Sex Roles, Vol. 42, Nos. 7/8, 2000

On the Margin: Power and Women's HIV Risk Reduction Strategies

Hortensia Amaro[1] **and Anita Raj**
School of Public Health, Boston University

HIV risk and prevention research has failed to investigate adequately the effects of gender-related factors such as relationship power, sexual communication, abuse, and gender roles on women's abilities to engage in protective actions. We propose that women's HIV risk from heterosexual transmission is embedded in the context of gender, race/ethnicity, and class oppression. This context has central implications for interpersonal relationship factors relevant to women's HIV risk. We suggest a framework for understanding women's HIV risk within the context of oppression and the role of power in intimate sexual relationships. Three common dynamics of oppression are considered: (1) Silencing, (2) Violence and Fear of Violence, and (3) Internalized Oppression. These dynamics are based on characteristics of oppression discussed in the work of Jean Baker Miller on gender, Hussain Bulhan on race, and Paulo Freire on class. These dynamics are discussed in the context of findings reported in this journal issue and those of other authors. Finally, the discussion identifies common patterns across studies, as well as areas of disagreement and directions for future research and public health prevention efforts.

> Never doubt that a small group of thoughtful committed citizens can change the world. Indeed, it is the only thing that ever has.
>
> *Margaret Mead*

INTRODUCTION

It has become increasingly evident that a two-part framework is necessary to understand HIV risk behaviors in women and to inform HIV preven-

[1]To whom correspondence should be addressed at School of Public Health, Boston University, 715 Albany St., T2W, Boston, Massachusetts 02188-2337.

0360-0025/00/0400-0723$18.00/0

tion strategies for them. This framework locates sexual behavior within a context of gender relations and considers the role of the social construction of race, ethnicity, and socioeconomic factors (Amaro, 1995). Although there has been increased attention to gender in HIV risk reduction research in the last few years, the existing studies have largely been based on individual cognitive-behavioral approaches that stress factors such as perceived risk, HIV knowledge, self-efficacy, and safer sex skills. For many years, research on women's HIV risk behaviors has ignored the dynamics of intimate relationships, male partner attitudes toward safer sex, male-perpetrated violence against women partners, the role of gender-based power, and the role of socioeconomic factors as elements in establishing HIV risk. Recently, some researchers have argued that such gender-based factors do affect the ability of women to engage in self-protective behaviors (Amaro, 1995; De Bruyn, 1992; Ehrhardt & Wasserheit, 1991; Felmlee, 1994; Gómez & Marín, 1996; Heise & Elias, 1995; Mann, Tarantola, & Netter, 1992; Molina & Basinait-Smith, 1998; Quina, Harlow, Morokoff, & Saxon, 1997; Wingood & DiClemente, 1998; Wyatt, 1994; Zierler & Krieger, 1997). This new line of HIV prevention research promises to provide useful information that can inform prevention strategies for American women. This is particularly important for African American women and Latinas,[2] among whom the incidence of HIV infection and AIDS in the United States is most rapidly rising (Centers for Disease Control and Prevention [CDC], 1999).

The studies presented in this issue make a significant contribution by providing empirical work on the association between women's HIV risk and their power in intimate female–male sexual relationships. Quina, Harlow, Morokoff, Burkholder, and Deiter's (2000) study, conducted with a predominantly White, more highly educated population of women, found that those at greatest risk for HIV infection had the least education, the least sexual power (i.e., were not sexually assertive), and a history of abuse. For the predominantly lower socioeconomic status Latina sample of Pulerwitz, Gortmaker, and DeJong (2000), lower relationship power (i.e., less autonomy over sexual decision-making), was not only associated with lower condom use, but also with lower education and relationship satisfaction and higher sexual and physical male partner-perpetrated abuse. Beadnell, Baker, Morrison, and Knox's (2000) study, which compared the HIV risk of women in battering relationships with the risk of those in relationships without such abuse, also found that abused women were more likely to report traditional sex roles, involvement with sex trade, involvement with a risky

[2]The term Latina is used interchangeably with the term Hispanic to refer to women of Latin American cultural heritage based in a mixture of Spanish, African, and indigenous linguistic and cultural roots. While most national data sources use the term Hispanic, we use the term Latina because it is the term with which the population of interest most often identifies itself.

partner, substance use, non-condom use, experience of coercive sex, and/or psychological distress. In addition, battered women reported lower perceptions of control over safer sex, lower self-efficacy in sexual negotiation, lower self-esteem, lower socioeconomic status, and lower likelihood of participating in an HIV intervention. Similarly, Gutiérrez, Oh, and Gillmore (2000) found in their study with adolescent girls and boys that there is a link between disempowerment and risk for girls, especially African American girls, although not boys, the latter regardless of race/ethnicity. Further, these authors found that perception of girls' power varies across domains. Girls in their study perceived themselves as having less interpersonal power (i.e., influence over relationship decision-making), but not significantly less personal or relationship power (i.e., personal strength and individual capability or perceptions of control over self in the relationship, respectively). However, the authors also note that these power variables, which contributed to a model explaining HIV risk, were less important than other psychosocial variables in explaining risk. These studies all indicate that relationship power is an important contextual variable that shapes women's ability to engage their partners in HIV-related protective behaviors, and gender-based power dynamics in relationships prevent women from initiating and sustaining sexual risk reduction in their relationships. However, as demonstrated by Gutiérrez et al. (2000), power dynamics by themselves are not sufficient to explain risk among women and girls.

Although these cited studies indicate that power is a major factor underlying women's HIV risk reduction practices, results from Bowleg, Belgrave, and Reisen (2000), Castañeda (2000), Simoni, Walters, and Nero (2000), and Wyatt et al. (2000) demonstrate that power is less predictive of sexual risk than is involvement in a relationship, the latter predictor is due to women's lower HIV risk perceptions when in relationships. Bowleg et al.'s (2000) study with an ethnically diverse sample of adult women found that neither traditional gender roles nor disempowerment were predictive of safer sex self-efficacy, nor were these mediating factors in the associations between safer sex self-efficacy and condom use. Castañeda's (2000) study with Mexican American women and men also assessed how relationship dynamics influenced HIV risk reduction practices, and her findings also demonstrate that risk reduction was less likely in these relationships, although sexual communication was more likely. Simoni et al.'s (2000) study with HIV-positive women found that these women were less likely to use condoms in their relationships with steady partners, regardless of partner HIV serostatus. Further, in newer relationships, these women were additionally less likely to negotiate safer sex with their partner. Wyatt et al. (2000), in their study with ethnically diverse women, found more autonomy in contraceptive decision-making among women who were older, unmar-

ried, African American, contraceptive users, or who had a history of STDs or unintended pregnancy. These authors additionally found that autonomous contraceptive decision-making did not necessarily result in less risky behavior, but more effective use of contraception was often a marker of close relationships and lower risk perceptions. Findings across these four studies indicate that disempowerment is less consequential if women have low HIV risk perceptions and, subsequently, low motivation to practice safer sex due to involvement in a close relationship. However, these findings also demonstrate that healthy close relationships have the potential to facilitate as well as hinder HIV risk reduction, as these women have more open communication with their partner around sexual decision-making (Castañeda, 2000; Simoni et al., 2000; Wyatt et al., 2000). Unfortunately, in practice, facilitation of risk reduction is the less common phenomenon.

Although articles in this issue assess how power dynamics in close heterosexual relationships influence women's sexual risk taking, results of these studies vary. This variance may be attributed to the use of different definitions of power (e.g., sexual assertiveness, abuse, autonomous contraceptive decision-making), different samples and methods (e.g., a self-administered survey with an ethnically diverse adolescent male and female sample, phone interviews with an ethnically diverse adult female sample, or interviewer-assisted interviews with a Latina sample), or different theoretical frameworks underlying the studies—Freire's (1970) participatory empowerment methods, the Sexual Health and Risk Taking Model (Wyatt et al., 2000), the Multifaceted Model of HIV Risk (Harlow et al., 1998). Nonetheless, the integrated findings of these studies help provide a piece of the puzzle as to how the marginalization of women in society and in their heterosexual relationships maintains their HIV risk.

Unfortunately, most of these studies, despite their diversity in racial/ethnic population, fail to address the role of culture in female disempowerment or to provide cultural definitions of female power. The study by Pulerwitz and colleagues (2000), which reports the development and validation of a relationship power scale with Latinas, comes closest to developing a culturally based definition of relationship power. In addition, few studies address the varying sources of women's power, including education, level of contribution to household income, responsibility for unpaid domestic labor, and societal and cultural belief systems regarding women's roles in the relationship. More of them demonstrate the role of socioeconomic status in women's HIV risk through the factors of education and income (Beadnell et al., 2000; Pulerwitz et al., 2000; Quina et al., 2000; Wyatt et al., 2000). Two of the studies show variations in risk behaviors and their predictors based on race/ethnicity (Gutiérrez et al., 2000; Wyatt et al., 2000). However, none of the studies helps us understand how women's

lack of power at the social and structural levels relates to HIV risk among women. Clearly, understanding the dynamics of oppression and how this has direct impact on female autonomy will be key to our understanding the link between power and risk; a framework that helps us conceptualize this link may be useful in helping us move forward with research, practice and policy.

