views they currently hold. Alexandra said:

I had a really bad experience where it made me appreciate my body more, I had a bad experience with a guy and he hurt me, and, um, I guess, I mean, I wish, I don't wish it would happen to everybody but, you know, the feelings of liking your body and really appreciating it and make sure you just don't throw it around to anybody you know...it made me really appreciate my body and not to be like the other girls you know

Alexandra, age 17

Another participant also spoke of sexual assault as changing her outlook. Avril said:

no man is going to do what \_\_\_\_\_ did to me, he had me emotionally wrapped and once he assaulted me I was, he killed me, as far as I was concerned you know, nobody's going to do that to me again and nobody's going to put me in a situation where I haven't thought through it clearly

Avril, age 19

In summary, pressure appeared to be an influential factor in women's accounts of their unsafe behaviour. Women described pressure, not only to have unsafe sex but also pressure to be sexually active. Pressure to have unsafe sex was often expressed in their male partner's requests that condoms not be used. Men also reported that their female partner's had requested that condoms not be used, however, males did not interpret such requests as pressure. More often males understood these requests to be permission giving.

The constructions of both males and females reflects a

larger societal discourse which holds women as responsible for all aspects of the sexual situation. An expression of the "double standard", Laws and Schwartz (1977) emphasize that "the total responsibility for resisting coitus falls to the female" (p. 49). It would seem from the accounts of the women in the present study, that this responsibility extends to the practice of safe sex as well. This was also alluded to in the previous section on responsibility. That women in the sample described having unsafe sex due to their male partner's coercion, however, speaks to existing power structures which accord ultimate power to males. Thus, while women have the responsibility for sexual situations, it is dubious as to whether they actually have the power to take responsibility and resist pressure from their partners.

Social Pressure. Another theme which was identified largely by virtue of contradictions within transcripts also dealt with the issue of pressure. However, as was stated, it remained distanced from the discussion of inter-personal pressure by virtue of respondents locating it at the social level. The perceived existence of influential social forces was most evidenced by what participants did not discuss.

On the surface, participants spoke in a general way about their control over their behaviour and sexual practices. Jocelyn stated her self-directedness quite forcefully when she said:

I have to watch out for myself, no one else is going to do it because I live by myself so I have

to kind of do this for myself and I was, oh so many lectures, so many people have given me lectures well you gotta do this and you gotta do that and you gotta take control and you gotta be right there and I'm like, yep, I know this, don't lecture me, so, I've had people tell me that and I know that because I'm on my own I have to be able to do what I want not what other people want me to do

Jocelyn, age 16

Interestingly, Jocelyn does not discuss just what those forces might be that would dissuade her from "doing what she wants". This absence was also noted in criticism of those who succumbed to "pressure". Again, the nature of those pressures were not well described. One view of those who "let themselves be pressured" was the following:

I think it's emotion, like they're emotionally weak...like if you're pressured into doing something then you should be emotionally strong enough to say no...[it's] a lot of things, just, society basically but you could, I don't know, I always blame it on the person just because, I don't know, it's not hard to say no and just walk away, if you don't want to do something, don't do it and that's how I always think

Ashley, age 16

While Ashley spoke of pressure and even mentioned "society" as a possible source of that pressure, her discussion of the mechanics of just how that pressure might be exerted remained illusive. Ultimately, she returned to the idea of personal control, and personal responsibility, as the solution without addressing the nature of those pressures.

Even those individuals who identify particular social forces (e.g., Esther talks of society and government) still do not elaborate on the nature or workings of these forces.

Esther talks of women who are pressured to have unsafe sex:

the choice is up to them, I mean, I don't know, maybe there's a personality variable involved in this, you know, submissive, passive women and that's how society wants us to be, that's how the government wants us to be...[but] I'm not, I'm not a passive, submissive person who can be coerced by anybody, I'm an independent, strong-minded person who knows what I want

Esther, age 23

As well, like most participants, Esther ultimately places herself outside the influence of those forces by virtue of her "strong-minded[ness]". In some ways, she seems to suggest that she need not understand what those forces are because she doesn't really view them as effecting her own behaviour. Nonetheless, while reaffirming their own personal control over their behaviour, participants continued to allude to social pressures that made controlling one's behaviour more difficult.

It is tempting, when considering the issue of safe sex from an applied perspective, to place the ultimate control for behaviour with the individual and ignore social pressures, much like the respondents in this study have done. Indeed, many media campaigns have been directed towards doing just that. The "Just Say No" campaign is a prime example. In essence this campaign confers the ultimate control for behaviour on the individual since all you have to do is say no. While a sense of personal responsibility and control may be an efficacious way of handling the problem of safe sex practices it may be a

dangerous over-simplification.

Many of my respondents spoke of doing what they want to do or directing their own behaviour, yet at the same time, they seemed to be somewhat aware of forces around them that made this more difficult, the forces that they spoke of having to struggle against. It is this researcher's concern that without a firm understanding of the social forces and structures that serve to influence behaviour, it is difficult for the individual to make an informed decision as to what they do indeed want to do. This is not to say that there is some core desire to take a particular action that is devoid of social influence. However, when those influences remain masked or un-examined it is questionable as to the extent that individuals are making decisions based on all the available information. For example, if women were more aware of the ways in which their behaviour is limited by social structures which render them powerless, as well as the ways in which their behaviour may serve to maintain those structures, they might make different choices as to the nature of their actions.

