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A Cultural Perspective on Sexual Health: HIV Positive and Negative Monolingual Hispanic Women in South Florida

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Abstract

This study explored feelings and attitudes with regard to HIV and sexual health among 82 monolingual Spanish-speaking, HIV-positive ($n = 30$) and at-risk women ($n = 52$), participating in the NOW en Español Project—a cognitive behavioral sexual risk-reduction intervention in Miami, Florida. Hispanic cultural values and beliefs, such as machismo, marianismo, and sexual silence, emerged throughout the intervention as important determinants of sexual behavior.

Recommendations for integrating these culture-specific issues in sexual health interventions for Hispanic women are provided.

Keywords

Hispanic women; culture; beliefs; values; sexual risk; HIV

Heterosexual transmission remains the principal source of HIV infection among women in the United States, accounting 80% of the newly diagnosed HIV/AIDS cases (Centers for Disease Control and Prevention [CDC], 2007). Seventy-six percent of HIV/AIDS infection cases reported in 2008 among Hispanic women in Miami-Dade County were through heterosexual contact (Florida Department of Health [FDOH], 2008). Minority women are disproportionately represented among HIV and AIDS cases, with 83% of all women who are HIV positive belonging to a minority group (CDC, 2007). Although minority women have shown the largest increase in rates of new AIDS cases in the United States, they remain relatively understudied.

Among Hispanics in Florida and Miami-Dade County, diagnosed HIV cases increased by 76% and 14%, respectively, between 1999 and 2008 (FDOH, 2008). With a population of 2.4 million, Miami-Dade County is primarily Hispanic (1.5 million). In more than half of the Miami-Dade County households, Spanish is routinely spoken, contributing to a complex dynamic of bilingualism and biculturalism among Hispanics in South Florida (U.S. Census Bureau, 2006).

Cultural values and beliefs influence the experiences of Hispanic women living with and at risk for HIV infection. Understanding both shared and diverging values and beliefs among Hispanics is critical, especially to the process of developing strategies for sexual risk-reduction interventions for monolingual Spanish-speaking Hispanic women. Sociocultural factors common to Hispanics may explain patterns of sexual behavior, which increase risk in this population. For instance, many women would risk having HIV infection rather than diminish their reproductive capacity and jeopardize their relationships (Panozzo, Battegay, Friedl, & Vernazza, 2003; Zorilla, 1999). Hispanic cultural norms prescribe submissive roles for women and domineering roles for men, which may explain why some women are aware of their risk of HIV infection, yet are unwilling to discuss or demand safer sex from their partner, fearing emotional and/or physical abuse or withdrawal of financial support (CDC, 2008). Thus, despite behavioral interventions, informational campaigns, and HIV-testing programs, infection rates among Hispanic women continue to increase (Amaro, 2000).

This article seeks to explore the feelings and perceptions about HIV and sexual health among HIV-positive and HIV-negative at-risk Hispanic women who participated in NOW en Español, a cognitive behavioral sexual risk-reduction intervention.

A Cultural Perspective

Prevention studies emphasize tailoring interventions to address the needs, beliefs, and values of specific target populations (Amaro, 1995). For instance, cultural beliefs may affect communication and strategies for prevention, attitudes regarding childbearing, contraception (Bloom, Singh, & Suchindran, 2004; Ehrhardt & Exner, 2000), and fidelity (Hirsch, Higgins, Bentley, & Nathanson, 2002). HIV prevention strategies are often undermined by disempowering social (e.g., marginalization, poverty, racism) and cultural factors (e.g., machismo, sexual silence; Marín, 2003). Results from various studies across the United States with high-risk Hispanics highlight several mediating factors between high-risk behaviors and acculturation: low prevalence of sexual barrier use and HIV testing; low acceptability of sexual barriers (male and female condoms); the influence of poverty, violence, drug dealing, and an environment of illegality; perception of AIDS-related risk; and alcohol use (Deren et al., 1997; Marks, Cantero, & Simoni, 1998; Sabogal & Catania, 1996; Sorensen, Lopez, & Anderson, 2001). For instance, although perceived risk of HIV infection may be low because of misinformation (Kalichman & Cain, 2005), among Hispanic women, avoidance of HIV testing may occur because of fear of ostracism from traditional support systems for bringing “shame” on their family and their community by determining their HIV status (Pederson, 1996).

Assimilating differences between traditional Hispanic culture and modern American lifestyle has become a source of personal and familial conflict for many Hispanics living in the United States. For example, first-generation Mexican immigrants generally maintained their traditional cultural values, whereas second- and third-generation Mexican immigrants tended to adopt the cultural values of their North American peers, often experiencing familial conflicts because of the cultural divide between them and their elders (Falicov, 2005).

In this context, acculturation represented the degree to which an individual from one culture adapts to the ways of life, customs, values, mores, and languages of the host culture (Berry, 1980; Sullivan et al., 2007). For this study, most participants were considered to be at a relatively low level of acculturation based on their inability to communicate effectively in English as compared to their fluency in Spanish.