GENDER, POWER, AND WOMEN'S RELATIONSHIPS: IMPLICATIONS FOR THE STUDY OF HIV RISK IN WOMEN

Researchers (Amaro, 1995; Zierler & Kreiger, 1997; National Institutes of Health [NIH] Consensus Panel, 1997) have discussed how women in close relationships may be at increased risk for HIV infection due to disempowerment within these relationships. However, there has been little research defining female disempowerment or making this definition operational to determine its connection to women's HIV risk. As noted earlier, articles in this issue cite data from diverse groups (e.g., race/ethnicity and economic status) and begin to shed light and raise new questions on the role women's power in their relationships plays in shaping their HIV prevention practices. It should be noted, however, that the articles are not consistent in their definitions of power and risk. Thus, our commentary is designed to integrate the findings presented in this journal issue with use of an organizing framework. Our framework is based on a concept of oppression dynamics that can help us to define and operationalize power in a way that can be useful in the development of HIV interventions for women. Although gender-based power differentials in heterosexual relationships can increase women's risk of HIV infection through injection drug use as well as sexual interactions, we will focus on sexual risk taking in our commentary due to space limitations and the focus of the research presented here.

After reviewing the need for new theoretical frameworks in HIV risk behavior research, four topics will be discussed: (1) oppression as an organizing concept for women's HIV risk, (2) characteristics ascribed to the oppressed, (3) dynamics of oppression, and (4) recommendations for future research and public health prevention practice.

NEED FOR NEW THEORETICAL FRAMEWORKS EMPLOYED IN HIV RISK BEHAVIOR RESEARCH

Most studies that have sought to investigate predictors of HIV risk have used models of behavior that do not consider power in relationships

between women and their male partners. Six models are among the most commonly used and critiqued in the literature: Health Belief Model, Theory of Reasoned Action, Social Cognitive Theory, AIDS Risk Reduction Model, Stages of Change Model, and Diffusion of Innovations Theory (see critiques by Amaro, 1995; Auerbach, Wypijewska, & Brodie, 1994; Ickovics & Rodin, 1992; Mann, 1991; Mann et al., 1992; Wingood & DiClemente, 1996; Zierler & Krieger, 1997). The Institute of Medicine's Report on AIDS and Behavior (Auerbach et al., 1994) concludes that

> Despite their conceptual contributions, current theoretical models are limited in their ability to predict risk behavior for two main reasons. First, with respect to sexual behavior, the models are based on the assumption that sexual encounters are regulated by self-formulated plans of action, and that individuals are acting in an intentional and volitional manner when engaging in sexual activity . . . Second, the dominant theoretical models of behavior do not easily accommodate contextual personal and sociocultural variables such as gender and racial/ethnic culture (p. 87).

A serious limitation of theoretical frameworks used in past research has been their inability to account for the individual or combined effects of gender, race/ethnicity, and class oppression, and particularly how these play out in dynamics of intimate relationships. For example, cognitive-behavioral models that have guided HIV research assume that behavior is largely under an individual's control. They fail to account for external factors (e.g., gender roles and gender sexual scripts that prescribe a passive role to women and an active role to men in sexuality) that may shape choices (e.g., lack of economic resources places some women at risk for becoming sex workers and this affects their ability to hold control over where, when, how, and with whom they have sex), expectations (e.g., cultural norms about sex within marriage), and at times the actual physical control (e.g., under situations of sexual assault or threat of harm) that an individual may have to engage in a behavior. We propose that the concept of oppression and its dynamics may provide a useful framework for understanding women's risk for HIV in the context of gender, race/ethnicity, and class. Using the concept of oppression as discussed by Miller (1986) for gender, Bulhan (1985) for race/ethnicity, and Freire & Ramos (1970, 1974) for class, we propose some common dynamics of oppression that have application to understanding women's HIV risk.

The Central Role of Oppression

The social status and roles assigned to groups based on gender, race/ethnicity, and class are profoundly relevant to understanding the nature and dynamics of women's risk of HIV infection and, eventually, in the reduction of such risk. At the center of socially constructed arrangements

are two facts. Certain groups are valued and others devalued, and expectations about appropriate behavior and ability are defined by the dominant and more powerful group (Miller, 1986; Bulhan, 1985; Essed, 1991; Freire, P & Ramos, 1970, 1974; Reid, 1993; Turner & Kramer, 1995). Bulhan (1985) observes that "few human encounters are exempt from oppression of one kind or another. For by virtue of our race, sex, or class, each of us happens to be a victim and/or perpetrator of oppression. Racism, sexism, and class exploitation are the most salient forms of oppression in the contemporary world" (p. vii).

Similarly, Miller (1986), in discussing gender-based oppression, states "We live in an androcentric society—organized in terms of men's experience, how they define it and elaborate on it through 'culture' and 'knowledge'. They hold all of the legitimate leadership, power, and authority. Permanent inequality sets conditions in motion so that one group is dominant and another is subordinate, whether based on class, sex, race, or other characteristic."

Paulo Freire (1970, p. 20) adds that oppression is dehumanizing to both the oppressed and the oppressor, although the latter is in a different manner. The oppressed are dehumanized by being turned from 'subjects' (those who have and create knowledge and act in the world) into 'objects' (those who are known or defined by the oppressor and who are acted upon). Freire refers to the disempowerment of individuals and groups according to social status, which results in lack of ability or power to play an active role in decisions about things that have direct impact on their lives; basic things such as who they are and what they can do are defined by the more powerful group. In language more familiar to psychologists, Reid (1993, p. 143) similarly observes that "Being silenced means having no access to dialogue and decision making. It means that others will set policies and define rules. In psychological research, poor women have been shut out and also shut up, that is, effectively silenced."

For example, the formulation of public health strategies to reduce HIV risk in the most vulnerable women, most of whom are poor and women of color, has not emerged from a discourse that is guided by or includes the voices of those most affected. In Freire's terms, poor women and women of color most affected by the HIV epidemic have been "acted upon" or turned into objects. Rather, those who our society regards as the ones who hold "knowledge" (experts) are the ones whose voices have guided the HIV/AIDS services and public health programs that are applied to poor women and women of color.

Feminist psychologists have long acknowledged that gender, race, and class are "an integral part of our social structures and institutions" (Koss et al., 1994, p. 4; Reid, 1993). Norms and role expectations that support

subordination based on gender (as well as class and race/ethnicity) are transmitted through the family, peers, the workplace, and policy and other social institutions (Koss et al., 1994). To the extent that populations of women most at risk for HIV are affected by oppression based on gender, race/ethnicity, and class, it would be profoundly critical to build an understanding of HIV risk that considers these significant power dynamics. Freire (1970, 1990) stresses that power in the context of oppression includes the prescription of acceptable behavior that is defined by the oppressor. Sexual behavior is shaped by prescribed gender roles, which in all societies are defined largely by the lower status ascribed to women (Ehrhardt & Wasserheit, 1991; Lips, 1999).

Although practitioners of HIV prevention programs internationally have brought attention to these issues for some time, research has lagged in the conceptualization and measurement of these factors. Researchers (Amaro, 1995; Wingood & DiClemente, 1998), as well as those who make and influence policy, have noted the need for more gender-relevant research. For example, the late Jonathan Mann (1991), past Director of the World Health Organization's AIDS Office, critically observed that ''Epidemiology has thus far not succeeded in providing sufficiently powerful understanding of the behavioral determinants of high-risk sexual behavior'' (p. 12). He added, ''Behaviors associated with sexual transmission of HIV are now being linked, at least conceptually, with issues of empowerment, social and economic status, education and age and sex roles'' (p. 12). The AIDS pandemic takes place within this social context and is intrinsically embedded in how gender, race/ethnicity, and class are defined, how resources are allocated, and how scientific activities are carried out (Haraway, 1991).

The framework of oppression invites us to consider the role of social institutions and their participation in oppression. In this case, the social sciences and public health system become important objects of our analysis since it is crucial to understand how these might be misused in the interests of oppression. Gender bias (Miller, 1986), racism (Bulhan, 1985), and class bias (Freire, 1970) in psychological research and public health programs have been well documented in the literature (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970; Reid, 1993; Reiker & Jankowski, 1995; Townsend, 1995; Turner & Kramer, 1995). Concrete examples of the participation of science, psychology, and public health practice in oppression can be found in the history of the eugenics movement (Bulhan, 1985; Galton, 1952; Hasian, 1996; Paul, 1995; Sanger, 1919). The field of public health as an institution has not been exempt as evidenced in its role in the Tuskegee experiment (Jones, 1993), the sterilization campaign in Puerto Rico and among women of color in the United States (Aptheker, 1974;

Health Research Group, 1973; Herold et al., 1986; Lopez, 1985; Rodriguez-Trias, 1984; Schenshul, Borrero, Barrera, Backstrand, & Guarnaccia, 1982; U.S. General Accounting Office, 1976; Warren, Westoff, Herold, Rochat, & Smith, 1986) and the use of racial and ethnic groups in unethical research (Gamble, 1997)

The relatively short history of HIV research has already manifested biases in its treatment of HIV in women. From the onset of HIV prevention research, this bias took the form of the invisibility of women in the research questions posed and the absence of women in the populations studied. A large proportion of HIV prevention research on women initially focused on women as perpetrators of infection (e.g., prostitutes and pregnant women). As studies on women emerged, the issues of gender were largely ignored and generic behavioral theories, not originally developed to study sexual behaviors, were applied to the study of risk factors in women. Many of these studies relied on middle-class students and non-Hispanic White samples—the female groups least affected by HIV/AIDS.