In summary, while participants alluded to pressures in society which made their decisions to practice safe sex more difficult, they were unable to describe these forces or their influence in any detail. To the extent that knowledge of these forces may render them less influential, research into safe sex behaviour cannot fail to elucidate the nature



of those social pressures and their impact on the individual.

### States of Consciousness

When participants spoke of unsafe behaviour, they often described this behaviour as occurring when they were in an altered state of consciousness and therefore, they were not responsible for their actions. For instance, the involvement of alcohol led some respondents to speak of their behaviour in the following way:

when you're drinking even if you only have a couple beers in you, like three or four beers you know, you still get a glow, like you still get a glow on, you know, enough to alter your thinking and it's like, oh, don't worry about it you know, who cares, or when you're stoned you're definitely not thinking straight and you don't know what you're thinking so it's like, who cares

Star, age 17

Phrases like, "you don't know what you're thinking" or "I just wasn't thinking" were other common ways in which people described their unsafe actions while under the influence of drugs or alcohol.

Another situation in which participants experienced 'altered states of consciousness' was during the "heat of the moment". One participant explained this feeling in the following way:

when I'm not thinking, that's the heat of the moment for me, where I just, my body is taking over and my higher, and emotions are making my decision and not intellect I guess you could say, when you know the consequences are always in the back of my head, but you're like, forget it, we'll"

deal with that in the morning, that's the heat of  
the moment to me...when the emotions just say good  
bye to the head

Avril, age 19

Another respondent described this situation as "you're  
body's going a million miles an hour but your heads not  
really workin'" (Lance). Each of these accounts implies a  
separation between what their "head" or rational mind is  
doing and what their "emotions" or some other irrational  
force within their body (e.g., hormones) is about. One  
respondent also used dissociative language to distance her  
present self from her previous self which had engaged in  
unsafe behaviour. She said:

I can honestly say that I was not thinking, like I  
mean, I don't even know who that person was that  
slept with \_\_\_\_, but it sure as hell was not me in  
any form

Avril, age 19

Thus, it seems that participants make a distinction between  
their thinking, rational, logical "I" and their unthinking,  
irrational, illogical "not I". To a certain extent, this  
distinction serves to abrogate responsibility for the unsafe  
actions. Wilful actions are the domain of the thinking "I",  
by extension unsafe behaviours, are the domain of the  
unthinking "not I", and in this way, participants cannot  
hold themselves, the "I", responsible for their unthinking,  
unsafe behaviours.

This separation can be interpreted by considering them  
to be expressions of the Western assumption of the rational  
unitary subject. Hollway (1989) describes one expression of

the rational unitary subject discourse as an explanation of behaviour which "allows for the existence of contradictory and potentially irreconcilable parts, but these are typically divided into reasons and feelings" (p. 49). The participants in this study are explaining their irrational behaviour in this way. In essence they are saying that unsafe behaviour has been determined by their emotions or feelings or other irrational forces and that their safe behaviour is the result of rational thought.

Other participants however, argue for the ultimate triumph of rationality over irrationality, or the "I" over the "not I". One respondent said:

um, say if you ah, have too much to drink, you don't know what you're doing, you're under the influence, your mind doesn't work like to it's fullest I guess you'd say um, if you're under the influence of drugs of course, um, oh, god, I can't, I don't even see myself even getting worked up to the point and forgetting about it, that's something you just can't forget about, so, like, even, even if, like, it's like right at the spur of the moment, you're like oh, and I'm like stop, whoa, stop, something's got to be done

Kait, age 19

This could also be explained in terms of another version of the rational unitary subject discourse which denies contradictions and posits a fundamentally unitary subject.

When examining Kait's account further however, she seemed to waver slightly on whether or not she felt that she was capable of being swayed from what she felt she should do. Although she seemed rather sure that she could step in

and decide to practice safe sex, she still insinuated that "getting worked up to the point" where she might "forget" about it was a possibility. Again, forgetting is another way of distancing the behaviour from your own control. If one "forgets", one cannot be rightly accused of acting wilfully in an undesirable fashion, since the vital information to ensure desirable behaviour is no longer available, it is forgotten. Thus, Kait's account still seems to more closely represent the expression of the rational unitary subject discourse expressed earlier.

Another respondent also indicated a similar ambivalence as to whether one's behaviour is always rationally determined. Initially, Esther felt that there were no mental conditions under which to justify not practising safe sex:

I don't care, o.k, unless you're totally passed out and can't move and the persons having sex with you without consent, then yeah, I could see that but, I don't care how stoned you are, how drunk you are, how tired are, whatever your state of mind is, you always know that you're engaging in sex and if you're engaging in sex without a condom

However, in a later statement, Esther allows for the possibility that her behaviour may not always be what she would choose it to be. She states:

you can never predict behaviour ever, I can't even predict my own behaviour, I can't say that I'll never not have safe sex

Esther, age 23

Thus, Esther also seems to espouse the duality of rational thought and irrational action.

Other points of interest also arise when one considers functions that may be served by this dualism. While on one hand participants speak of their rational ability to assume control for their actions, they also describe feelings of having their behaviour out of their control. As was previously stated, one function of this duality may serve to abrogate responsibility or blame for unsafe or irrational actions. It could also be asked what function is served by shielding the individual from taking responsibility for their own irrational and self-injurious behaviours? While it is beyond the scope of this study to discuss this question in depth, the need to protect oneself from one's own desires for self-destruction could also be considered a point worth analysing in future discussions of risk behaviour.