The degree of participant acculturation could affect a woman's perception of sexual health and communication on such topics. Hispanic values centered on family loyalty and unity and supported by cultural beliefs, such as machismo, are often contradicted by American ideals such as individuality, independence, gender equality, sexual freedom, and diversity (Bernal & Shapiro, 2005). These machismo beliefs also reinforce the male-dominated aspect of sexual behavior among the Hispanic community.

Machismo and *marianismo* involve gender stereotypes, valued and sustained within Hispanic culture. Machismo embodies the masculine ideal where the man is proud, aggressive, and dominant. The masculinity of a machismo male is often expressed through sexuality. One study found that machismo men had multiple sexual partners, avoided expressing feelings, resulting in less intimate relationships with partners, took greater risks, and, more often, conceptualized male–female relationships as inherently problematic (Marín, 2003). In contrast, marianismo embodies the feminine ideal, the opposite and complement of male, in which the woman is expected to emulate traditional roles of being tender, devoted, passive, and submissive to the male (Durik et al., 2006; Espin, 1986). Traditionally, Hispanic men are viewed as the head of the household. Characteristics, such as strength, power, and dominance, make a man “macho” and is viewed as a desirable mate (Marín, 2003). Thus, less-acculturated Hispanic women may be the less assertive partner in a relationship, particularly in the context of sexuality.

Other themes central to Hispanic culture include *sexual silence*, *familismo*, *simpatia*, and *personalismo*. The Hispanic community strongly ascribes to the cultural value of sexual silence, the complete suppression of openly discussing sex and sexuality (Amaro & Raj, 2000). Sexual silence stems from beliefs endorsed by both men and women such as women should be less experienced and should know less about sex than men. A woman's knowledge about sex or high level of comfort discussing sexual topics could stigmatize her as promiscuous and “experienced” in sexual matters. This discomfort with talking about sex results in a decreased ability to negotiate sex and condom use (Marín, 2003), and can be a significant barrier to a Hispanic woman's desire to improve her sexual health. Sexual silence perpetuates sexual coercion and inhibits women from discussing sexual issues with their partners such as condom use and extramarital relationships (Marín, 2003; Noland, 2006).

Methods

The NOW en Español intervention was adapted from the parent NOW (New Opportunities for Women) project, a binational study on sexual barrier acceptability among multiethnic HIV-positive women in the United States (Miami, Florida) and Africa (Lusaka, Zambia). The NOW en Español project was created to reach out to an important subpopulation within the Hispanic community in Miami-Dade County: HIV-positive and at-risk, monolingual

Spanish-speaking women. All procedures were approved by the Institutional Review Board of the University of Miami, Miller School of Medicine. Quantitative data on this sample can be found in the study of Villar-Loubet, Jones, Waldrop-Valverde, Bruscantini, and Weiss (2011).

Recruitment

The recruitment of Hispanic women can be a significant challenge when conducting research concerning culturally sensitive issues such as HIV/AIDS. Alvarez, Vasquez, Mayorga, Feaster, and Mitrani (2006) noted various pragmatic barriers to participation, such as poor access to health care, distrust of the medical and mental health professions, lack of health insurance, family responsibilities, and transportation problems. Hispanic participants face additional challenges because of language barriers and anxiety about discussing “negatively perceived health topics” such as sexually transmitted infections and condom use (Larkey et al., 2002).

Study candidates were drawn primarily from hospital outpatient clinics, community health centers, agencies in the Miami-Dade County area, and through participant referrals. Recruiters established relationships with local community organizations and social service agencies serving Hispanic women. Developing a close working relationship with these agencies, caseworkers and outreach counselors, encouraged trust in the project and increased the project’s visibility in the community. Interactions with study candidates required an awareness of and sensitivity to the stigma associated with HIV/AIDS and sexually transmitted diseases (STDs) in the Hispanic community. Recruitment was especially challenging because of confidentiality. HIV-positive women were resistant to enroll when they were informed of their potential participation in group sessions. Study candidates were advised that the groups consisted of both HIV-positive and HIV-negative women and that those who were randomized into the group condition were not required to disclose their HIV status. They were also assured that the group therapists would not discuss individual participants’ health status, unless the participant opted to do so.

Translation: Cultural and Linguistic Adaptation

Prior to the adaptation of the intervention, focus groups with Hispanic women were convened to inform the components of the intervention. Project materials were subjected to a rigorous translation and back-translation process to create a culturally and a linguistically appropriate intervention program for monolingual Hispanic women. The project, including the consent, assessment, and intervention phases, was conducted entirely in Spanish. Intervention manuals, visual materials, and assessment measures were provided in Spanish. The assessors and interventionists were bilingual (i.e., fluent in English and Spanish) and were experienced in working with HIV-positive and at-risk Hispanic women.

To adapt the intervention to the study population, a “cultural brokerage” process was used to address linguistic and cultural considerations. Spanish language project materials were subjected to a rigorous translation and back-translation process to create a linguistically appropriate intervention, addressing the use of different Spanish words by Hispanic subgroups to describe the same object or concept. The cultural brokerage process considered

how the translation reflected the cultural values of the target populations to ensure culturally equivalent meaning, particularly as related to attitudes and beliefs regarding illness, misconceptions about HIV, and level of acculturation. It was theorized that offering the intervention in culturally, as well as linguistically, accurate Spanish would improve the likelihood that less acculturated women could receive significant benefit from the program.

