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Early Life Circumstances as Contributors to HIV Infection

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Abstract

Adolescents may come from family settings that heighten their vulnerability to early sexual initiation, promiscuity and sexual exploitation. To illuminate how this may occur, we present a set of five representative cases of HIV-infected females from a sample of 26 adolescent and young adult HIV-infected females (ages 16–24) enrolled in a study about the adaptive challenges people their age faced living with the disease. Study participants were recruited from five New York City adolescent HIV clinics that provided comprehensive specialty medical and supportive ancillary social services to adolescents and young adults with HIV. Study participants completed a battery of standardized measures, using ACASI, and participated in a semi-structured in-depth interview. Using the qualitative interview data, we illustrate how early life and family circumstances including neglectful or dysfunctional parenting (e.g., low parental supervision), sexual abuse, and unstable housing placed these young women on a risk trajectory for HIV infection.

Introduction

In 2010, there were an estimated 37,225 adolescents and young adults (ages 15–24) living with HIV/AIDS in the United States (CDC, 2011). In 2011, there were there 13,229 new HIV/AIDS cases diagnosed in this age group (CDC, 2011). Reducing new infections among young people requires a better understanding of the factors that place them at heightened risk of acquiring HIV. Given this population's young age, an examination of their early family environment or the settings in which they were raised, and of the quality of the adult supervision and care they received is a useful starting point for understanding these factors. Indeed, in the last two decades, there has been a rapid proliferation of research linking early family environment and adverse life experiences (such as sexual, physical, or emotional

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abuse; unstable housing; or parental substance abuse or mental illness) with subsequent problems including depression, suicide attempts, low-self-esteem, sexual risk behavior, and substance use/abuse (Gudjonsson, Sigurdsson, & Tryggvadóttir, 2011; Joiner et al., 2007; Jones et al., 2010; Shin, Miller, & Teicher, 2013; Teicher, Samson, Polcari, & Andersen, 2009).

Background

Parental Neglect

Early neglect – physical and/or emotional – has been found to be associated with a wide range of negative outcomes in childhood, adolescence and even adulthood (Hildyard & Wolfe, 2002; Jonson-Reid, Kohl, & Drake, 2012). For example, research has demonstrated a relationship between low parental monitoring of children and family conflict on one hand, and increased smoking, alcohol abuse, drug abuse, sexual promiscuity and prostitution on the other (Jonson-Reid et al., 2012; Repetti, Taylor, & Seeman, 2002; Shin et al., 2013; Wilson & Widom, 2008). In adolescence, when children begin spending more time with peers and often experience social pressure to engage in sex, and/or substance abuse, supervision by a parent (or a parent surrogate) becomes increasingly important. When such supervision is absent or lax, the opportunity to engage in risky behaviors can increase. For instance, in a study of the impact of parental monitoring on sexual risk-taking among sexually active Black adolescent females, those who perceived low parental supervision were more likely to engage in sexual risk-taking (DiClemente et al., 2001). Another study of the long-term impact of childhood neglect on African American women at risk for HIV revealed that women who reported neglect in childhood or adolescence had lower self-esteem, held more negative attitudes toward condom use and were involved in a greater number of HIV-related risk behaviors (Klein, Elifson, & Sterk, 2007). In fact, among other family stressors, remarkably high rates of parental abandonment and inadequate parental care or supervision were found in a sample of HIV-infected adolescents (Kadivar, Garvie, Sinnock, Heston, & Flynn, 2006).

Childhood sexual abuse

The relationship of childhood sexual abuse (CSA) to a host of subsequent adverse outcomes has received a great deal of attention by researchers and clinicians alike. Browne and Finkelhor (1986) have noted that while most of the research on the impact of CSA has focused on the long term consequences in adulthood, important short-term consequences that manifest in childhood and adolescence deserve greater attention. Among the short-term effects of CSA is the greater likelihood of developing some inappropriate sexualized behavior including sexual play in children and sexual acting out and promiscuity in adolescents (Beitchman, Zucker, Hood, daCosta, & Akman, 1991; Putnam, 2003). An increased risk for mental health problems (e.g., anxiety, depression, suicidal ideation) and substance use in adolescence and adulthood are also common sequelae of CSA (Beitchman et al., 1991; Dube et al., 2003; Fergusson, McLeod & Horwood, 2013; Hillberg, Hamilton-Giachritsis, & Dixon, 2011; Shin et al., 2013; Wilson, 2010). An association between CSA and earlier initiation of voluntary sexual contact and engagement in sexual practices during adolescence and adulthood, such as prostitution, promiscuity and risky sexual behavior have