Another interesting facet of this duality however, is that both agents of action are located within the individual. If participants were indeed attempting to deny responsibility for their unsafe actions, they could usefully explain their unsafe actions in terms of external pressures operating to dissuade them from their will. However, most of the participants accounts located the agent of their unsafe behaviour within themselves, for example, 'my emotions', 'my hormones'. To a certain extent, this seems counter-intuitive. That participants would locate the agent of positive action within themselves (e.g., my mind, my

intellect) is understandable as it grants them personal control over their actions. If one considers control as important to the individual, this may explain the tendency to also locate their unsafe behaviours within themselves because to locate control of one's behaviours outside of oneself is to give up ultimate control of one's behaviour.

## Chapter 4

### Discussion

#### Discussion of Themes

The themes which emerged in this study will be discussed in terms of the expectations of the study, their contribution to the existing body of knowledge and their support of current research.

A number of expectations, based on previous research, as to what might be contained within respondents' accounts were posited prior to beginning the interview process. To a great extent, these expectations were supported. Almost all respondents expressed favourable attitudes towards safe sex, as well as showing a reasonable degree of knowledge regarding safe sex practices. A variety of attitudes towards condoms were also expressed. The expectation that many of these opinions of condoms would be negative was also supported. Other expectations of this study were that respondents would not view themselves at personal risk of contracting HIV and that risk was perceived to be linked to promiscuous behaviour. These expectations were strongly supported. Risk was, in fact, described by many participants to be related to promiscuity and although a general perception of risk was discussed, most respondents did not feel that they were at personal risk. It was also supported that participants offered explanations of their risk behaviour similar to those described by health

professionals (e.g., my hormones took over). As well, alcohol and substance use were cited as reasons why participants engaged in unsafe sex. Lastly, as was expected, both male and female respondents reported that sexual partners had requested that safe sex not be practised at some point in time.

What becomes obvious when attempting to discuss the findings of the present study, is the fundamentally different quality of information accruing from qualitative, open-ended inquiry. While the present study supported much of what has been suggested by earlier research, it also provided a much deeper understanding of how participants understand their own behaviour, and thus sheds new light on the topic. Connections between attitudes and behaviour, for example, are not clean cut. As this study suggests, there are often more complicated meaning systems behind what positivist research would call a relationship between two variables. Importantly, it is the meanings behind these relationships which are most instructive for applied purposes. Perhaps most of all, this study, and the type of methodology employed, served to provide a deeper understanding of the meaning systems utilized by the participants. A better understanding of the participants' constructions of safe sex also revealed discrepancies and contradictions not apparent in much of the previous literature.



In an effort to explain why condoms are frequently not used by adolescents and youth, research on attitudes towards condoms suggested that non-use may be due to the fact that youth and adolescents consider condoms unattractive and difficult to use (Malavaud, Dumay & Malavaud, 1990; Sheeran, Abraham, Abrams, Spears et al., 1990). This study however, provides an alternate suggestion as to why condoms are not used as well as perhaps why they are negatively evaluated. In the present study, condom use was directly related to the concept of trust. Participants who were in relationships described not using condoms as an expression of trust; trust that their partner is monogamous, trust that their partner is aware of their HIV status, trust that their partner would disclose any prior risk and trust that their partner is honest. In fact, participants discussing risk expressly communicated that being in a monogamous, therefore trusting relationship put them at much less risk having unprotected sex. Conversely then, condom use symbolized distrust in the relationship. This construction was found in both heterosexual and gay male participants' accounts. If condoms do symbolize distrust for these participants this may account for the dislike of condoms and tendencies towards unprotected sex.

Trust in one's partner as a way of lessening the risk of unsafe sex has also been found by other researchers. A study by Hernandez and Smith (1990) suggested that

inaccurate self-perceptions of monogamy and abstinence may lead students to assume falsely that they are safe from sexually transmitted diseases. Similarly, Maticka-Tyndale (1992) found that amongst coitally active youth, trusting one's partner was a personal rule for safe sex. Contrary to the Maticka-Tyndale study, males and females in the present study did not appear to define trust differently where affection based relationships were concerned. An interesting difference in the present study however, was the observation that some female participants appear to be having unsafe sex as a way of creating trust in a relationship and ensuring that it is a "good" one. While trust alone is insufficient to reduce risk, the concept of using unsafe sex to create "trust" in a relationship is in some ways much more frightening and potentially risky. There was no indication that males had similar constructions.

The idea of trust as a component of romantic love is one well embedded in our social fabric. Work by Davis, Heiger and Richburg (1984, cited in Davis & Roberts, 1985, p.153) described a genuinely high love profile as containing a high degree of care, need, trust and passion. Furthermore, the conception of trust held by many includes the concept of sexual exclusivity (Laws & Schwartz, 1977). However, as is the case with most youth, serial monogamy may be a more apt descriptor of their sexual practices. Thus,

although trust is expected in intimate relationships, the concept of serial monogamy makes trust alone less viable as a means of reducing the risk of unsafe sex. Also problematic is the presence of what Laws and Schwartz (1977) refer to as the "double standard" and the "standard of permissiveness" which "permit them [men] to be in love without being committed to monogamy" (p.114). While it would be erroneous to suggest that all women remain completely monogamous, this state of affairs may be more detrimental to the woman who believes herself to be in a "trusting" (i.e., monogamous) relationship while her partner is operating under a different standard.