Although Spanish is the common language among Hispanic subgroups, careful linguistic translation was employed to account for the different colloquial Spanish words used to describe the same object or concept; this included words for sexual terms and relationships. Equal consideration was given to cultural values and beliefs regarding illness, HIV, and acculturation. Respectful of Hispanic cultural values, the intervention employed more passive sexual negotiation skills, highlighting awareness of safety issues and risk factors (e.g., physical abuse by male partner, loss of economic support) for the woman and for her children. For instance, in the English language intervention, assertiveness and empowerment were promoted, and women were encouraged to discuss with their partners information on sexual barrier use and the importance of monogamy and limiting the number of sexual partners. The Spanish intervention, reflecting Hispanic cultural mores, adopted a more passive, indirect approach to addressing these issues.

Intervention

The development of the NOW en Español intervention was guided by the theories of reasoned action and planned behavior as predictors of sexual barrier use (Albarracín, Johnson, Fishbein, & Muellerleile, 2001). The theory of reasoned action postulates that intentions influence attitudes and subjective norms, which influence beliefs about behavior (Fishbein & Ajzen, 1975). The theory of planned behavior proposes that perceived behavioral control influences intentions and behavior (Ajzen, 1985). Within this model, the study was designed to influence risk-reduction strategies and future sexual behavior intentions by increasing knowledge, exposure to and use of sexual barriers, improving sexual negotiation skills, and influencing attitudes and beliefs about individual risk behaviors.

The project targeted psychosocial, behavioral, and environmental factors that might influence the initiation and the maintenance of sexual barriers. Emphasis was placed on group participation, cognitive behavioral approaches to HIV/STD prevention and transmission, reproductive choice, conflict resolution, sexual negotiation, and experiential skill training to increase use of negotiation skills and adherence to sexual barriers. Participants were introduced to various methods to reduce the risk of sexual transmission of STDs, such as abstinence, masturbation, monogamy, and correct and consistent use of male and female condoms.

The intervention employed a closed, structured group session limited to 10 participants. Three monthly, 2-hour sessions were led by two trained therapists. Role-playing techniques were employed as a tool for women to rehearse positive and appropriate communication with their partners. Participants were followed for 12 months to ascertain sustainability of learned sexual risk-reducing behaviors.

The major issues addressed in the intervention included the following:

HIV and Sexual Risk—Individual knowledge of HIV and transmission was assessed during an initial discussion about HIV. Myths and misconceptions were discussed, and women were encouraged to brainstorm problems and to propose solutions. During the cultural brokerage process, the informational components of the intervention were adapted to address common myths and misconceptions among the Hispanic community in relation to HIV/STD transmission and stigma. Questions regarding HIV included, but were not limited to, the following: What do you know about HIV? How can you become infected with HIV? How can you tell if someone has the virus? How could you be certain that someone does not have the virus?

Sexual Barriers—Prior experience with sexual barriers was discussed at the onset of the sexual barrier component. Questions included the following: Has anybody in the group or a friend of anyone in the group used male or female condoms? What did you use? What was that experience like? What made you decide to use the product? What do you think it would be like to use this product?

Therapists encouraged discussion of emotional responses (i.e., thoughts, feelings, concerns) that might arise from suggesting the use of male or female condoms to their partners. For some Hispanic women, the thought of discussing the use of male or female condoms with their partner was stressful. With this in mind, the intervention was modified through the cultural brokerage process by placing additional emphasis and time on the woman's emotional response to this suggestion. Sample questions included the following: Do you have any concerns about using male or female condoms with your husband or boyfriend? What kind of thoughts or feelings might women have about using male or female condoms with their husband or boyfriend? How do you think your partner will respond to your request to use a condom (male/female) during sex?

The women were provided with the opportunity to use the sexual barrier products and to discuss their experience with the sexual barriers. Questions asked included the following: What sort of experiences did you have using male and/or female condoms? Were there any problems with the products? How did your partner respond to the use of a male and/or female condom? Do you plan to use either product again? Have you or would you recommend male or female condoms to others?

Sexual Negotiation—Sexual negotiation was an essential component of the sessions. For some Hispanic women, it was common not to discuss sex with her partner and acquiesce to his sexual needs. This, in turn, could contribute to a woman's apprehension to engage in sexual negotiations with her partner. To address this concern through the cultural brokerage process, the intervention was modified in response to Hispanic cultural values by placing additional emphasis and time on role-playing scenarios that women would typically encounter when discussing the use of male or female condoms with male partners. Women were asked to discuss how they might negotiate use of sexual barriers (condoms) with their partner(s). The following questions were asked during the group sessions: In a committed relationship, why might a woman want to protect herself (from STDs and HIV)? What are

the situations in which a woman might wish to protect herself by using a barrier product and not discuss it with her partner? Why might it be a problem to get your partner to agree to use a barrier product? How would your partner feel about using a male condom? How would your partner feel about you using a female condom? What are some of the things husbands or boyfriends may say when we bring up sexual protection?