Only recently has a new body of work emerged that has attempted to name, measure, and study gender-specific variables related to women's risk of infection. This area of work is still under development and in need of frameworks that help us to understand the unique role of gender in sexuality and sexual relationships and how these affect women's HIV risk. The work presented in this issue is one of the most recent efforts to develop this area of research. It is our hope that it will contribute to an increasing theoretical dialogue and empirical body of work that elucidates the role of oppression via gender in women's HIV risk.

Characteristics Ascribed to the Oppressed

One of the most common characteristics of oppression is the ascription by the dominant group of negative and disempowering characteristics among the oppressed such as intellectual inferiority, emotional immaturity or oversensibility, or sexual pathology[3] (Broverman et al., 1970; Essed, 1991; Frye, 1983; Reiker & Jankowski, 1995; Townsend, 1995; Turner & Kramer, 1995; Young, 1990). These ascribed characteristics serve a basic function in social control of a group by supporting beliefs of superiority among the dominant group and the internalization of a sense of inferiority, hopelessness, and fatalism among the oppressed group. Women, persons of color, and the poor have been characterized as incompetent, lazy ingrates indifferent to the generous gestures of the dominant class. These groups

[3]For a bibliography of research documenting beliefs and stereotypes of these groups see the Internet note www.yale.edu/implicit/info/bibliography.html/ [1999, October 1].

have been defined as subhuman or infantile, dependent, maladjusted, dumb, passive, of low-level individuation, and unable to abstract or synthesize (Broverman et al., 1970; Bulhan, 1985; Essed, 1991; Freire, 1970; Miller, 1986). Reflections of these socially based ascriptions can be found easily through the history of documented social and medical science (Broverman et al., 1970; Bulhan, 1985; Miller, 1986). Lips (1999), in summarizing research on gender stereotypes, notes that even the positive stereotypes of women have not served them well: ''In keeping with stereotypes of femininity, the ascribed positive qualities are communal ones: *helpful, gentle, kind, understanding.* Yet, when it comes to instrumental, competence-related qualities that people consider necessary for the accomplishment of high-quality work, women are often judged wanting'' (p. 16). Although most of these studies have been conducted with White, middle-class American women, Freire's & Ramos' (1970, 1974), Bulhan's (1985), and Reid's (1993) discussions of stereotypes of class and race indicate that poor women and women of color are also seen as lacking in competence.

The characteristics ascribed to socially subordinate groups both reflect and reinforce the lower power status of these groups. When women deviate from the stereotype and exercise power and authority, they are more likely to receive negative evaluation (Lips, 1999). Several dynamics of oppression have been noted as critical tools for keeping subservient groups in ''their place.'' Because these dynamics can pervasively define the life experiences of lower status groups, they are likely to be relevant to our understanding of the context of HIV risk in women.

Dynamics of Oppression

The marginalization of groups, whether based on gender, race/ethnicity, or class, is carried out through a number of common dynamics that are relevant to the understanding HIV risk among women. These dynamics include (1) Silencing, (2) Violence and Fear of Violence, and (3) Internalized Oppression. This section describes these dynamics and relates them to the realities of women's risk of HIV infection.

Silencing

The silencing of groups can occur in both explicit and implicit ways. Generally this involves discouraging subordinates' full and free expression of their experience, characterizing subordinates falsely, and describes this as the normal or natural situation ordered by higher and better powers

ranging from God to biology (Bulhan, 1985; Freire, 1970; Miller, 1986; Reid, 1993). Reiker and Jankowski (1995, p. 43) point out that the term *silence* refers "to the actual loss of voice, and metaphorically to the silencing or loss of the self," which has been associated with psychological distress evident in many oppressed groups. Silencing also involves systematic exclusion of the life experience and views of subordinates from the culture and from the construction of what is called knowledge (Bulhan, 1985; Freire, 1970; Miller, 1986). An example of silencing in the creation of knowledge is provided by Reid (1993, p. 133). She points out that even feminist theory and research has "been directed to the explication of women's essential experience of gender, as if this could be separated from the confounds of class and race."

The dynamic of silencing has taken place on many levels in relation to women's HIV risk. At the policy level, the lack of attention to the epidemic in women has been well documented (Auerbach et al., 1994; Corea, 1992). Both medical and behavioral research as well as the public health community have largely ignored, or at least given inadequate attention to, the issue of HIV risk in women. Even the definition of symptoms for an AIDS diagnosis demonstrated gender bias. It took the organized voice of those most affected, women with HIV and their advocates, to integrate women's specific symptoms of AIDS into the definition accepted by the medical community. One concrete example of female invisibility within the scientific response to women's risk of infection is the lack of attention given to women-controlled methods of protection. In an editorial in the *American Journal of Public Health,* Malcom Potts (1994) stated, "The most glaring gap in AIDS prevention is the lack of a method a woman can use when she suspects her partner may have a sexually transmitted disease or human immunodeficiency virus (HIV) infection and she cannot compel him to use a condom" (p. 890). The lack of such a method leaves women with one protective behavior, negotiation of condom use, a behavior that under ideal circumstances may lead to condom use by the male partner. Although the female condom is another potential method available to women, it has yet to overcome a number of barriers to broad use including its high cost, limited acceptibility among some groups, low availability, reported discomfort and/or decreased sexual pleasure, aesthetic objections, and mixed acceptability to women and their male partners (Cecil, Perry, Seal, & Pinkerton, 1998; Gilbert, 1999; Liskin & Sakondhavat, 1992). Further, the use of the female condom requires partner cooperation; for this reason it faces some of the same problems as use of the male condom (Cecil et al., 1998; Liskin & Sakondhavat, 1992). Research is needed on the female condom to document the long-term adoption of this method among the women most vulnerable to STDs and HIV (Cecil et al., 1998).

Most studies have primarily documented the initial response to being introduced to the female condom and women's willingness to try it, which may be quite different from their willingness to use it consistently.

Research on microbicides promises to provide a truly female-controlled method that potentially could be low cost, easily available, and broadly adapted (Darroch & Frost, 2000). Yet current research suggests that even if a safe and available microbicide were available, not all women would use it and there would still be a need for use of the male condom (Darroch & Frost, 1999). In addition, research is at least 5 years away from having a safe and reliable microbicide method on the market (Heise, 2000). For these reasons, in fact, behavioral interventions that promote the use of the male condom are currently the major tools for reducing risk in women (NIH Consensus Panel, 1997).

At the individual level, negotiation of condom use takes place within the context of relationships and, more broadly, within the context of social norms that prescribe expected sexual behavior in which women are to be passive and men are to "take the lead" (McCormick, 1994; Perper & Weis, 1987). Thus, to address HIV risk among women, researchers must understand how such gender norms affect women's silencing and the successful strategies that some girls and women develop to regain their voice.

Silencing of girls and women, especially in mixed gender groups, has been documented in studies throughout the life span (Aries, 1976; Brown & Gilligan, 1992; Eichenbaum & Orbach, 1988; Gilligan, Lyons, & Hanmer, 1990; Gilligan, Rogers, & Tolman, 1991; Lips, 1999; Reid, 1993). Social institutions such as the media, family, schools, and work settings reinforce this dynamic. For example, it has been convincingly established that both male and female teachers pay more attention to boys than to girls (Sadker & Sadker, 1985). Many girls who start their educational careers as outspoken are shaped into more passive behavior by the treatment they receive from teachers (Irvine, 1986). The treatment that girls receive in classrooms results in the collective silencing of girls. Many girls "are afraid to speak out about their opinions, nervous about proffering answers in the classroom, intimidated at the prospect of risking failure or disapproval by saying what they think" (Lips, 1999, p. 113).