also been documented (Roe-Sepowitz, 2012; Saewyc, Taylor, Homma, & Ogilvie, 2008; Senn, Carey, & Coury-Doniger, 2011; Wilson & Widom, 2010). Although the statistical association between sexual abuse in childhood or early adolescence and sexual risk behavior in adolescence or young adulthood has been well documented, much less work has focused on interpreting this association. Among the intervening factors that have been proposed in the literature are: disinhibition (Bornovalova, Gwadz, Kahler, Aklin, & Lejuez, 2008), a diminished ability to accurately appraise risky situations (Smith, Davis, & Fricker-Elhai, 2004), the formation of maladaptive sexual scripts (Browning & Laumann, 1997; Hussen, Bowleg, Sangaramoorthy, & Malebranche, 2012), poor impulse control (Artime & Peterson, 2012), anxious reactions to sex secondary to traumatic sexualization (Paul, Catania, Pollack, & Stall, 2001), the use of escapist and avoidant coping strategies such as substance use (Hamburger, Leeb, & Swahn, 2008; Schraufnagel, Davis, George, & Norris, 2010; Sumner et al., 2010), and a preoccupation with and precocious interest in sex (Finkelhor & Browne, 1985; Trickett, Kurtz & Noll, 2005).

Unstable Housing and Homelessness

Intolerable family conflict or parental abuse are a common reason why young people chose to or have to leave their home which exposes them to physical, sexual and emotional harm (Hyde, 2005; Kral, Molnar, Booth, & Watters, 1997). Some of these end up homeless, whereas others are passed on from one relative to another, facing ongoing instability in their living situation. In a study of almost 700 homeless youth (ages 12–20), conflict with parents or guardians was the most frequently endorsed reason for leaving. This reason was rated as “very important” or “important” by 74% of females and 73% of males (Rosenthal, Mallett, & Myers, 2006).

As Clatts and Davis (1999) suggested, often homeless youth are not “runaways” but rather “castaways” and “throwaways” who are in this predicament because they leave foster care or group homes, they experience neglect and/or abandonment, or their families become homeless. Discussing the impact on youth of being told to leave their home by parents or caretakers, Ringwalt, Greene, and Robertson (1998) noted, “Perceiving themselves to be unwanted at home, it is hardly surprising that their allegiance to social norms of conduct is attenuated and that thrown away youth are more likely to report engaging in a spectrum of self-destructive behaviors” (p.250), such as suicidal behavior and substance use.

Once on the street, youth constitute an extremely vulnerable population who often must trade sex and/or drugs for money or shelter to survive (Milburn, Rotheram-Borus, Rice, Mallet, & Rosenthal, 2006; Walls & Bell, 2011). Survival sex is more prevalent among homeless youth who are not in shelters (Greene, Ennett, & Ringwalt, 1999; Roy, Haley, Leclerc, Boudreau, & Boivin, 2007; Walls & Bell, 2011). A study of homeless youth found that 74% reported (ever) engaging in sex while under the influence of alcohol or drugs (Kennedy, Tucker, Green, Golinelli & Ewing, 2012; Kral et al., 1997; Tucker et al., 2012). Homeless youth are at higher risk than their housed counterparts for exposure to sexually transmitted diseases, physical and sexual victimization, and drug use/abuse (Milburn et al., 2006; Tyler, Whitbeck, Hoyt, & Cauce, 2004). Also, this population has disproportionately

high rates of HIV infection (Beech, Myers, Beech & Kernick, 2003; Kipke, O'Connor, Palmer, & MacKenzie, 1995).