The present study also investigated whether or not pressure to have unsafe sex had been within the experience of the participants. Most women described having felt pressured into having unsafe sex at some time. Research by Breakwell, Fife and Clayden (1991) suggests perceptions of personal control over sexual relationships and the perceived ability to use condoms, whatever the situation, predicted intentions to use condoms in young women. Thus, it may be that the pressure experienced by these young women served to lessen their perception of control over the situation and resulted in lack of condom use.

The pressure perceived by female participants also reflects societal power differentials between men and women which accord men more power and make it difficult for women

to address this pressure. Laws and Schwartz (1977) describe the socially determined female sex role in the following way:

Female sex role scripts might be thought of as a collection of prescriptions for femininity - including, for example, the expectation that women shall be passive rather than aggressive, reactive rather than agentic (p.10)

With such prescriptions for the balance of power in operation it is perhaps not surprising that women describe such pressure to accede to their male partner's requests to not use condoms. Women also spoke of the pressure to be sexually active. In fact, they often seemed to consider this type of pressure to be more problematic and pertinent to them than the pressure to have unsafe sex. For them, it seemed that addressing the question of pressure to have unsafe sex prior to addressing the issue of pressure to just be sexually active was putting the cart before the horse, so to speak.

Men in this study also gave accounts of their female partners requesting them not to use condoms. However, these requests were not considered to be pressure, rather they were construed as permission giving. This construction speaks to two related ideas. Not only does this support the idea that men perceive women as relatively powerless, constructing them as unable to exert pressure, merely to give permission, or yield to their requests, but it also speaks to the concept of responsibility. Men and women in

this study both spoke of how ensuring condom use was the female's responsibility. For example, male's constructions of women as giving permission for unsafe sex places the responsibility for condom use on the female partner. Furthermore, female participants' accounts of feeling pressured to be sexually active and by extension, to resist the sexual advances of their male partners also underscores the assumption that women are responsible for resisting coitus (Laws & Schwartz, 1977) and for obtaining birth control. Female participants were able to identify numerous social institutions which served to foist such responsibility onto women. Specifically, women talked about the readiness of the medical system to prescribe oral contraceptives for women, and sex education classes which taught women about birth control but did little to teach the same to males. Unfortunately, these institutions form a part of the larger social system, one which while laying responsibility on women serves to also dis-empower them at the same time.

Another factor which seemed to be at work in both males and female accounts of pressure and responsibility was the discourse of the male sexual drive (Hollway, 1989; Laws & Schwartz, 1977). Most participants constructed the male sex drive to be natural and unstoppable since "that's what men are like". Placed in opposition to this was the corollary discourse of the weak or non-existent female sexual drive.

With the construction of females as not desiring sexual contact, they are left with the responsibility of staying off the advances of the "uncontrollable" male. Thus, women seemed to feel both the pressure to be sexually active and to have unsafe sex as well as the responsibility to resist such pressures. As was previously mentioned, because society does not give women the power to effectively deal with such pressure, women are placed in an untenable position. When one considers the rise in HIV among women (Haines, 1989; Health and Welfare Canada, 1989a; Holman, 1989) this paradox becomes a grave concern.

When asked about risk, participants voiced the opinion that everyone who is sexually active is at risk of contracting HIV. Participants also cited promiscuity, IV drug use and "homosexuality" as risk factors. However, few participants considered themselves to be personally at risk of exposure to HIV. This is inkeeping with prior research (Harrison, Wambach, Byers, Imershein et al., 1991). What was particularly illuminating however, was the ways in which participants constructed their definitions of risk to preclude considering themselves to be at risk. Specifically, participants described risk as associated with being a person of colour, being of low socio-economic status, and not associated with institutions representing the middle class (e.g., universities). Geographical area (e.g., cities bigger than theirs) was also cited as a risk

factor. Perceived risk reduction based on geographical area was also found by Maticka-Tyndale (1992). As was previously indicated however, these risk factors in no way applied to the participants who discussed them, nor did they include the most obvious risk factor (i.e., having unprotected sex). In this way, participants were defining themselves 'out of' risk.

Other strategies were also used to avoid considering oneself to be at risk. Lesbian participants felt they were at less risk because their partners were women, while individuals in relationships claimed that being monogamous meant they were not at risk. What was puzzling however, was that participants who claimed that monogamy lessened their risk also voiced the opinion that one could not be sure that one's partner was indeed monogamous. People seemed to tolerate inconsistency by saying that while one can't assume monogamy in general, within 'their' monogamous relationship it was a valid form of risk reduction.

Still other participants spoke of getting to know their partners as a way of reducing risk. Juran (1989) reported that sexual history taking is a popular way of lessening perceived risk. However, the accounts of this study's respondents indicate that getting to know your partner seldom includes asking questions pertinent to HIV (e.g., Have you been tested before?). This was supported by a study carried out by Ingham, Woodcock and Stenner (1991) who

found that while "getting to know your partner" is a popular promotion for less risky sex, there is little evidence to suggest that attempts are made to assess HIV risk factors in prospective partners.

Perhaps most interesting was a trend that was found within many women's accounts. Because the "double standard" does not allow women to label as "sexually active" without social stigmatization and because being "sexually active" has the added connotation of being at risk for HIV, many women seem to be redefining what the term "sexually active" means to them. By so doing, they avoid considering themselves to be sexually active and thus, avoid being labelled promiscuous or considering themselves to be at risk of HIV. Denial of being sexually active can put women at risk of not practising safe sex (see Whitley & Schofield, 1985 for a review) and as such, this finding is of vital concern.