Later in life, in the context of relationships with male partners, Jack (1991) proposes that gender roles that do not allow women to express their desires and needs in relationships result in silencing as women attempt to establish satisfying connections with male partners. Further, using a scale for Silencing the Self, Jack and Dill (1992) demonstrated that silencing is associated with higher rates of depression in women. Although the application of the concept of silencing to girls and women of color and/or lower socioeconomic class has received mixed results (Lips, 1999), some evidence

of its application to diverse racial/ethnic groups has been reported (Gratch, Bassett, & Attra, 1995). Way's (1995) study of urban, poor, and working class and ethnically diverse girls suggests that there may be varying patterns in the situations and relationships in which girls are silenced. She concludes that "The experience of marginalization in terms of class, gender, and, frequently, race and ethnicity may force urban, poor, and working class adolescent girls to realize that to survive in the world, they will have to speak up" (Way, 1995, p. 124). Yet, Way (1995) notes that speaking out does not generalize to all relationships. Even girls who were outspoken with their friends, teachers, and family members were often not outspoken in their relationship with boys "because they were not sure if they could protect their own feeling or listen to themselves in these relationships" (pp. 121–122). This is consistent with our own study of African American and Latina adolescent girls. This study revealed that, within the context of their relationships with male partners, girls quickly learn that there may be repercussions, such as alienation or even violence, to their speaking out (Weintraub, Lacet, Bonet, & Amaro, 1996).

Thus, both the framework of oppression and empirical evidence suggest that silencing is an important variable to operationalize and to measure in understanding women's relationships with male partners. It seems especially important to investigate the association between silencing and women's HIV risk. Recent studies with women and adolescent girls indicate that they may remain silent about condom use in their relationships due to the stigma attached to asking their partners to use condoms (Holland, Ramazanoglu, Scott, Sharpe, & Thompson, 1992; Worth, 1989). A study of adult African American women suggests that while fear of partner reaction does not seem to affect women's attempts at negotiation, it is associated with lower levels of effectiveness in negotiation as indicated by lower levels of condom use (Raj, Silverman, Wingood, & DiClemente, 1997). Findings from these studies indicate that silencing occurs both internally, when women do not negotiate condom use due to fear of stigma, and externally, when women's attempts to negotiate condom use are ignored by their partners.

Authors of papers in this issue also study variables related to silencing through the operationalization of variables such as gender roles and communication with partners about sex and HIV risk. Although the measures and results do not yet provide definitive answers, we begin to see evidence in some studies of the association between these variables and HIV risk. Bowleg et al. (2000) demonstrate that higher socioeconomic class (as measured through education) is associated with greater use of both expressive (female stereotypical) and instrumental (male stereotypical) gender roles. This suggests that women with lower education have less access to the use

of both of these means of giving voice to their desires regarding influence on sexual partners. Beadnell et al.'s (2000) study also revealed that women in abusive relationships, compared with women whose relationships were not marked by recent physical abuse, reported more traditional sex roles and lower self-efficacy in sexual negotiation, as well as lower perceptions of control over safer sex. Again, these results provide evidence that traditional sex roles may keep women in disempowering relationships from voicing their needs to their male partners.

Communication was also analyzed by many of the articles in this issue, and findings reveal that communication results in a double-edged sword for women seeking HIV prevention within their close relationships. Castañeda (2000) found that women reporting greater sexual communication and decision-making with their partners were more likely to be in close (e.g., longer term, steady, or marital) relationships. However, women in close relationships were also less likely to perceive themselves at risk for HIV infection (Bowleg et al., 2000; Castañeda, 2000) and engage in safer sex practice (Wyatt et al., 2000). Even HIV-positive women were less likely to use condoms in their close relationships, regardless of partner serostatus (Simoni et al., 2000).

Nonetheless, Quina et al. (2000) point out that having voice (communication) within a sexual relationship is determined by the power dynamics of the relationship, with abused (sexually coerced) women reporting significantly lower communication. Furthermore, women with at least one known partner risk had significantly lower levels of communication of HIV-related information and refusal sexual assertiveness. Quina et al. (2000) conclude that a woman's hesitation to express her sexual needs and to discuss HIV risk reduction are based on a woman's understanding of power and interpersonal danger in the particular relationship. The integrated findings of these studies on sexual communication in close relationships reveal two important points. First, women at lower risk for HIV are more likely to communicate with their partner, but still are not likely to use condoms, with the effect that their actions are silenced. Second, women at higher risk for HIV are less likely to communicate with their partner and less likely to use condoms, again with the effect that their voices and actions are silenced.

Violence and Fear

Bulhan (1985), Miller (1986), and Freire (1970) all speak to the role of violence and fear of violence in promoting oppression. As these authors have observed that, in order to support the power of the oppressor, efforts toward freedom of the oppressed are typically suppressed through the use

of constant control by means of violence, threat of violence, or both. Miller (1986) argues that in order to maintain power, members of the oppressor group must make direct force or threat of violence obviously available. They must also make it appear that subordinates have no cause for anger and that there is something wrong with subordinates when they demonstrate anger. Miller also notes that the dominant group behaves in predictable ways: It acts destructively to subordinate groups and restricts the subordinate group's range of actions and reactions to destructive treatment (Miller, 1986).

Viewed in the context of oppression, ''Male violence against women is seen as a manifestation of gender inequality and as a mechanism for the subordination of women'' (Koss et al., 1994, p. 4). Estimates based on the National Violence Against Women Survey reveal that 1.5 million adult American women each year are raped or physically assaulted by an intimate partner (Tjaden & Thoennes, 1998). Indeed, violence perpetuated against women within relationships with male partners is the leading cause of injury to women in the United States (Dwyer, Smokowski, Bricout, & Woarski, 1995). These data clearly establish violence against women as a critical factor to consider in women's heterosexual relationships and their ability to negotiate safer sex. The experience of partner-perpetuated violence is even more common among women who abuse alcohol and/or drugs and among those whose partners abuse these substances (Amaro, Fried, Cabral, & Zuckerman, 1990; Fullilove, Lown, & Fullilove, 1992; Koss et al., 1994).

The dynamic of violence in women's HIV risk has been documented in a number of studies (Axelrod, Myers, Durvasula, Wyatt, & Cheng, 1999; Bowen & Michal-Johnson, 1995; Molina & Basinait-Smith, 1998; Raj & Wingood, 1997; Wingood & DiClemente, 1997). In this journal issue, several of the articles extend our understanding of the association between violence and women's HIV risk. Beadnell et al. (2000), Pulerwitz et al. (2000), and Quina et al. (2000) found that history of physical and sexual abuse is associated with condom use and partner risk. Further, Quina et al. (2000) found that history of sexual abuse, although unrelated to sexual or HIV related communication with their partner, was associated with greater fear of partner reaction to sexual negotiation. In addition, Beadnell et al. (2000) found that women physically abused by their current male partner reported lower self-efficacy in sexual negotiation and increased likelihood of involvement with a risky partner. These findings all indicate either direct or indirect effects of abuse, current and past, on women's HIV risk. Overall, these studies clearly reveal that women currently in an abusive relationship are at greater risk for HIV. However, they perceive and are given less control over their sexual experiences within their close relationships.

Fear is related to violence as a mechanism for marginalization. Fear

is an integral part of the dynamics of oppression and works through self-criticism, self-blame, and fear of selfishness (Miller, 1986). Koss et al. (1994) note that ''Male-perpetuated violence is a major cause of fear, distress, injury and even death toward women in this country'' (p. ix). Miller (1986) points out that fear in women is facilitated by the internalized notions that self-determination is wrong, evil, and destructive, and that fully applying one's self-determination would result in abandonment or chaos. As mentioned previously, research shows that girls remain silent with male partners about their HIV prevention needs; this fear is entrenched in the social stigma attached to condom use and the positive social status attached to women's involvement in a relationship (Holland et al., 1992; Worth, 1989). Although most of the studies in this issue focused on markers of a woman's fear in a relationship (e.g., violence, powerlessness) (Beadnell et al., 2000; Bowleg et al., 2000; Gutiérrez et al., 2000; Pulerwitz et al., 2000; Quina et al., 2000). Quina et al. (2000) addressed the association between a woman's fear of partner response and condom negotiation. They found that women who anticipated a negative partner response to safer sex negotiation were less likely to engage in sexual communication with that partner, an outcome associated with greater sexual risk. However, as mentioned before, although fear silences women, greater sexual communication may still be insufficient to increase use of risk reduction practices for women in close relationships. This is especially valid if there is a partner opposition and history of abuse.

Internalized Oppression

The third mechanism for marginalization of groups is through internalized oppression. Three common sentiments arise in all subordinate groups through internalization of ascribed characteristics: (1) I am weak, (2) I am unworthy, and (3) I have no right or cause to be angry (Miller, 1986). Freire (1970) states that submerged in reality, the oppressed cannot perceive clearly the social order, which serves the interests of the oppressor. In discussing race/ethnicity, Williams, Lavizzo-Mourey, & Warren (1994) describe internalized oppression as the belief by persons of color of the inferiority of their group. West (1993) argues that the long-term effect of racism results in a ''limited capacity to ward off self-contempt and self hatred'' (p. 17). Freire (1970) believed that inaccurate perceptions about the oppressor and of one's group result in feelings of emotional dependence on the oppressor. The oppressed internalize the messages and attributes promoted about them, which can result in the direction of aggression toward one's own group (horizontal aggression) and the oppression of others within one's group.