In summary, youth experiencing early life stressors are a population at increased risk for HIV. Further, these risk factors often co-occur (Rutter, 1979; Trentacosta et al., 2008) with the presence of each additional factor adding to the child's cumulative risk for problem behaviors (Trentacosta et al., 2008). Below, data gathered in a qualitative descriptive study of adolescents' and young adults' psychosocial adjustment to living with HIV disease are presented. The focus is on trying to better elucidate how their early life experiences and family context contributed to their vulnerability to HIV infection with the hope that such insights can lead to early recognition of high-risk youth and inform the development of better primary prevention interventions.

Methods

Study Design and Participants

To be eligible for participation in the study, individuals had to: (a) be 13–24 years of age; (b) have been diagnosed as HIV-infected; (c) be cognitively competent to participate; (d) have acquired HIV through sexual or injecting drug use behavior. All participants denied engaging in injection drug use and claimed to have become infected through unsafe sexual practices. Twenty-nine participants (49%) self-identified as female, including three male-to-female transgender individuals not included in the current analysis. Of the 26 females included, 73% identified as heterosexual, 19% as bisexual, and the remaining women did not reply to this item. Most identified as Black (65%), 23% as Hispanic, and 12% as "Other." The mean age of participants at the time of their interview was 21 (range = 16 – 24 years), while at the time of their HIV diagnosis it was 17.6 (range = 15 – 23). Just under one-third of the youth (31%) were enrolled in school at the time of the interview. Only 19% were currently employed, 11% full time and 8% part time. In the present report, we use five cases to illustrate some of the vulnerability factors shared by many of the female participants and how they contributed to becoming infected.

Recruitment and Procedures

Study participants were recruited from five New York City adolescent HIV clinics that provided comprehensive specialty medical and supportive ancillary social services to adolescents and young adults with HIV. Clinic staff members approached and informed patients about study participation during a routine clinic visit. Patients who were severely ill or deemed by their providers not to be developmentally or cognitively capable of providing informed consent or completing the interview questions were not approached or recruited. The majority of those approached chose to be screened, and when found eligible, elected to participate in the study.

Data Collection

After obtaining informed consent, each participant completed a brief survey using audio computer-assisted self-interviews (ACASI) that elicited demographic and behavioral data and also a small battery of psychosocial measures. These included measures of self-esteem,

depressive symptomatology, social support and conflict, HIV stigma, coping, substance use, sexual behavior, HIV disclosure, and self-reported health measures. The average time for completion of the ACASI was 25 minutes. Immediately afterward, each participant took part in a face-to-face, semi-structured in-depth interview aimed at understanding her experiences living with HIV. An interview guide organized around topic areas related to the study aims was used to gather the qualitative data. All interviews were conducted by graduate students who underwent intensive training that included home study materials, meeting with the senior investigators, and mock interviews. The quality of interviewing was monitored throughout the data collection. The interview typically took 3–4 hours to complete (usually with a couple of short breaks) and was audio-taped for later transcription. Each participant received \$50 compensation for her time and \$8 in transportation vouchers.

Data Analysis

An inductive approach was used in the analysis of the data. Analysis began with the development, testing and refinement of a coding scheme that allowed us to systematically identify and conceptually define the themes and sub-themes present in the text, as well as the relationships among them while keeping them in context. The coding scheme had a hierarchical structure. At the highest level were core codes that related to the study's primary analytic foci. Specific aspects or dimensions of the core codes were assigned subcodes. The coding scheme had 3 main domains: background-related codes, codes related to the adaptive challenges the participants confronted in relation to their illness, and codes associated with the age-related developmental challenges they contended with. The application of the coding scheme to all the interview text systematically organized it and facilitated its analysis. ATLAS.ti (Muhr, 1997), a qualitative data analysis software, was used to assist in the coding and data analysis.

Although early life psychosocial vulnerabilities and traumatic experiences were not primary research foci, while constructing the coding scheme, the researchers recognized the salience of these topics and developed two codes and one subcode that were primarily used to extract data for this analysis. These codes were: "Family History," which captured the participants' early family life and background experiences; the code "Trauma," which captured traumatic experiences such as past physical or sexual abuse, rape and other violent assaults; and the subcode of "Old Risk Behavior," capturing sexual risk taking prior to one's HIV diagnosis. In addition to the coding scheme, the research team also constructed analytic profiles for each participant: summaries of their life experiences before and after their HIV diagnosis that also included important biographical facts. These profiles enabled the researchers to contextualize the different forms of early disadvantages (e.g., parental neglect, sexual exploitation, homelessness) that rendered participants psychosocially vulnerable and contributed to their HIV risk behavior.