While participants' explanations for their unsafe behaviour were expected (e.g., my hormones took over, I was drunk) this study allowed for a closer examination of these explanations and why these are often utilized. What was consistent about all accounts was their tendency to describe their unsafe actions as caused by forces outside their rational mind. Hormones, alcohol, drugs all took on a life of their own and in many participants accounts were viewed as "causing" the unsafe sex. This reasoning is reflective



of the discourse of the rational unitary self (Holloway, 1989). As such, it represents one way of accounting for one's behaviour in a culturally sanctioned fashion, although there are other ways of accounting for one's behaviour (Slugoski & Ginsberg, 1989). Because it is culturally unacceptable to admit to having undertaken potentially self-injurious behaviour (i.e., having unsafe sex), these participants have ascribed agency for their unsafe behaviour to factors beyond their rational control. The assumption being that had I been in control, I would have made the rational decision and not had unsafe sex. This schism also allowed participants to abrogate responsibility for their unsafe actions. This denial of volitional action may make it doubtful that participants will attempt to take responsibility for their actions in the future.

### Limitations

Although this study provided much illuminating information on the ways in which the participants construct safe sex, certain limitations need to be addressed. One of the aims in qualitative research involves sampling a wide diversity of opinion. Specific sampling techniques such as theoretical sampling can be utilized to insure that a full range of differences on dimensions of interest are represented amongst those sampled (Strauss & Corbin, 1990). While attempts were made to represent a diversity of opinion

in this study, the extent to which this was accomplished could be questioned. The use of a method such as theoretical sampling would have increased the representativeness of the sample but this was not done. While this limitation does not invalidate the findings of this study, certain caveats should be made explicit.

Firstly, of the 24 participants in this sample, only two lesbians and two gay men were represented. It should be noted that the responses made by heterosexual and gay and lesbian participants in this study did not differ in obvious ways. However, both lesbians and gay men may have very different understandings of safe sex than their heterosexual counterparts and it is clear that the number of gay and lesbian participants in this sample is not large enough to reveal the diversity of opinion in this community. Therefore, it would have been advisable for a larger number of lesbian and gay participants to be interviewed.

Secondly, the sample was limited to those individuals in the Windsor area. Utilizing participants from different geographical areas may have provided the researcher with different understandings of safe sex and this would be useful to examine in further inquiry. However, it was the hope of the present study to make use of the information obtained to directly benefit the target population. Restricting participation to those individuals from the Windsor area made it more likely that the information

obtained would be most pertinent to them and most immediately beneficial.

Thirdly, the heavy representation of male juvenile offenders (6 of the 12 male participants) may also have served to misrepresent the views of non-offending males. One study by Nader, Wexler, Patterson, McKusick et al. (1989) suggested that incarcerated youth may not be typical of all youth, because they have demonstrated significantly poorer knowledge about AIDS than their non-incarcerated peers. Further, the life experience of some of the juvenile offenders interviewed would not be viewed as typical of that of many adolescents. In comparing the views put forward by offending adolescent males with non-offending adolescent males however, there did not appear to be a great deal of difference, nor did the juvenile offenders interviewed show a significantly different level of knowledge of AIDS. It would be advisable however, to include more non-offending males in the study to ensure the validity of this trend.

In general, it was very difficult to find males who were willing to participate in the study. Although the researcher asked male respondents to reflect on why many of their counter-parts were unwilling to participate, few answers were given. It might have been expedient to include a male interviewer in the research process in order to foster conditions which might be more favourable to potential male respondents.

Another problem with the present study is that of the age spread of respondents. The span of participant ages from 16 to 24 covered both high school and University aged participants. Although much of the research does not suggest that adolescents and youth differ in many ways where HIV and AIDS is concerned, it was this researcher's feeling that there were some differences between these groups. While trends were not clear, it seemed as though older respondents may have a somewhat more cynical (or realistic) view of safe sex. Limiting investigation to each of those groups individually may have been a more effective way of understanding differences between these groups. Also, although it is ethically difficult to interview participants under the age of 16 as parental consent is needed, it would be advisable to extend the lower age limit downward. As many of the participants indicated, as well as many of the current statistics on age of first sexual experience, adolescents are beginning sexual activity at 11 and 12 years of age. Thus, it would be vital to include these younger participants in future explorations of adolescents views of safe sex.

Ethnic diversity was also not obtained in the present sample. The area in which the study was undertaken is an ethnically varied city, thus, to adequately represent these groups, a larger number of representatives of ethnic minorities should have been included.

While not pertinent to the question of representativeness of the sample, a further criticism involves an omission in the interview protocol. It was suggested that homophobia may be a factor in understanding unsafe sexual behaviour (A. Sears, personal communication, September 1993). No probing for homophobia was carried out during interviews in the present study. It may be advisable to ask more specific questions regarding homophobia to elicit such attitudes and understand how they might be involved in unsafe sexual practices.

Another common criticism levelled at qualitative research involves that of the validity of accounts. It could be viewed as a concern that the participants involved were not relaying accurate information regarding their sexual behaviour. This may be due to the desire to be viewed in a positive light by the researcher or as a reticence to discuss personal information regarding one's sexual practices with a stranger. Although the focus of this study was not on the number of people practising safe or unsafe sex, there are a few more compelling counters to this criticism.

Firstly, it could be argued that a quantitative approach to this subject area would be no more likely to obtain "truthful" accounts of participants sexual behaviour than a qualitative approach. That demand characteristics would still be at work and that the topic area continues to

be highly personal would place similar limitations over both methods.