Although none of the studies in this issue directly assess the role of internalized oppression on women's HIV risk, facets of women's internalized oppression do appear to affect women's perceptions of sexual control. As mentioned previously, several studies indicate that women who may feel at risk for HIV in their newer relationships remain silent in terms of sexual negotiation (Bowleg et al., 2000; Castañeda, 2000; Simoni et al., 2000; Wyatt et al., 2000). These authors suggest that women do not use their voices due to socialization of passive feminine gender roles, fear of partner violence, perceptions of low power, or fear of disrupting relationships when alternative partners may not be readily available. While these markers of internalized oppression were presented in articles from this issue, development of ethnic identity continues to be overlooked as a facet of oppression that may have an impact on women's HIV risk.

A number of researchers who study development of racial and ethnic identity among U.S. 'minority' groups have documented that in early stages of ethnic identity development, oppressed ethnic groups internalize negative views of their group that have been prescribed by the larger, dominant group. This negative internalization may result in an individual not wanting to be seen as a member of his or her own ethnic group (Atkinson, Morten & Sue, 1983; Cross, 1978; Helms, 1990; Kim, 1981; Marcia, 1966; Phinney, 1993; Powell-Hopson & Hopson, 1998; Russell, Wilson, & Hall, 1992). Alternatively, exploration, knowledge, and acceptance of one's cultural group, which have been linked to healthier psychological development, often characterize higher levels of racial and ethnic identity development.

When studying ethnic groups, HIV research has generally categorized individuals solely on their reported ethnic identification. However, groups and individuals are not homogeneous in their ways of coping with the social meaning of being a member of a subservient group, which suggests that this is an important factor to consider and to measure. The responses of groups ascribed lower status in a society are complex and depend on many historical and situational contextual factors. Berry (1984) proposed four strategies adopted by members of nondominant cultural groups in response to domination: (1) integration, (2) assimilation, (3) separation, and (4) marginalization. These strategies have important implications for identity, values, attitudes, and abilities and are expressed in behaviors and social relations. Of these responses, marginalization, which involves disengagement with the culture of origin as well as lack of integration into the new culture, has been associated with the most negative outcomes (Berry, 1984). For example, in a study of illicit drug use, Amaro and colleagues (Amaro, Whitaker, Coffman, & Hereen, 1990) found that Latinos who were highly acculturated, but who were not integrated into the U.S. mainstream (as reflected in their poverty status) had by far the highest rates of

illicit drug use. This literature would suggest that marginalization may be another relevant factor in HIV risk among some women of color. Yet, research on HIV risk behaviors has given little attention to these factors.

CONCLUSIONS AND RECOMMENDATIONS FOR FUTURE RESEARCH AND PRACTICE

The collection of research published in this journal issue is helping to pave the way for greater understanding of the association between female disempowerment and women's health. However, as pointed out in the 1997 NIH Consensus Panel on Interventions to Reduce HIV Risk Behaviors, more research is needed "to understand the role of community expectations of women and power differentials in their relationships with men" (NIH, 1997, p. 18). Yet, many researchers who study adolescent and adult women's HIV risk behaviors continue to ignore the context of gender in women's risk (e.g., Heckman et al., 1996; Jemmott, Jemmott, & Fong, 1998; Kalichman, Hunter, & Kelly, 1992; Kalichman, Kelly, Hunter, Murphy, & Tyler, 1993). Findings from research presented in this volume and in other studies clearly demonstrate that gender-related factors are critical to women's risk and future research needs to incorporate these in order to be useful in public health practice. Future research on HIV risk behaviors and intervention research among adolescent and adult women and men should seek to add to our understanding of how gender shapes HIV risk for both women and men. To avoid doing so is to contribute to the silencing of women's experience and to the denial of the central role of gender, which is one of the most well-documented and powerful social stratification categories.

Integration of the voices of those affected into the knowledge development and intervention process. A first step in responding to the dynamics of oppression is to change the manner in which we create knowledge by allowing the voices of those most affected to inform our work. This will require that we think critically about the mechanisms for generating knowledge and develop methods to incorporate the expertise of affected groups in guiding our research. One potentially promising avenue is the integration of affected individuals and nonscientist community members in scientific review committees. This strategy has been successfully used in the National Institutes of Health review committees for breast cancer research and in the University of California's Universitywide AIDS Research Program.

A second strategy for integrating the voice of affected groups is to develop and test the efficacy and effectiveness of HIV prevention programs that are rooted in popular education approaches (Ferreira-Pinto, 1995;

Freire, 1970; Merideth, 1994; Werner, 1982). For example, the Massachusetts Department of Public Health's HIV/AIDS Bureau has implemented HIV prevention programs throughout the state employing an adult popular education methodology. In this approach, women recruited from the affected communities participate in a process of reflection and critical analyses. Through group discussions they develop their own understanding of how factors such as gender, race/ethnicity, and class impact their daily lives, including their risk of HIV infection.[4] This process, which may take from 4 months to 1 year, leads to the development of community-based actions and special projects initiated and designed by the participants and funded by the health department. The goals of this approach are individual behavior change, as well as social change through the development of local leaders, changes in social norms, and the development of strategies for reducing risk among community members that emerge from the group itself. Evaluating the effectiveness of these interventions on individual- and community-level risk behaviors will present major challenges to researchers. However, evaluation of the process of change involved in these programs could provide valuable information regarding how communities understand and respond to HIV risk.

Research on interventions that target women with a history of abuse. In addition to development of more contextually based programs accounting for the social and political structures in which women's sexual decision-making occurs, programs for women must account for the pervasiveness of historical and current intimate violence in women's lives. Findings from these studies, which are consistent with the proposed theoretical framework, reveal the need to develop effective intervention strategies for women with a history of abuse and those who are currently in abusive relationships. It has been well documented that history of abuse, as well as current abuse in a relationship, are not only common for women, but also major risk factors for unprotected sex and for HIV infection (Cunningham, Stiffman, Dore, & Earls, 1994; Golding, 1996; Harlow et al., 1998; Irwin et al., 1995; Plichta & Abraham, 1996; Thompson, Potter, Sanderson, & Maibach, 1997; Zierler et al., 1991). Yet, most of the tested prevention approaches with women (e.g., Carey et al., 1997; DiClemente & Wingood, 1995; Eldridge et al., 1997; Hobfoll, Jackson, Lavin, Britton, & Shepherd, 1994; Kalichman, Rompa, & Coley, 1996; Kelly et al., 1994; Rhodes, Wolitski, & Thornton-Johnson, 1992; Santinelli et al., 1995; Stevens, Estruda, & Estrada, 1998) do not sufficiently address abuse and may not be appropriate for women

[4]Personal communication (1999) with Dalila Balfour, Program Manager, regarding popular education HIV prevention programs for women funded by the Massachusetts Department of Public Health, HIV/AIDS Bureau.

in such relationships. Prevention approaches for this population may need to focus not only on HIV risk behaviors, but also on post-traumatic stress disorder, depression, anxiety, and social isolation of women with an abuse history (Hans, 1999; McCauley et al., 1995; Roberts, Lawrence, Williams, & Raphael, 1998; Samson, Bensen, Beck, Price, & Nimmer, 1999; Scholle, Rost, & Golding, 1998; Sutherland, Bybee, & Sullivan, 1998). Because women with an abuse history are also more likely to abuse substances (Hans, 1999; McCauley et al., 1995; Roberts et al., 1998), prevention approaches for sexual and drug use risk reduction in women are needed as well.

Interventions and research on male gender norms and HIV risk. Clearly, programs to reduce HIV risk for women cannot solely focus on women if they are to be successful. Women-only programs must address risk factors stemming from male partners and close relationships. However, women-only programs alone are insufficient to address the relationship context. There must also be programs that include male partners, as they are clearly affecting women's HIV prevention practice. This can be done with male-only interventions as well as couple interventions. Evidence (Gilmore, DeLamater, & Wagstaff, 1996; Pleck, Sonenstein, & Ku, 1993; Whitehead, 1997) suggests that adherence to traditional beliefs regarding male gender roles is a major predictor of sexual risk behavior in young men. Yet, we have a limited understanding of heterosexual male sexuality, male gender role norms and beliefs, and male decision-making regarding HIV-related risk behaviors. Public health interventionists also have little expertise in the development of effective strategies to reduce sexual risk behaviors among heterosexual men at risk. A comprehensive strategy to reduce risk of HIV infection in women must include the development of a knowledge base on heterosexual male sexuality and sexual risk taking as well as the development and testing of prevention approaches targeted to men and couples. In addition to understanding how gender as a social variable affects women's risk, we also need to understand how it affects men's risk behaviors. This approach is consistent with an oppression framework, which recognizes that the dynamics of oppression work on both the oppressor and the oppressed.