Findings

The data revealed that approximately 70% of the female sample experienced a variety of exceptional stresses and hardships in childhood and/or adolescence. These adversities stemmed from the actions and inactions of parents or surrogate caregivers who seemed ill-equipped or disinclined to provide the basic emotional and practical support and protection

necessary for safe and healthy development. As a consequence of these circumstances, the narratives of these females participants were replete with the following recurring themes: feeling unwanted, unloved and unlovable; feeling betrayed, disappointed in others, and let down; feeling their relationships with parents and caregivers were perpetually conflicted, insecure and impermanent. The cases presented illustrate how the participants' attempts to deal with these feelings left them vulnerable to emotional and sexual exploitation that resulted in their becoming HIV infected.

A 21-year-old female participant (#208), born in the Caribbean and diagnosed at age 16, described how when she was three years old her mother, father, and older sister emigrated to the U.S. leaving her behind to be raised by her grandparents. By the time she came to the U.S. at age 11, her parents were no longer living together, and she moved in with her mother. A year later, her father died, depriving her of the opportunity to build a meaningful relationship with him as she was entering adolescence. She learned at the time of his death that he had had AIDS. Subsequently, her mother was evicted from her NY apartment, and over the past 5 years, the participant had lived in a variety of places with different people. She reported:

And from 2000 to now [2005], I've been from house to house. I never had a stable place. ...I lived with so much people from 2000 to now it's ridiculous. I lived with my boyfriend I got – then I lived with my grandmother, my friend – I never had a stable place after that, always on the run.

The participant indicated that she did not feel close to anyone in her family. She did not consider her mother or sister "immediate family" because she could not rely on them for advice, emotional or practical support. Although the participant, her mother, and her sister had been once again living together for the past few months, there was very little communication between her and them and she did not feel they had a trusting relationship. As a result, she had not disclosed her HIV-positive status to either one because she was concerned that they might violate her confidence and share her status with others. She attributed the emotional distance between her and her mother to their long separation early in her life which prevented them from forming a strong bond, an opportunity her older sister was fortunate to have. She said:

My mother and my sister is real close. ...I guess that's the problem. Because she grew up with my mother, they're close, and I didn't make up here until I was 11.

Prior to her HIV diagnosis she described herself as a "mean" person who would "cuss out" people who said something she didn't like and was "looking for a fight". She would often get in fist fights with females peers. She reported that her mother although aware, chose to minimize or even ignore these problems.

The participant became sexually active young and was pregnant at age 14. When she disclosed her pregnancy to her mother, the later indicated she was embarrassed and did not show any compassion or understanding of how frightening this must have been for such a young girl. She beat the participant and a blow in her stomach led to bleeding, complications and abortion.

Significantly, the one individual the participant said she felt close to and shared her feelings with was her 49-year-old former boyfriend with whom she had had a 5-year relationship. According to the participant, this man had fathered 23 children with 13 different women. When describing her relationship with this older man, she referred to the loss of her father and to her search for a relationship with a loving adult male figure:

The only person I'm close to is my ex-boyfriend. ... We haven't been together for five years and I'm still close with him. ... He's my father because he's older than me ... that's the kind of relationship we have, like a father-daughter relationship. He will be 49 this year ... We were like best friends for like a year – like I told you, I came up here in '96 and my father died in '97 so I never had a father figure. And he was older than me, so we was always best friends... then we got together.