Secondly, the mere fact that many respondents quite openly described their unsafe sexual behaviour suggests that this is perhaps not the taboo subject that one might expect it to be. Lastly, the present study was not fundamentally concerned with the apparent truth or falsity of participants accounts. Because the study was concerned with understanding the ways in which adolescents construct safe sex behaviour, any account which could be viewed as plausible within their social context is of value and is, in essence, truthful. Kitzinger (1987) states this most succinctly regarding social constructionism:

From this perspective, false accounts (even deliberately falsified accounts or 'lies') are as meaningful as correct accounts in so far as a plausible lie is (by definition) what could be a correct account in that society (p. 73)

In this way, any account provided by participants is valuable since it reflects socially relevant constructions of the phenomenon in question.

Lastly, it could be argued that the information obtained and the analysis of the themes was carried out within a narrow system of interpretation. The researcher does not contend that the system of interpretation used herein is exhaustive or devoid of criticism. In fact, it is the aim of social constructionism "to recognize and appreciate the reflexivity of its own theory" (Kitzinger, p.

189). Thus, any criticism of the schemes of interpretation used are welcomed, expected and viewed as fundamental to the utilization of a social constructionist framework.

A related criticism of social constructionism deals with the extent to which one can make interpretive statements from data collected under the social constructionist paradigm. Social constructionism has been criticized, along with other approaches (e.g., ethogenics) for its lack of consideration of the social and political embeddedness of the constructions it describes. Collier, Minton and Reynolds (1991), state:

What tends to be neglected in these approaches is a critical perspective that takes the interface between communication and the social context into account and recognizes ethical and political issues. (p. 288)

The researcher notes this criticism and recognizes it as a potential limitation to utilizing a social constructionist approach. However, the information gleaned from this inquiry would seem to far outweigh these criticisms when considering the utility of these accounts for informing future inquiry and educative interventions.

### Recommendations

Education. The findings of this study carry many implications for safe sex education with adolescents and youth. In general, it appears that greater focus needs to be put on just what makes activities risky. Participants in

this study did not consider themselves to be at risk and actively constructed their definitions of risk to preclude considering themselves to be at risk. What seems to be missed by many of the respondents is the bottom line; having unprotected sex is a risk. Emphasis needs to be put on the fact that getting to know one's partner, being in a relationship, having only one partner, trusting one's partner, trusting in monogamy, that none of these are as effective at reducing risk as simply using a condom or a dental dam.

It is also necessary to ensure that knowledge gaps are understood and addressed. For example, participants in this study and other studies (Maticka-Tyndale, 1992) report confusion surrounding the risk associated with oral sex. This type of information could easily be incorporated into more educational programs. Furthermore, factors which make it difficult to acknowledge one's sexual activity, such as the "double standard" for women, also need to be addressed on both a social and an individual level.

This is not to say that there are no barriers to communicating this information to adolescents. One barrier was obvious in the dialogue on trust. That unsafe sex is regarded as affirming the quality of a relationship is an assumption that needs to be dealt with in interventions with adolescents. Educators need to challenge adolescents to reconstruct their beliefs about what trust means in a



relationship. For example, trust could be expressed in terms of caring about another individual, and in this way, practising safe sex within a relationship is an expression of caring and commitment to the well being of one's partner.

Trust in monogamy is also complicated by the existence of the double standard which permits men sexual freedom not allowed to women. Thus, women may be placed at greater risk by believing in a standard that is not uniform across genders. In this way, education also needs to challenge taken for granted assumptions regarding pre-existing sex roles and encourage individuals to engage in active negotiation and communication with their sexual partners.

Power differentials within society also represent problematic barriers to instituting behaviour change within adolescent groups. For females, their lack of power makes it difficult for them to negotiate safe sex with an unwilling partner. This was attested to in the dialogue on pressure. Furthermore, this power differential is reinforced by societal institutions which, while supporting discourse which holds women as responsible for safe sex serves to ultimately disempower them.

Pressure on women is further exacerbated by the common discourse of the male sexual drive. Participants felt that men were "naturally" driven by their sexual instincts and that women are responsible for controlling men's instincts. This represents only one of many possible constructions of

sexuality and as such, educators must help adolescents reconstruct their view of sexuality so that responsibility can be more equally distributed

That men and women view requests to have unsafe sex differently suggests that males and females have different educational needs. Women need to understand that the responsibility for having safe sex is not theirs alone and be empowered to demand that condoms be used by their male partners. Males need to realize that they are also responsible for practising safe sex and respecting the wishes of their partner. To this end, education programs need to discuss power differentials and domination discourse with their young participants and work towards alleviating the power imbalance. Illuminating these forces may be the first step to mitigating their influence.

Additionally, dialogue on states of consciousness points to the necessity for educators to draw attention to how people can deny responsibility for their actions based on their 'state of mind'. Irrational actions such as having unsafe sex, need to be understood as under the control of the individual so strategies to avoid such situations can be made.

A last consideration for AIDS education with adolescents also addresses the concept of responsibility. The predominant idea circulated amongst respondents in the present study is that safe sex is something that you do for

yourself. There seems to be no emphasis on safe sex as something that one does to protect another human being or the community at large. Constructing safe sex as something that one can do for the betterment of the entire community may provide some adolescents with an added rationale for practising safe sex.