Use of theoretical frameworks that integrate social-structural factors and cognitive-behavioral factors. Although we recommend the use of a theoretical framework for women's HIV interventions based on the dynamics of oppression, we do not suggest that this requires the negation of individually based factors such as self-efficacy and social outcome expectancies. Research published in this issue provides support for the need for further HIV prevention research that studies individual cognitive-behavioral factors within the context of the larger social dynamics of oppression.

For example, such a model might include cognitive-behavioral factors such as perceived self-efficacy as immediate predictors of HIV risk behaviors while investigating how the underlying contextual factors of silencing, violence and fear, and internalized oppression and resistance affect more immediate cognitive-behavioral factors. This will require that we continue to develop and test measurement instruments that operationalize relationship power, individual autonomy, social and political power, communication within intimate relationships, and internalization of negative ascribed characteristics based on gender, class, or race/ethnicity.

REFERENCES

Amaro, H. (1995). Love, sex and power. Considering women's realities in HIV prevention. *American Psychologist, 50,* 437–447.

Amaro, H., Fried, L., Cabral, H., & Zuckerman, B. (1990). Violence during pregnancy: The relationship to drug use among women and their partners. *American Journal of Public Health, 80,* 575–579.

Amaro, H., Whitaker, R., Coffman, G., and Heeren, T. (1990). Acculturation and marijuana and cocaine use: Findings from the Hispanic HANES. *American Journal of Public Health, 80*(Supplement), 54–60.

Aptheker, H. (1974). Sterilization, experimentation and imperialism. *Political Affairs, 53,* 37–48.

Aries, E. (1975). Interaction patterns and themes of male, female, and mixed groups. *Small Group Behavior, 7,* 7–18.

Atkinson, D., Morten, G., & Sue, D. W. (1983). *Counseling American minorities.* Dubuque, IA: Wm. C. Brown.

Auerbach, J. D., Wypijewska, C., and Brodie, H. (Eds.). (1994). *AIDS and behavior: An integrated approach.* Washington, DC: Institute of Medicine, National Academy Press.

Axelrod, J., Myers, H. F., Durvasula, R. S., Wyatt, G. E., & Cheng, M. (1999). The impact of relationship violence, HIV and ethnicity on adjustment in women. *Cultural Diversity and Ethnic Minority Psychology, 5,* 263–275.

Beadnell, B., Baker, S. A., Morrison, D. M., & Knox, K. (2000). HIV/STD risk factors for women with violent male partners. *Sex Roles,* this issue.

Broverman, I. K., Broverman, D. M., Clarkson, S. E., Rosenkrantz, P. S., & Vogel, S. R. (1970). Sex-role stereotypes and clinical judgements of mental health. *Journal of Consulting and Clinical Psychology, 34*(1), 1–7.

Berry, J. W. (1984). Cultural relations in plural societies: Alternatives to segregation and their socio-psychological implications. In N. Baker Miller and M. B. Brewer (Eds.), *Groups in contact* (pp. 11–27). New York: Academic Press.

Bowen, S. P., & Michal-Johnson, P. (1996). HIV/AIDS: A crucible for understanding the dark side of sexual interactions. In. S. Duck & J. T. Wood (Eds.) Confronting relationship challenges (pp. 150–180). Thousand Oaks, CA: Sage.

Bowleg, L., Belgrave, F. Z., and Reisen, C. A. (2000). Gender roles, power strategies, and precautionary sexual self-efficacy: Implications for Black and Latina women's HIV/AIDS protective behaviors. *Sex Roles,* this issue.

Brown, L. M., & Gilligan, C. (1992). *Meeting at the crossroads: Women's psychology and girls' development.* Cambridge, MA: Harvard University Press.

Bulhan, H. A. (1985). *Frantz Fanon and the psychology of oppression.* New York: Plenum Press.

Carey, M. P., Maisto, S. A., Kalichman, S. C., Forsyth, A. D., Wright, E. M., & Johnson, B. T. (1997). Enhancing motivation to reduce the risk of HIV infection for economically disadvantaged urban women. *Journal of Consulting and Clinical Psychology, 65,* 531–541.

Castañeda, D. (2000). The close relationship context and HIV/AIDS risk reduction among Mexican Americans. *Sex Roles,* this issue.
Cecil, H., Perry, M. J., Seal, D. W., & Pinkerton, S. D. (1998). The female condom: What we have learned thus far. *AIDS and Behavior, 2,* 241–256.
Centers for Disease Control and Prevention. (1999). *HIV/AIDS Surveillance Report: Midyear Edition, 11,* 3–42.
Corea, G. (1992). *The Invisible Epidemic.* New York: Harper/Collins.
Cross, W. E., Jr. (1978). The Thomas and Cross models of psychological nigrescence: A literature review. *Journal of Black Psychology, 4,* 13–31.
Cunningham, R. M., Stiffman, A. R., Dore, P., & Earls, F. (1994). The association of physical and sexual abuse with HIV risk behaviors in adolescence and young adulthood: Implications for health. *Child Abuse and Neglect, 18,* 233–245.
Darroch, J. E., & Frost, J. J. (2000). Women's interest in vaginal microbicides. *Family Planning Perspectives, 31,* 16–23.
DeBruyn, M. (1992). Women and AIDS in developing countries. *Social Science and Medicine, 34,* 249–262.
DiClemente, R. J., & Wingood, G. M. (1995). A randomized controlled trial of an HIV sexual risk-reduction intervention for young African-American women. *Journal of the American Medical Association, 274,* 1271–1276.
Dwyer, D. C., Smokowski, P. R., Bricout, J. C., & Woarski, J. S. (1995). Domestic violence research: Theoretical and practice implications for social work. *Clinical Social Work Journal, 23,* 185–198.
Ehrhardt, A. A., and Wasserheit, J. N. (1991). Age, gender, and sexual risk behaviors for sexually transmitted disease in the United States. In J. N. Wasserheit, S. O. Aral, and K. K. Holmes (Eds.), *Research issues in human behavior and sexually transmitted diseases in the AIDS era* (pp. 97–121). Washington, DC: American Society for Microbiology.
Eichenbaum, L., & Orbach, S. (1988). *Between women: Love, envy, and competition in women's friendships.* New York: Viking.
Eldridge, G. D., St. Lawrence, J. S., Little, C. E., Shelby, M. C., Brasfield, T. L., Service, J. W., & Sly, K. (1997). Evaluation of the HIV risk reduction intervention for women entering inpatient substance abuse treatment. *AIDS Education and Prevention, 9*(Supplement 1), 62–76.
Essed, P. (1991). *Understanding everyday racism.* London: Sage.
Felmlee, D. H. (1994). Who's on top? Power dynamics in romantic relationships. *Sex Roles, 31,* 275–295.
Ferreira-Pinto, J. B. (1995). HIV/AIDS prevention among female sexual partners of injection drug users in Cuidad Juarez, Mexico. *AIDS Care, 7,* 477–488.
Freire, P. (1970). *Pedagogy of the oppressed.* New York: Seabury Press.
Freire, P., & Ramos, M. B. (1974). *Education for critical consciousness.* New York: Continuum.
Frye, M. (1983). Sexism. In *The politics of reality: Essays in feminist theory* (pp. 17–40). Freedom, CA: Crossing Press.
Fullilove, M. T., Fullilove, R. E., Haynes, K., & Gross, S. (1990). Black women and AIDS prevention: A view towards understanding the gender rules. *Journal of Sex Research, 27,* 46–64.
Fullilove, M. T., Lown, E. A., & Fullilove, R. E. (1992). Crackvhos and skeezers: Traumatic experiences of women crack users. *Journal of Sex Research, 29*(2), 275–287.
Galton, F. (1952 [1892]). The comparative worth of different races. In *Hereditary genius: An inquiry into its laws and consequences* (pp. 325–337). New York: Horizon Press.
Gamble, V. N. (1997). Under the shadow of Tuskegee: African Americans and health care. *American Journal of Public Health, 87,* 1773–1778.
Gilbert, L. K. (1999). The female condom in the US: Lessons learned. *American Journal of Public Health, 89*(6, Insert), 1–28.
Gilligan, C., Lyons, N. P., & Hanmer, T. J. (1990). *Making connections: The relational worlds of adolescent girls at Emma Willard School.* Cambridge, MA: Harvard University Press.
Gilligan, C., Rogers, A. G., & Tolman, D. L. (1991). *Women, girls, and psychotherapy: Reframing resistance.* New York: Haworth Press.