At the time of the interview, the participant had not yet revealed her HIV-positive status to him or confronted him about his status. However, she felt certain that he had infected her because she claimed she have tested seronegative while with him, was monogamous during their relationship, yet subsequently tested seropositive. Further, he never questioned why she was taking medications; nor had he questioned why she wanted to use condoms when they had previously been having unprotected sex, although she had offered as an explanation that she had stopped using other contraception. Despite believing he had knowingly infected her and that he had concurrent sexual relationships with other women, she maintained her relationship with this much older man for years after her diagnosis. Her anger toward him was short lived, “After I found out my status and, I stayed away from him for like two months. After I stayed away from him for two months, then I moved in with him. I think I was 18.” She lived with him for three years, and finally ended the relationship when she became “tired” of his philandering behavior. Her intent to maintain her relationship with this man seemed to be a clear indication of a strongly felt need for a parental/father figure. Even after the break-up, she described him as her “best friend” and the only person she opened up to and felt supported by. Throughout the interview, the participant expressed ambivalence about breaking up with him and the hope that they could re-establish a relationship even as friends, since they had stopped being sexually active:

But if it's up to me, I would get back with my old boyfriend. Yeah I would get back with him. Me and him is still friends, we still best friends. The reason why – because he's in Trinidad right now. If he was up here, I wouldn't be with my sister ... I'd be by him. ... just friends.

Another 20-year-old Black female participant (#101) diagnosed at age 18, felt that she had never been shown real love by her parents or been a central focus of their attention. Her parents had separated when she was 8 years old. Throughout her childhood and adolescence, she had had to care for her mother, who had chronic health problems related to cancer. Instead of expressing appreciation for her daughter's care, the participant indicated that her mother criticizing her for providing inadequate help.

She reported that when she was 11, her mother's boyfriend began molesting her and an older female cousin who was living with her family. The cousin told the participant's mother and her own mother about the abuse. Both women, however, dismissed the allegations choosing instead to believe that because her cousin had been molested and raped while in foster care,

she was imagining the molestation and had convinced the participant that she was also experiencing molestation. The mother stayed with the boyfriend, even though he was subsequently accused of molesting another female child. At a later time, the participant's mother asked her if the claims of abuse she and her cousin had made about the boyfriend had been true. When she confirmed that they were, her mother beat her with an extension cord. The participant recalled:

And she's [my mother] is like, you know, "Just tell me the truth." And then I told her the truth, and then I got a beating. And I got beaten not with a belt – it was with an extension cord. So I'm like okay I tell you the truth and then you whip my ass with an extension cord. And then her excuse for being with him is, you know, she wanted us to have a luxury life. What luxury? Cable? I could survive with... I don't need that. Cable? A dollar on the dresser before you go to school? No. Because that ain't even gonna get you a beef patty nowadays. So it wasn't – I never understood that. Then she stayed and I had to stay there. Then my sister left, so I ran away. I left.

After running away from home at 15, she lived for three years with friends. At 18, she moved back in with her mother. However, when unaffordable rent increases forced them to leave the apartment, she moved in with a disabled uncle she was close to, but who died a few months later. At the time of the study, she was again temporarily living with friends.

Nine years before the participant was born, her mother had had twin girls with a man who subsequently died. When her mother married the participant's biological father, he adopted the twins. While growing up, she always felt that the twins were given more attention and received preferential treatment by her mother. She also reported that the twins always stuck together, had each other's support while she was left out and felt alone. At the time of her interview, her parents had separated and her father was living with a girlfriend and her young daughter from a previous relationship. Although the participant claimed she had a good relationship with her father and they spoke often, she also complained that he only "shows his love through money." She appeared hurt and disappointed that her father had not invited her to live with him, although she claimed to understand his reasons. Thus the participant felt that both of her parents valued other children more than her; her father even preferring a non-biological child to the participant.

The participant reported that between the ages of 11 and 18 she was a member of a well-known NYC gang and the "only girl in that circle." Asked why she joined the gang, she replied that it provided her with a sense of belonging to a "family": "It was things going on at home. Wasn't nobody there, I felt I couldn't talk to anybody." The gang also gave her the attention she had craved so much at home but never received, "I liked the fame, the attention." The gang might have also offered protection and a sense of safety her mother obviously failed to provide.

She believed she became infected through unprotected sex with an ex-boyfriend. However, she never confronted him and was not sure of his HIV status. He had been physically and verbally abusive toward her, and controlling, at times restricting her communication with family and friends. In retrospect, she believed that while they were together, he was having

concurrent sexual relationships with both men and women. She had not disclosed to anyone her HIV status in part because she worries it would further damage her already blemished reputation.