Qualitative Statements

The statements presented were transcribed and translated from Spanish to English from the audio recordings made during the group intervention sessions with HIV-positive and HIV-negative at-risk Hispanic women. Because of confidentiality issues, the women neither identified themselves in the recordings, nor disclosed their HIV status, unless the woman indicated or implied her HIV status while speaking. Open-ended “grand tour” questions were used to solicit thoughts and feelings on various sexual health topics. Themes were identified through an extensive review of the transcriptions. A collection of topics emerged through the review process, and once they reached the point of data saturation, certain cultural themes became prominent, such as machismo, marianismo, and sexual silence.

Results

Participant Characteristics

The sample ($n = 82$) consisted of 30 HIV-positive and 52 HIV-negative at-risk Hispanic women from South Florida. The average age of the sample was 44 years old, $SD = 12.05$. The women identified themselves as Central American ($n = 38$), South American ($n = 17$), Puerto Rican ($n = 15$), and Cuban ($n = 12$). Only 13% ($n = 11$) of the sample were born in the United States. Of those women born outside of the United States, 36% ($n = 25$) were from South America, 31% ($n = 22$) were from Central America, 29% ($n = 20$) were from the Caribbean, and 4% ($n = 4$) were from other areas. The average age of immigration to the United States was 31 years ($SD = 12.08$).

More than half of the participants were Catholic (56%, $n = 46$) and 51% attended church services on a regular basis ($n = 41$). Sixty-four percent of the women were unemployed ($n = 53$), with 18.3% on disability ($n = 15$). The average income level was less than \$5,000 annually (54%, $n = 44$), and the average level of educational attainment was 10th grade or equivalent ($SD = 3.63$). Participants reported marital status at baseline as single (36%, $n = 29$), married (35%, $n = 28$), separated (11%, $n = 9$), divorced (11%, $n = 9$), and widowed (6%, $n = 5$). Almost all the women had children (93%, $n = 76$), and few were raising other people's children (5%, $n = 4$).

Self-reported primary routes of HIV infection for those participants who were HIV positive at baseline assessment ($n = 30$) were sexual intercourse (77%, $n = 23$) and blood transfusion (13%, $n = 4$). The remaining participants (10%, $n = 3$) reported that they were unsure how they became infected with HIV. Average length of time since HIV diagnosis to baseline assessment was 10 years ($SD = 4.93$). Nineteen years was the longest time since diagnosis ($n = 2$), and the most recent diagnoses were within 4 years ($n = 2$).

Intervention Themes

Themes salient throughout the intervention were identified following the review of audio recordings to identify categories related to sexual health. Some participants found the educational component of the intervention most useful: “I didn’t know about my reproductive cycle, but now I know how to protect myself if I’m not ready for another pregnancy.”

Therapists frequently encountered misconceptions about HIV and condom use held by both HIV-positive and HIV-negative at-risk women: “I’m really careful ... I’m always on top of my menstrual cycle because I’m afraid of bleeding onto the floor or on the toilet seat and passing on what I have (HIV) to someone else.” “It’s important to take care of yourself, but we don’t have to use condoms anymore because I know I won’t take his life (since both are HIV positive).” “So you can’t use two male condoms at the same time? That’s good to know. I’m going to tell people I know, because my partner likes to use two condoms. Next time, I’ll tell him not to.” “And what if someone in the family is HIV positive? Can you become infected by drinking from the same cup?” Myths and misconceptions were addressed during the HIV education component of the intervention.

Impact of HIV on Relationships—A common theme during group sessions involved the impact of being HIV positive has on sexual desire and, ultimately, its effect on a romantic relationship: “HIV has really affected me sexually. I’ve lost any sexual desire, I’ve lost it, and I’m scared of losing my husband because I’m not having sex with him.” Other HIV-positive women expressed their fears of infecting men who refused to use sexual barriers: “I’m doing well right now, and I’ve been healthy for 12 years, but if I infected someone else and they died, how could I cope with that? It can happen.” One woman described her distress:

It’s hard for me because I’ve had partners that I’ve told about my condition [HIV positive], and some men still don’t want to take care of themselves [use condoms], so I feel like my vagina is a terrorist. When a partner tells me he doesn’t care and doesn’t want to use a condom, it makes me feel very sad because I’ve lived 12 years with the virus, and what if I pass it on to my partner and he doesn’t take care of himself or the virus affects him differently and then he dies? I would feel so guilty. These thoughts take away any sexual desires I may have had.

Another woman shared a similar view:

My husband and I were married 10 years before he became HIV positive; and he knew I was HIV positive from the beginning. He would take care of himself sometimes, and sometimes he just didn’t want to [use condoms], and look at what happened to him [he tested HIV positive and died a year later]. My fear is to infect someone. I fear being an instrument of illness to another person.