Future Research. In a general sense, it is obvious that the methodology employed in this study yielded a very rich body of information. Open-ended inquiry allowed the participants to provide a clear picture of their reality and illuminated contradictions and hidden assumptions regarding safe sex and HIV that may have been missed by more traditional methods. Thus, it would be highly valuable for future research to utilize a similar methodological approach.

Numerous specific research projects are also suggested by the findings of this study. Firstly, women who had experienced some form of sexual assault seemed to have somewhat different opinions and accounts of pressure to have unsafe sex and their reactions to that pressure. It would be interesting to find out just how these women construct their assault as causative to their current attitudes.

The present study also highlighted ways in which the media may be mis-interpreted by the consumers of safe sex advertising. Presenting individuals with common advertising messages and asking them to explain what those messages mean

to them, how they construct their understandings of those messages, may provide further direction to producers of AIDS education as to where their efforts are falling short with adolescents.

In future research, attempts will be made to incorporate the findings of this study into AIDS education programs directly accessible to the participants and the groups they represent. An evaluation of the effectiveness of these interventions could then be carried out to determine the utility of the information contained herein.

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## APPENDIX A

## Breakdown of Participant by Age and Sex

Males		Females	
Age of Participant	Frequency of Occurrence	Age of Participant	Frequency of Occurrence
16	**	16	***
17	**	17	*
18	**	18	
19		19	**
20		20	
21	*	21	***
22	*	22	**
23	**	23	*
24	**	24	



APPENDIX B  
Background Questionnaire

- A. Are you a student at this time? (If you answer "no" to this item, please proceed directly to item C.)

1). yes  
2). no

- B. What is your student status?

1). full-time high school  
2). part-time high school  
3). full-time university  
4). part-time university

**\*\*ALL RESPONDENTS PLEASE COMPLETE THE FOLLOWING QUESTIONS\*\***

- C. What is your age? \_\_\_\_\_ years, sex? \_\_\_\_\_  
(male/female)

- D. What is your marital status?

1). single  
2). married  
3). divorced/separated  
4). widowed  
5). common-law

- E. At present are you involved in a relationship?

1). yes  
2). no (skip to G.)

- F. How would you describe this relationship? Pick as many adjectives as you need.

1). romantic                      2). long-term  
3). sexual                        4). short-term  
5). friendship                  6). other (specify  
\_\_\_\_\_)

- G. At present, what best represents your sexual orientation?

1). heterosexual  
2). gay  
3). lesbian  
4). bisexual  
5). not sure  
6). other, please state \_\_\_\_\_

H. What are your current living arrangements?

- 1). living with parent(s)/siblings
- 2). living alone
- 3). living with roommate(s) (non-sexual relationship)
- 4). living with partner (sexual relationship)
- 5). living with partner and dependent children
- 6). living with dependent children
- 7). other (specify) \_\_\_\_\_

I. Do you consider yourself to be part of a particular ethnic group(s)? If so, please list.

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J. What, if any, is your current religious affiliation?

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## APPENDIX C

## Interview Schedule

## 1). Attitudes Toward Safe Sex

Sample Questions: "What do you think about safe sex?"  
"How do you feel about using condoms?"

## 2). Perception of Risk

Sample Questions: "Have you ever been concerned about being at risk?"  
"Do you feel that you're in a high risk group?"

## 3). Behavioural Motivators

Sample Question: "What kinds of things effect your decisions about safe sex?"

## 4). Perceived Coercion to Engage in Unsafe Sex

Sample Question: "Have you ever been in a situation where you've felt pressured to have unsafe sex?"

## 5). Substance Use

Sample Question: "Some of the people we've talked to have said that having a few drinks or taking drugs has effected their decisions about safe sex, what do you think about that?"

## 6). Self versus Other

Sample Question: "What do other people you know think about safe sex?"

## 7). Sources of Knowledge

Sample Questions: "Where or how did you learn about safe sex?"  
"Did you think that was enough?"

## 8). Other Concerns

Sample Question: "Is there anything important that we didn't ask about?"

## APPENDIX D

## Consent Form

Research Title: AIDS Education: A Social  
Constructionist Approach  
Investigator: Julie Fraser

The purpose of this document is to inform you of the existence of the University of Windsor Psychology Department Ethics Committee whose purpose it is to protect your rights and welfare. Any concerns about this study should be addressed to Dr. Ron Frisch, Department of Psychology Ethics Committee, University of Windsor, Windsor, Ontario, N9B 3P4, (519) 253-4243 ext. 7012.

This study is attempting to understand what people feel motivates their decisions about safe sex. It is hoped that knowing this will help to improve current AIDS education programs.

I understand that I will be interviewed and asked about my opinions and impressions of safe sex behaviour and that these interviews will be recorded for transcription purposes and subsequently erased. Further, I will be asked to complete a short Demographics Questionnaire and an AIDS Knowledge Test. It is the responsibility of both investigators to keep the identity and opinions of all participants strictly confidential.

I willingly consent to participate in this study and realize that I can withdraw from the study at any time for any reason.

I also agree to permit excerpts of my responses to be used in research publications or for teaching purposes since my individual responses will be kept strictly anonymous.

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

## APPENDIX E

## Introduction to Study

"I thought I'd start things off by telling you a little bit about myself and about why I'm doing this research. What initially made me curious was my own experience. I noticed that people, including myself, who know a lot about AIDS, who even know people who are HIV positive, still continue to have unsafe sex. So I had to ask myself why do people have unsafe sex, even though they know it's unsafe?"