Gilmore, S., DeLamater, J., & Wagstaff, D. (1996). Sexual decision-making by inner city Black adolescent males: A focus groups study. *Journal of Sex Research, 33,* 363–371.
Golding, J. (1996). Sexual assault history and women's reproductive and sexual health. *Psychology of Women Quarterly, 20,* 101–121.
Gómez, C., & Marín, B. (1996). Gender, culture and power: Barriers to HIV prevention strategies for women. *Journal of Sex Research, 33,* 355–362.
Gratch, L. V., Bassett, M. E., & Attra, S. L. (1995). The relationship of gender and ethnicity to self-silencing and depression among college students. *Psychology of Women Quarterly, 19,* 509–516.
Gutiérrez, L. M., Oh, H. J., & Gillmore, M. R. (2000). Toward an understanding of (Em)Power(Ment) for HIV/AIDS prevention with adolescent women. *Sex Roles,* this issue.
Harding, S. (1991). 'Strong objectivity' and socially situated knowledge. In *Whose science? Whose knowledge? Thinking from women's lives* (pp. 138–163). Ithaca, NY: Cornell University Press.
Harlow, L. L., Rose, J. S., Morokoff, P. J., Quina, K., Mayer, K., Mitchell, K., & Schnoll, R. (1998). Women HIV sexual risk takers: Related behaviors, interpersonal issues, and attitudes. *Women's Health, 4*(4), 407–439.
Hans, S. L. (1999). Demographic and psychosocial characteristics of substance-abusing pregnant women. *Clinical Perinatology, 26,* 55–74.
Hasian, M. A. (1996). Race and African American interpretations of eugenics. In *The rhetoric of eugenics in Anglo American thought* (pp. 51–88). Athens, GA: University of Georgia Press.
Health Research Group. (1973). *A Health Research Group study of surgical sterilization: Present abuses and proposed regulations.* Washington, DC: Author.
Heckman, T. G., Sikkema, K. L., Kelly, J. A., Fuqua, R. W., Mercer, M. B., Hoffman, R. G., Winett, R. A., Anderson, E. S., Perry, M. J., Roffman, R. A., Solomon, L. J., Wagstraff, D. A., Cargil, v. Norman, D., & Crumble, D. (1996). Predictors of condom use and human immunodeficiency virus test seeking among woman living in inner-city public housing developments. *Sexually Transmitted Diseases, 32,* 357–365.
Heise, L. (1999). *Topical microbicides: New hope for STI/HIV prevention.* Takoma Park, MD: Center for Health and Gender Equity.
Heise, L. L., & Elias, C. (1995). Transforming AIDS prevention to meet women's needs: A focus on developing countries. *Social Science and Medicine, 40,* 931–943.
Helms, J. (1990). *Black and White racial identity: Theory, research, and practice.* New York: Greenwood.
Herold, J. W., Warren, C. W., Smith, J. C., Rochat, R. W., Martinez, R., & Vera, M. (1986). Contraceptive use and the need for family planning in Puerto Rico. *Family Planning Perspectives, 18,* 185–192.
Hobfoll, S. E., Jackson, A. P., Lavin, J., Britton, P. J., & Shepherd, J. B. (1994). Reducing inner-city women's AIDS risk activities: A study of single, pregnant women. *Health Psychology, 13,* 397–403.
Holland, J., Ramazanoglu, C., Scott, S., Sharpe, S., & Thompson, R. (1992). Risk, power, and the possibility of pleasure: Young women and safer sex. *AIDS Care, 4,* 273–283.
Ickovics, J., & Rodin, J. (1992). Women and AIDS in the United States: Epidemiology, natural history, and mediation mechanisms. *Health Psychology, 11,* 1–16.
Irvine, J. J. (1986). Teacher–student interactions: Effects of student race, sex, and grade level. *Journal of Educational Psychology, 78,* 14–21.
Irwin, K. L., Edlin, B. R., Wong, L., Faruque, S., McCoy, H. V., Word, C., Schilling, R., McCoy, C. B., Evans, P. E., Holmberg, S. D., et al. (1995). Urban rape survivors: Characteristics and prevalence of human immunodeficiency virus and other sexually transmitted infections. *Obstetrics and Gynecology, 85,* 330–336.
Jack, D. C. (1991). *Silencing the self: Women and depression.* Cambridge, MA: Harvard University Press.
Jack, D. C., and Dill, D. (1992). The Silencing the Self Scale: Schemas of intimacy associated with depression in women. *Psychology of Women Quarterly, 16,* 97–106.
Jemmott, J. B., Jemmott, L. S., & Fong, G. T. (1998). Abstinence and safer sex HIV risk-

reduction interventions for African American adolescents. *Journal of the American Medical Association, 279,* 1529–1536.
Jones, J. (1993). *Bad blood: The Tuskegee syphilis experiment.* New York: Free Press.
Kalichman, S. C., Hunter, T. L., & Kelly, J. A. (1992). Perceptions of AIDS susceptibility among minority and nonminority women at risk for HIV infection. *Journal of Consulting and Clinical Psychology, 60,* 725–732.
Kalichman, S. C., Kelly, J. A., Hunter, T. L., Murphy, D. A., & Tyler, R. (1993). Culturally tailored HIV-AIDS risk-reduction messages targeted to African-American urban women: Impact and risk sensitization and risk reduction. *Journal of Consulting and Clinical Psychology, 61,* 291–295.
Kalichman, S. C., Rompa, D., & Coley, B. (1996). Experimental component analysis of a behavioral HIV-AIDS prevention intervention for inner-city women. *Journal of Consulting and Clinical Psychology, 64,* 687–693.
Kelly, J. A., Murphy, D. A., Washington, C. D., Wilson, T. S., Koob, J. J., Davis, D. R., Ledezma, G., & Davantes, B. (1994). The effects of HIV/AIDS intervention groups for high-risk women in urban clinics. *American Journal of Public Health, 84,* 1918–1922.
Kim, J. (1981). *The process of Asian-American identity development: A study of Japanese American women's perceptions of their struggle to achieve positive identities.* Doctoral dissertation, University of Massachusetts, Amherst, Massachusetts [cited in J. S. Phinney (1993)]. A three-stage model of ethnic identity development in adolescence. In M. B. Bernal and G. P. Knight (Eds.), Ethnic identity: Formation and transmission among Hispanics and other minorities (pp. 61–79). New York: State University of New York.
Koss, M. P., Goodman, L. A., Browne, A., Fitzgerald, L. F., Puryear-Keita, G., & Russo, N. F. (1994). *No safe haven: Male violence against women at home, at work, and in the community.* Washington, DC: American Psychological Association.
La Guardia, K. (1991). AIDS and reproductive health: Women's perspectives. In L. C. Chen, J. Sepulveda Amor, and S. J. Segal (Eds.), AIDS and women's reproductive health (pp. 17–25). Plenum Press, New York.
Lips, H. M. (1999). *A new psychology of women: Gender, culture, and ethnicity.* London: Mayfield.
Liskin, L. S., & Sakondhvat, C. (1992). The female condom: A new option for women. In J. Mann, D. J. M. Tarantola, & T. W. Netter (Eds.), *AIDS in the world. A global report.* Cambridge, MA: Harvard University Press.
Lopez, I. (1985). *Sterilization of Puerto Rican women in New York City.* Doctoral Dissertation, Columbia University, New York.
Mann, J. (1991). AIDS: Challenges to epidemiology in the 1990s. In L. C. Chen, J. Sepulveda Amor, and S. J. Segal (Eds.), AIDS and women's reproductive health (pp. 11–15). Plenum Press, New York.
Mann, J., Tarantola, D., & Netter, T. (Eds.). (1992). *AIDS in the world.* Cambridge, MA: Harvard University Press.
Marcia, J. (1966). Development and validation of ego-identity status. *Journal of Personality and Social Psychology, 3,* 551–558.
McCauley, J., Kern, D. E., Kolodner, K., Dill, L., Schroeder, A. F., DeChant, H. K., Ryden, J., Bass, E. B., & Derogatis, L. R. (1995). The "battering syndrome": Prevalence and clinical characteristics of domestic violence in primary care internal medicine practices. *Annals of Internal Medicine, 123,* 737–146.
McCormick, N. (1994). *Sexual salvation: Affirming women's sexual rights and pleasures.* Westport, CT: Praeger.
Merideth, E. (1994). Critical pedagogy and its application to health education: A critical appraisal of the Casa en Casa model. *Health Education Quarterly, 21,* 355–367.
Miller, J. B. (1986). *Toward a new psychology of women.* Boston: Beacon Press.
Molina, L. D., & Basinait-Smith, C. (1998). Revisiting the intersection between domestic abuse and HIV risk. *American Journal of Public Health, 88,* 1267–1268.
National Institutes of Health [NIH] Consensus Panel. (1997). Interventions to Prevent HIV Risk Behaviors. *NIH Consensus Statement Online* 1997, Feb 11–13; 15(2), 1–41.

Paul, D. B. (1995). Whose country is this? Eugenics and race. *Controlling human heredity: 1865 to the present* (pp. 97–114). Atlantic Highlands, NJ: Humanities Press.

Perper, T., & Weis, D. L. (1987). Proceptive and rejective strategies of US and Canadian college women. *Journal of Sex Research, 23,* 455–480.

Phinney, J. S. (1993). A three-stage model of ethnic identity development in adolescence. In M. B. Bernal and G. P. Knight (Eds.), *Ethnic identity: Formation and transmission among Hispanics and other minorities* (pp. 61–79). New York: State University of New York.

Piper, A. (1990). Higher-order discrimination. In O. Flanagan & A. O. Rorty (Eds.), Identity, character, and morality: Essays in moral psychology (pp. 285–309). Cambridge, MA: MIT Press.