Other women expressed a significantly different view on infecting men:

I’m not that scared about infecting a man, because most of them cheat on their wives by going out and looking for women in the street. They are to blame and I feel they deserve it [to become infected with HIV]. That’s how I see it. The

problem is that they then will go home and infect their wives who are at home. Almost all of the penises on the street have a woman at home, then they go home and put their wife at risk, and what if she's pregnant? Now they put the baby at risk.

Intense emotions were also elicited when discussing disclosure of HIV status:

I told my husband I was HIV positive after we had been married for 4 months. He was so upset that he hit me. He had never done that before. After three days of arguing, I packed my bags and left the house. I went to my mother's house. We were separated for 4 months when he came looking for me to talk. We walked to the park and sat down on a bench. I started to cry and told him that if he wanted to be with me, he had to take the test [HIV test]. I told him that if he was [HIV] negative, he could forget about us, but that if he was [HIV] positive, we could get back together. That's how it happened ... he tested [HIV] positive and we got back together.

Sexual Barrier Product Acceptability—Some women expressed their preferences for male condoms over female condoms as sexual barriers: "I've used it all [male and female condoms] and the male condom is the most convenient for me." "The female condom doesn't work for me ... when I have used it, I get scared that it's going to stay inside of me. It's very complicated. I like the male condom better." "I had to use it [female condom] two times to learn how to put it on correctly."

Other women experienced relief at having the option to use the female condom: "I feel in control when I use the female condom. My husband didn't even realize I had it on when we had sex." "I like female condoms because [with them] I know that I'm protected."

Women discussed their partner's reactions to male and female condoms: "Many men don't like male condoms, even more than women [dislike them]."

I couldn't use the female condom but since you [group therapist] explained it to us again, I was able to put it on. I liked it as much as the male condom. My partner had never seen it [female condom], and he later told me that he liked it because it didn't feel tight like the male condom.

Culture, Family, and Sexual Health—The dissonance associated with traditional cultural values on sexual health and sexual decision making was reflected in the participant responses to the intervention.

"Many parents think that it's disrespectful of them [son/daughter] to ask them [the parents] questions about sex. I have been talking with my daughter about protection after group." Other women expressed similar experiences with sharing the sexual risk-reduction information with their teenage and adult children, even those who still reside in their country of origin:

After every group session we've had, I've spoken to my sons on the phone [in Nicaragua], and I've educated them on using condoms, and I've told them that I

would send them some condoms and the information on how to use them. Teaching them about this is very important to me because being so far away from them is difficult for me, but I feel that this way, I am doing something good by teaching them how to protect themselves. They don't learn about condoms or STDs in school. My daughters don't know anything about this. When I visit them this year, I'm going to talk to them about this. My daughters are all adults and have their boyfriends, but they aren't married yet. I told my husband that I was going to talk to them so that they could see the huge risk in not taking care of themselves [by not using condoms].

Machismo and Marianismo—The cultural themes of machismo and marianismo emerged throughout the intervention as important determinants of sexual behavior among these women. Their impact on women's sexual experiences and negotiation was clear throughout the intervention:

That's the reason why now many housewives become [HIV] positive, because the man comes home and she doesn't know what he's done on the street. If the woman asks him to wear a condom, he'll get upset, even if he's had sex with other women. All they [men] have to do is get upset, and they win [the argument].

One woman gave condoms to her female friend in an effort to educate and empower her, resulting in unforeseen negative consequences for that friend:

I gave my friend some of the condoms we got here, three condoms. When her husband found them, he got so upset! He even came to my house to ask me why his wife had condoms on her ... he was furious. He didn't believe me when I told him that she was not cheating on him.

Sexual Negotiation and Sexual Silence—Some women actively practiced their sexual negotiation skills outside of the intervention: "I told him [husband] that we had to try it [condom] for the study, and he accepted that." One woman expressed concern over her husband's possible infidelity during a period of separation:

I've been with my husband for many years, but we were separated for some time. Before, I never used condoms with him, but now that we're back together, I've been so scared that it's caused problems for us, because I don't know what he was doing when we were separated. I used to think I had control over him, but now I know that I don't have control over him, and that I don't know what he's doing when he's not at my side. Even though he tells me that he didn't have sex with anyone, I told him that if he wants to have sex with me, he has to use a condom ... and he's using them [condoms].

Other women endorsed experiences and beliefs more consistent with the strongly held Hispanic cultural belief of sexual silence; the complete suppression of openly discussing sex and sexuality (Amaro & Raj, 2000). This 50-year-old woman discussed her reaction to sexual barriers:

I feel the female condom is grotesque ... hanging out of your vagina ... it looks horrible! I can only imagine if my partner saw it on me, he'd lose his erection. I

guess it depends on the person and what generation you're from. Look, my daughter is 22 years old and so is her boyfriend. They've been together for 3 years, and their first sexual experience was with each other. For them, using a condom is normal because they learned about them in school. For them, watching a porno is normal, and they get sexually aroused with it. There's nothing sexually abnormal for them. She tells me, "Mom, for us it's normal, for you it's not, because you were taught that sex was bad." For me, a porno movie is something that is immoral and doesn't excite me [sexually]. For me a condom, I've never used it, so how am I going to start using it now that I'm an older woman?