"With this question in mind, I started looking at the research. Well, there is lots to say that just knowing about AIDS doesn't mean you'll have safe sex. There is also lots of theories that try to explain why people don't have safe sex. Some of these make sense to me and my experience, some don't. I started to realize that what is meaningful to me isn't necessarily meaningful to someone else. People understand the things they do in many different ways because they're different people with different histories."

"Another thing I realized was that people don't always make decisions logically - like most theories expect - sometimes people react illogically, especially where something like sex is concerned."

"As a result of all that, I decided that the best way to find out what is effecting people's decisions about safe sex is to ask them. I think that by having a better understanding of people's motivations where safe sex is concerned will lead to better AIDS education. In a nutshell, that's why I'm doing what I'm doing. Would you like to know anything else?"

"O.K., what about you? What do you think about safe sex?"

## APPENDIX F

## Questions Used to Probe for Distress

"Well, this is great! You've given me lots of information. How do you feel right now?"

"We've talked about some pretty heavy issues and sometimes these topics leave people with questions or concerns. Just for a moment, I want to give you the chance to think about your experience during the interview. Take a minute if you need to."

"Are there any questions that came up for you during the interview or just now as you thought about it?"

"Did anything disturb you during the interview?"

"Are you feeling o.k. right now?"

"Great! I just want you to know that if any questions or concerns come up for you at any time, a day from now, a week from now or even a month from now, please get in touch. I may not be able to answer all your questions but if I can't I'll send you to someone who can."

"Any other reflections on the interview?"

## APPENDIX G

## Debriefing and Feedback Sheet

The purpose of our research is to become aware of people's opinions and attitudes about safe sex and to find out what is affecting people's decisions about safe sex. In order to get as much specific information as possible, we chose to do interviews. Not only do interviews provide more information than traditional research methods they can also yield information that is unexpected. With a better understanding of what is affecting people's decisions about safe sex, we hope to improve education about AIDS.

About AIDS and Safe Sex...

Although some people might try to tell you otherwise, the HIV virus can't be transmitted through casual contact such as shaking hands, hugging, kissing, sharing eating utensils or by donating blood. You can get HIV however, when bodily fluids (semen and blood in particular) from an infected individual enter your blood stream. The only method of effectively protecting yourself from AIDS 100% of the time is to not have sex at all and not use intravenous drugs. Since this isn't always possible or desirable, here are some things you should keep in mind.

If you are an IV drug user, always use new, sterilized needles. If one isn't available, make sure the needle you're using is clean. You can clean your needles by filling the syringe with bleach, squirting it out and repeating this procedure. Afterwards, fill the syringe with warm soapy water, squirt it out and repeat this again. NEVER SHARE A NEEDLE.

If you're having sex with men, you can greatly reduce your chances of getting AIDS by ALWAYS using a latex condom. Sheepskin condoms may feel better but they don't prevent the transmission of the HIV virus. Make sure to read the instructions on the condom package first. In general, remember to squeeze the tip of the condom so that air can't be trapped inside the condom. This helps to prevent the condom from breaking during sex. Most common brands of condoms are made for use during vaginal sex. While there are condoms made especially for use during anal sex, proper use of condoms makes the possibility of breakage much less likely.

The chances of getting AIDS by having oral sex performed on you is very slim. If you are giving oral sex, however, precautions should be taken. Asking your male partner to wear a condom and/or your female partner to use a dental dam can help prevent semen, blood, or vaginal secretions from entering your blood stream through a cut or

sore in your mouth.

As a further thing to consider, safe sex doesn't become irrelevant as soon as you're dating a steady partner. Simply thinking that you know your partner well enough to not use condoms is not a good enough reason. You can't tell by looking at someone that they have HIV. Often, people don't even know themselves that they have the virus. Also, people don't always tell their partners the whole truth about their sexual past or present. Always use a condom with a new partner. If you are involved in a long-term, monogamous relationship with the same person and you choose to stop using condoms, you should go together to be tested for HIV more than once, before discontinuing condom use.

If you have unanswered questions or concerns about HIV, or want to inquire about anonymous testing, there are many useful resources in the Windsor area. Here are just two:

AIDS Committee of Windsor  
2090 Wyandotte St. E.  
phone; 973-0222

HIV Care Program and  
Anonymous Testing Clinic  
Metropolitan General  
Hospital  
Kildare Wing  
2240 Kildare Ave.  
phone; 254-6115

If you have any more questions about this study, please feel free to contact Julie Fraser (258-9097) at any time in the future. If you had a good experience, tell a friend! If you are interested in either a copy of the final results (tentative date: Sept. 1993) or participating in possible future research, please fill out the following page and return it to the interviewer.

Thank-you very much for your time and your invaluable input.



Intention for Follow-up

I would like...

- a). to receive a copy of this study upon completion in September of 1993

and/or

- b). to be contacted if subjects are needed for future research

or

- c). no further contact with the researchers

If you selected option a). and/or b). please fill out the following information in order to be contacted in the future.

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Please keep in mind that the address you give must be valid as of September 1993 in order for us to send you a copy of the study. The above information will only be kept until we use it (i.e., until we phone or write you). For the sake of confidentiality, it will then be destroyed.

## Vita Auctoris

Julie Fraser was born to Yvonne and Cameron Fraser on January 3rd., 1966, in Peterborough, Ontario. In 1985 she graduated from Northwestern Secondary School in Stratford. She received a Joint Honours B.A. in Psychology and Music at the University of Waterloo in 1990. Since 1991, she has been a graduate student in the adult clinical psychology program at the University of Windsor.