Pleck, J., Sonenstein, F. L., & Ku, L. C. (1993). Masculinity ideology: Its impact on adolescent males' heterosexual relationships. *Journal of Social Issues, 49,* 11–29.

Plichta, S. B., & Abraham, C. (1996). Violence and gynecological health in women <50 years old. *American Journal of Obstetrics and Gynecology, 174,* 903–907.

Potts, M. (1994). The urgent need for a vaginal microbicide in the prevention of HIV transmission. *American Journal of Public Health, 84,* 890–891.

Powell-Hopson, D., & Hopson, D. S. (1988). Implications of doll color preferences among Black preschool children and White preschool children. *Journal of Black Psychology, 14,* 57–63.

Pulerwitz, J., Gortmaker, S. L., & DeJong, W. (2000). Measuring sexual relationship power in HIV/STD research. *Sex Roles,* this issue.

Quina, K., Harlow, L. L., Morokoff, P. J., Burkholder, G., & Deiter, P. J. (2000). Sexual communication in relationships: When words speak louder than actions. *Sex Roles,* this issue.

Quina, K., Harlow, L. L., Morokoff, P. J., & Saxon, S. E. (1997). Interpersonal power and women's HIV risk. In J. Manlowe & N. Goldstein (Eds.), *Gender and the politics of HIV* (pp. 188–206). New York: New York University Press.

Raj, A., Silverman, J., Wingood, G., & DiClemente, R. (1997, November). *Predictors of relationship abuse among African-American women.* Presented at the 125th Annual Meeting of the American Public Health Association, Indianapolis, Indiana.

Raj, A., & Wingood, G. (1997, May). *The relationship between condom use and fear of conflict resulting from safer sex negotiation among low-income African-American women.* Presented at the 1997 Women and HIV Conference, Los Angeles, California.

Reid, P. (1993). Poor women in psychological research. Shut up and shut out. *Psychology of Women Quarterly, 17,* 133–150.

Reiker, P. P., & Jankowski, M. K. (1995). Sexism and women's psychological status. In C. V. Willie, P. P. Reiker, B. M. Kramer, & B. S. Brown (Eds.), Mental health, racism and sexism (pp. 27–50). Pittsburgh, PA: University of Pittsburgh Press.

Rhodes, F., Wolitski, R. J., & Thornton-Johnson, S. (1992). An experiential program to reduce AIDS among female sex partners of injection-drug users. *Health and Social Work, 17,* 261–272.

Roberts, G. L., Lawrence, J. M., Williams, G. M., & Raphael, B. (1998). The impact of domestic violence on women's mental health. *Australian-New Zealand Journal of Public Health, 22,* 796–801.

Rodriguez-Trias, H. (1984). The women's health movement: Women take power. In V. Sidel & R. Sidel (Eds.), *Reforming medicine: Lessons of the last quarter century* (pp. 107–126). New York: Pantheon.

Russell, K., Wilson, M., & Hall, R. (1992). Embracing whiteness. In K. Russell, M. Wislon, & R. Hall (Eds.), *The color complex: The politics of skin color among African Americans* (pp. 41–61). New York: Doubleday.

Sadker, M., & Sadker, D. (1985). Sexism in the schoolroom of the 80's. *Psychology Today, 19,* 54–57.

Samson, A. Y., Bensen, S., Beck, A., Price, D., & Nimmer, C. (1999). Posttraumatic stress disorder in primary care. *Journal of Family Practice, 48,* 222–227.

Sanger, M. (1919). Birth control and racial betterment. *Birth Control Review, 1919*(February), 11–12.

Santinelli, J. S., Celantano, D. D., Rozsenich, C., Crump, A. D., Davis, M. V., Polacsek, M., Augustyn, M., Rolf, J., McAlister, A. L., & Burwell, L.-W. (1995). Interim outcomes for a community-based program to prevent perinatal HIV transmission. *AIDS Education and Prevention, 7,* 210–220.

Schensul, S., Borrero, M., Barrera, V., Backstrand, J., & Guarnaccia, P. (1982). A model of fertility control in a Puerto Rican community. *Urban Anthropology, 11,* 81–100.

Scholle, S. H., Rost, K. M., & Golding, J. M. (1998). Physical abuse among depressed women. *Journal of General Internal Medicine, 13,* 607–613.

Simoni, J. M., Walters, K. L., & Nero, D. K. (2000). Safer sex among HIV+ women: The role of relationships. *Journal of Sex Role,* this issue..

Stevens, S. J., Estruda, A. L., & Estrada, B. D. (1998). HIV sex and drug risk behavior and behavior change in a national sample of injection drug and crack cocaine using women. *Women and Health, 27,* 25–48.

Sutherland, C., Bybee, D., & Sullivan, C. (1998). The long-term effects of battering on women's health. *Women's Health, 4,* 41–70.

Thompson, N. J., Potter, J. S., Sanderson, C. A., & Maibach, E. W. (1997). The relationship of sexual abuse and HIV risk behaviors among heterosexual adult female STD patients. *Child Abuse and Neglect, 21,* 149–156.

Tjaden, P., & Thoennes, N. (1998, November). *Prevalence, incidence, and consequences of violence against women: findings from the national violence against women survey.* National Institute of Justice/Centers for Disease Control and Prevention: Partners in Research on Violence Against Women. Washington, DC: U.S. Department of Justice, Office of Justice Programs.

Townsend, J. (1995). Racial, ethnic, and mental illness stereotypes: Cognitive process and behavioral effects. In C. V. Willie, P. P. Reiker, B. M. Kramer, & B. S. Brown (Eds.), Mental health, racism and sexism (pp. 51–118). Pittsburgh, PA: University of Pittsburgh Press.

Turner, C. B., & Kramer, B. M. (1995). Connections between racism and mental health. In C. V. Willie, P. P. Reiker, B. M. Kramer, & B. S. Brown (Eds.), Mental health, racism and sexism (pp. 3–26). Pittsburgh, PA: University of Pittsburgh Press.

U.S. General Accounting Office. (1976). *Report to Honorable James G. Abourezk,* B164031 {5}, November.

Warren, C. W., Westoff, C. F., Herold, J. M., Rochat, R. W., & Smith, J. C. (1986). Contraceptive sterilization in Puerto Rico, *Demography, 23,* 351–356.

Way, N. (1995). ''Can't you see the courage, the strength that I have?'' Listening to urban adolescent girls speak about their relationships. *Psychology of Women Quarterly, 19,* 107–128.

Weintraub, T. A., Lacet, B., Bonet, C., & Amaro, H. (1996, November). *Violence: A pervasive reality for high risk adolescent girls.* Presentation at the American Public Health Association Conference, New York.

Werner, D. (1982). *Helping health workers learn: A book of methods, aids and ideas for instructors at the village level.* Berkeley, CA: Hesperian Foundation.

West, C. (1993). *Race matters.* Boston. Beacon Press.

Whitehead, T. (1997). Urban low-income African American men, HIV/AIDS, and gender identity. *Medical Anthropology Quarterly, 11,* 411–447.

Williams, D. R., Lavizzo-Mourey, R., & Warren, R. C. (1994). The concept of race and health status in America. *Public Health Reports, 109,* 26–41.

Wingood, G. M., & DiClemente, R. J. (1996). HIV sexual risk reduction interventions for women: A review. *American Journal of Preventive Medicine, 12,* 209–217.

Wingood, G. M., & DiClemente, R. J. (1997). The effects of an abusive primary partner on the condom use and sexual negotiation practices of African-American women. *American Journal of Public Health, 87,* 1016–1018.

Wingood, G. M., & DiClemente, R. J. (1998). Relationship characteristics and gender-related factors associated with non-condom use among young adult African-American women. *American Journal of Community Psychology, 26,* 29–51.

Worth, D. (1989). Sexual decision-making and AIDS: Why condom promotion among vulnerable women is likely to fail. *Studies in Family Planning, 20,* 297–307.
Wyatt, G. E. (1994). The sociocultural relevance of sex research: Challenges for the 1990s and beyond. *American Psychologist, 49,* 748–754.
Wyatt, G. E., Vargas Carmona, J., Burns Loeb, T., Guthrie, D., Chin, D., & Gordon, G. (2000). Factors affecting HIV contraceptive decision making among women. *Sex Roles,* this issue.
Young, I. M. (1990). Five faces of oppression. In I. M. Young (Ed.), *Justice and the politics of difference* (pp. 39–63). Princeton, NJ: Princeton University Press.
Zierler, S., Feingold, L., Laufer, D., Velentgas, P., Kantrowitz-Gordon, I., & Mayer, K. (1991). Adult survivors of childhood sexual abuse and subsequent risk of HIV infection. *American Journal of Public Health, 81,* 572–575.
Zierler, S., & Krieger, N. (1989). Reframing women's risk: Social inequalities and HIV infection. *Annual Review of Public Health, 18,* 401–436.