Beliefs About Illness and Stigma-Related Diseases—Stigma about illness and disease, particularly HIV/AIDS, is deeply ingrained in Hispanic culture. Hispanic families encourage secrecy and are deeply affected by the response of outsiders. Hispanic women approached during recruitment were concerned with issues of confidentiality and being recognized by others while participating in the study. HIV-positive participants feared being randomized to the group condition and being identified by other women as HIV positive. HIV-negative women were equally concerned with overall participation in and association with a project that focused on sexual risk reduction for fear that they would be erroneously identified as HIV positive or sexually promiscuous. The importance and impact of confidentiality in the lives of these women was apparent.

That happens to me with my family, because sometimes I see someone on the street while I'm with my mother. My mom asks me, "And her?" and I say to her, "No, I met her in the cafeteria" or I say anywhere else. And then she'll ask me, "Is she also sick [HIV positive]?" And I say to her, "No mamá, I met her in the cafeteria." I can't tell my mom that she's positive [HIV positive].

Another participant stated:

I have a friend who is not HIV positive, but she knows that I am [HIV positive]. When I see her on the street and she's with someone who doesn't know that I'm HIV positive, she turns away from me as if she doesn't know me. That hurts my feelings, but I don't think she does it because she's ashamed of me but because she's afraid of letting it slip that I'm HIV positive, and then she would break my trust in her.

Many women shared similar experiences with HIV stigma: "I can't stand it when someone knows I have the virus [HIV] and doesn't speak to me. It hurts my heart; it makes me feel as if my heart is being torn apart." Other women discussed their openness with others: "... the whole world knows what I have [HIV] because I am active in the community, and I am not ashamed."

Another HIV-positive woman explained how difficult it is for her to educate others about HIV without disclosing her status or arousing the other person's suspicions of her HIV status:

When I've been put in the position to tell another person that they should get tested [for HIV], they ask me "Why?" I try to teach them about HIV, but they always try

to get personal and want to know why I know so much about the virus. I tell them it's because I've taken classes at the hospital [University of Miami/Jackson Memorial Medical Center]. But it can be really scary for me, because even though I don't want people to know I'm HIV positive, I like to teach as many as I can about the virus. There are so many things that people don't understand. For example, when I say that you can never really know if someone is positive [HIV positive], some people tell me that they can tell because if someone is skinny and looks unhealthy, then they must be sick with AIDS, but if a person is overweight, then she is healthy and doesn't have the virus [HIV].

Beliefs about HIV/AIDS and the associated stigma were recurrent themes throughout the intervention.

Discussion

This study explored the thoughts, feelings, emotions, and attitudes of HIV-positive and HIV-negative, at-risk, monolingual, Spanish-speaking women participating in a group intervention on sexual risk reduction in Miami, Florida. Cultural themes, values, and beliefs, such as *marianismo*, *machismo*, and sexual silence, affected how women communicated about safer sex with their families and sexual partners. In the Hispanic community, more traditional values are typically associated with persons who only speak Spanish, and this, in turn, affects communication about sexual issues in Hispanic families. It was hypothesized that these less acculturated women would have more difficulties in discussing sexual issues within the family.

In accordance with the literature on traditional Hispanic gender roles of *machismo* and *marianismo*, women in this study endorsed the dominant male and submissive female aspect of Hispanic sexual relationships. Men make the sexual decisions in the relationship, and the woman is expected to acquiesce. Alternately, whereas the woman is in control of the household and the children, men are responsible for providing financial support. It has been well documented that financial dependence and the loss thereof is one reason why women may fear communicating about safer sex with their partner (CDC, 2008). The dominance of the *machismo* stereotype and submissive nature of *marianismo* in Hispanic relationships may create a sense of inadequacy among Hispanic women, perpetuating mistrust, fear, lack of freedom of expression, and negative communication among the couple.

Sexual silence is a cultural value that is deeply woven into Hispanic culture. The women in this study were particularly open about their experiences and not being able to discuss sex and sexual protection. In traditional Hispanic families, sexual issues are not discussed openly, and the intervention emphasized opening the lines of communication within families. As described in the literature, sexual silence perpetuates sexual coercion and inhibits the Hispanic woman from discussing sexual issues, such as condom use and extramarital relationships, with her partner (Noland, 2006; Marín, 2003). As noted by Zambrana, Cornelius, Boykin, and Lopez (2004), increasing parent-child communication about protective sexual practices could reduce the child's risk of contracting STDs. It is of interest that one aspect of the women's response to the intervention was to recognize the

importance of these discussions with their children (both adult and teenage) and to initiate these conversations even with children in their home country.

HIV-related stigma was an important determinant of how these Hispanic women interacted with other women and how they perceived themselves. Other Hispanic values well documented in the literature such as familismo, simpatia, personalismo, and religion and spirituality did not emerge as salient themes during the course of this study.

Nonetheless, these cultural values may provide opportunities to influence the attitudes, thoughts, and behaviors of this population. Personalismo, for instance, involves showing respect toward and developing personable relationships with family members, friends, and prominent members of the community. The latter typically includes health care professionals who are viewed as authority figures and, therefore, deserving of respect (Paris, Bedregal, Añez, Shahar, & Davidson, 2004; Santiago-Rivera, 2003). For this reason, it may be of value to encourage health care professionals to *proactively* address sexual risk and barrier options with Hispanic women. It is this avoidance of speaking of uncomfortable topics, such as sexuality and protection, which may serve to keep the Hispanic community at arm's reach from life-saving information such as sexual risk-reduction education. Additionally, conducting a more thorough sexual history during the review process would offer health care providers insight as to a woman's sexual risk behavior.

It is important to point out several limitations of this study. First, the sample size was modest, which limited our ability to focus on differences among the numerous Hispanic subgroups in South Florida (e.g., Cuban, South American, Central American, Puerto Rican, Dominican, Mexican, and others). Second, all qualitative data were collected in a group format; structured qualitative interviews were not conducted. Participant statements were recorded from the group intervention sessions, transcribed and translated from Spanish to English. The transcriptions were then analyzed using content analysis until a theme emerged and became saturated. Combining individual with group qualitative data would strengthen the results and their implications. Third, one could not match the data to a specific individual because of the way the data was collected. Because the statements made during the intervention were audio recorded, the participant making the statement was anonymous to the researcher conducting the qualitative analysis. Therefore, the level of acculturation of each woman could not be related to the individual statements. It would have been helpful to match the level of acculturation to the individual statements to determine the impact of acculturation on the salient themes that emerged.

Despite efforts to inform the various segments of the population about the consequences of unprotected sex, less-acculturated Hispanic women continue to engage in risky sexual behavior. These women may be aware of their partner's sexual risk behaviors, but cultural considerations, embodied in the themes of marianismo, machismo, and sexual silence, prevent them from being able to effectively respond with protective measures.

Future studies with Hispanic monolingual, Spanishspeaking women should consider how to address the inhibitory effects of these cultural values. Involving male partners and

expanding the sexual negotiation component of the intervention may be fruitful avenues to explore in the design of future interventions.

Cultural values and beliefs affect the experiences of Hispanic women living with and at risk for HIV infection. Gaining a better understanding of these cultural values and beliefs may enable health care providers and therapists to use them as the foundation for the development of more effective sexual risk-reduction interventions for women in Spanish-speaking communities.

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References

- Ajzen, I. From intentions to actions: A theory of planned behavior. In: Kuhi, J.; Beckmann, J., editors. Action control: From cognition to behavior. Springer Publishing; Heidelberg: 1985. p. 11-39.
- Albarracín D, Johnson BT, Fishbein M, Muellerleile PA. Theories of reasoned action and planned behavior as models of condom use: A meta-analysis. *Psychology Bulletin*. 2001; 127(1):142-161.
- Alvarez RA, Vasquez E, Mayorga CC, Feaster DJ, Mitrani VB. Increasing minority research participation through community organization outreach. *Western Journal of Nursing Research*. 2006; 28(5):541-560. [PubMed: 16829637]
- Amaro H. Love, sex, and power. Considering women's realities in HIV prevention. *American Psychologist*. 1995; 50(6):437-447. [PubMed: 7598292]
- Amaro, H. Love, sex, and power: Advancements in research on the context of women's HIV risk; Master lecture presented at the Society for Behavioral Medicine; Nashville, TN. 2000, April;
- Amaro H, Raj A. On the margin: Power and women's HIV risk reduction strategies. *Sex Roles*. 2000; 42:723-749.
- Bernal, G.; Shapiro, E. Cuban families. In: McGoldrick, M.; Giordano, J.; García-Preto, N., editors. Ethnicity and family therapy. 3rd ed.. Guilford Press; New York: 2005. p. 202-215.
- Berry, JW. Acculturation as varieties of adaptation. In: Padilla, AM., editor. Acculturation: Theory, models, and some new findings. Westview; Boulder, CO: 1980. p. 9-25.
- Bloom, SS.; Singh, KK.; Suchindran, CM. The effect of couple communication on the probability of husbands' extramarital sex in North India; Paper presented at meeting of the XV International Conference on AIDS; Bangkok, Thailand. 2004, July;
- Centers for Disease Control and Prevention. CDC HIV/AIDS fact sheet: HIV/AIDS among women. U.S. Department of Health and Human Services, Author; Atlanta, GA: 2007.
- Centers for Disease Control and Prevention. HIV/AIDS among Hispanics/Latinos. U.S. Department of Health and Human Services, CDC; Atlanta: 2008. Retrieved April 2008, from <http://www.cdc.gov/hiv/hispanics/resources/factsheets/pdf/Hispanic.pdf>
- Deren S, Shedlin M, Davis WR, Clatts MC, Balcorta S, Beardsley MM, et al. Dominican, Mexican, and Puerto Rican prostitutes: Drug use and sexual behaviors. *Hispanic Journal of Behavioral Sciences*. 1997; 19(2):202-213. [PubMed: 12292462]
- Durik AM, Hyde JS, Marks AC, Roy AL, Anaya D, Schultz G. Ethnicity and gender stereotypes of emotion. *Sex Roles*. 2006; 54:429-445.
- Ehrhardt AA, Exner TM. Prevention of sexual risk behavior for HIV infection with women. *AIDS*. 2000; 14(Suppl. 2):S53-S58. [PubMed: 11061642]
- Espin, OM. Cultural and historical influences on sexuality in Hispanic/Latina women. In: Cole, JB., editor. All American women: Lines that divide, ties that bind. Free Press; New York: 1986. p. 272-284.

- Falicov, CJ. Mexican families. In: McGoldrick, M.; Giordano, J.; Garcia-Preto, N., editors. *Ethnicities and family therapy*. 3rd ed.. Guilford Press; New York: 2005. p. 229-241.
- Fishbein, M.; Ajzen, I. *Belief, attitude, intention, and behavior: An introduction to theory and research*. Addison-Wesley; Reading, MA: 1975.
- Florida Department of Health. *HIV/AIDS among Hispanics, 2008*. Bureau of HIV/AIDS and MDCHD-HIV/AIDS Surveillance; Florida, FL: 2008.
- Hirsch JS, Higgins J, Bentley ME, Nathanson CA. The social constructions of sexuality: Marital infidelity and sexually transmitted disease-HIV risk in a Mexican migrant community. *American Journal of Public Health*. 2002; 92(8):1227–1237. [PubMed: 12144974]
- Kalichman SC, Cain D. Perception of local HIV/AIDS prevalence and risks for HIV/AIDS and other sexually transmitted infections: Preliminary study of intuitive epidemiology. *Annals of Behavioral Medicine*. 2005; 29(2):100–105. [PubMed: 15823783]
- Larkey LK, Staten LK, Ritenbaugh C, Hall RA, Buller DB, Bassford T, et al. Recruitment of Hispanic women to the Women's Health Initiative: The case of Embajadoras in Arizona. *Controlled Clinical Trials*. 2002; 23(3):289–298. [PubMed: 12057880]
- Marín BV. HIV prevention in the Hispanic community: Sex, culture, and empowerment. *Journal of Transcultural Nursing*. 2003; 14(3):186–192. [PubMed: 12861921]
- Marks G, Cantero PJ, Simoni JM. Is acculturation associated with sexual risk behaviours? An investigation of HIV-positive Latino men and women. *AIDS Care*. 1998; 10(3):283–295. [PubMed: 9828972]
- Noland CM. Listening to the sound of silence: Gender roles and communication about sex in Puerto Rico. *Sex Roles*. 2006; 55:283–294.
- Panozzo L, Battegay M, Friedl A, Vernazza PL. High risk behaviour and fertility desires among heterosexual HIV-positive patients with a serodiscordant partner—two challenging issues. *Swiss Medical Weekly*. 2003; 133(7-8):124–127. [PubMed: 12644959]
- Paris M, Bedregal LE, Añez LM, Shahar G, Davidson L. Psychometric properties of the Spanish version of the Therapeutic Collaboration Scale (TCS). *Hispanic Journal of Behavioral Sciences*. 2004; 26(3):390–402.
- Pedersen, PB. *Counseling across cultures*. 4th ed.. Pedersen, PB.; Draguns, JG.; Lonner, WJ.; Trimble, JE., editors. Sage; Thousand Oaks, CA: 1996.
- Sabogal F, Catania JA. HIV risk factors, condom use, and HIV antibody testing among heterosexual Hispanics: The National AIDS Behavioral Surveys (NABS). *Hispanic Journal of Behavioral Sciences*. 1996; 18(3):367–391. [PubMed: 12320746]
- Santiago-Rivera AL. Latinos, value, and family transitions: Practical considerations for counseling. *Journal of Counseling and Human Development*. 2003; 35:1–12.
- Sorensen W, Lopez L, Anderson P. Latino AIDS immigrants in the Western Gulf states: A different population and the need for innovative prevention strategies. *Journal of Health & Social Policy*. 2001; 13(1):1–19. [PubMed: 11190659]
- Sullivan S, Schwartz SJ, Prado G, Huang S, Pantin H, Scapocznik J. A bidimensional model of acculturation for examining differences in family functioning and behavior problems in Hispanic immigrant adolescents. *Journal of Early Adolescence*. 2007; 27(4):405–430.
- U.S. Census Bureau. American community survey. 2006. Retrieved April 2008 from <http://www.factfinder.census.gov>
- Villar-Loubet OM, Jones DJ, Waldrop-Valverde D, Bruscantini L, Weiss SW. Sexual barrier acceptability among multiethnic HIV-positive and at-risk women. *Journal of Women's Health*. 2011; 20(3):365–373.
- Zambrana RE, Cornelius LJ, Boykin SS, Lopez DS. Latinas and HIV/AIDS risk factors: Implications for harm reduction strategies. *American Journal of Public Health*. 2004; 94(7):1152–1158. [PubMed: 15226136]
- Zorilla, C. Navigating into the new millennium through collaboration; Paper presented at meeting of the 1999 National Conference on Women and HIV/AIDS; Los Angeles, CA. 1999, October;