Another 22-year-old Black heterosexual female participant (#205) lived with her mother growing up but felt a lack of closeness between them because of her mother's strict religious beliefs. She reported that she was unable to discuss "normal things" with her mother without feeling judged. She and her older brother were often left home alone. On one such occasion when she was 10 or 11, she was molested by her brother who was 4 years older and under the influence of alcohol and drugs. When she told her mother what had happened, her mother questioned the brother about the accusation. However, he denied any wrong doing and her mother believed him rather than the participant. Her mother actually slapped her in the face and told her not to lie again. Since that time, she said, she and her brother had not had a close relationship. She was also estranged from her biological father, who lived in the Caribbean.

While growing up the participant indicated that her mother "was out doing her own little thing, so I was basically left on my own". This lack of supervision allowed her at age 13 to be initiated into sexual activity by a 30-year-old man. At the time she was convinced he loved her, and therefore she did not see anything wrong with their having sex. Now more mature she realized how inappropriate his behavior had been, given her youth and their age difference:

I thought I found it [love] but I didn't. My friend's boyfriend that had broke my virginity –he was 30 years old and I was 13 – at that point in time I didn't see nothing wrong with it because I was like okay, he loves me, whatever, whatever ... At that point in time I didn't see nothing wrong with it, but now as I get older I'm like dag, yo, what the hell was on your mind? Or what the hell was he thinking?

The participant called her early teens a "looking for love period" when she had been very sexually promiscuous "just hopping from this guy to that guy to this guy and not caring". She attributed her "promiscuous lifestyle" to both the molestation and a complete lack of parental oversight which enabled her to become sexually "out of control" and ultimately HIV-positive:

I blame the situation that I'm in now [being HIV positive] because – by him [brother] doing that to me [molesting me]...that just led me to the type of life that I was living – because one, I didn't have no guidance [from my mother] and two, stuff like that got introduced to me at such a young age, so after that I just went out of control...because I was living that promiscuous lifestyle...I had no father figure in my life or nothing like that. So I figured it was the right thing to do at the time because basically I was going out there looking for love in all the wrong places, looking for love in other men.

She repeatedly referred to how being deprived of a father's guidance and protection while growing up had been detrimental and contributed to her having many sexual partners. As a result, she indicated not knowing who infected her and stated, "From somebody – some nasty person, probably, that they either didn't know or they just didn't care. ...It was that I

was sleeping with that much people.” Like many other participants, her search for a parent figure that would love her and keep her safe made her vulnerable to sexual exploitation by older men.

Another participant, a 19-year-old Black young woman (#410) diagnosed at age 17, had a 5-month-old son at the time of her interview. She too described a childhood marked by housing instability and inconsistent caregivers. Born in Africa, she had come to the U.S. at age 11. Her father stayed in Africa and she had not seen him since she left, although they still communicated by mail and phone. While growing up, she experienced a history of intense, chronic conflict with her mother, who the participant saw as an excessively restrictive and punitive parent:

And then if you come in like even five minutes late she wouldn't open the door – “What're you doing knocking on my door? Go back to where you came from.” So I'll leave. Every time I'd be gone for like a week or two and she'll have the cops out looking for me talking about [how] I just got up and left. No, you told me go back to where I came from, that's why I left. So I wasn't never really a runaway. But since that's what everybody considers – so I just said I was a runaway. I know I wasn't. She was putting me out. So if you putting me out I'm not gonna come running to you, begging you, because that's what you want. You want somebody to get down on their knees and kiss your feet. No, I'm not doing none of that. So that's why we can't get along.

This young woman felt unwanted and unloved by her mother who “put her out” and told her, “Go back to where you came from”. At one point she lived away from home for 3 months, moving back and forth among her friends' and her aunt's homes. With no parental monitoring, she became sexually active at 13 years old, and at 14 became pregnant and had an abortion. Around that time, her mother filed to have her designated as a Person in Need of Supervision (PINS) and as a result, starting at age 14 she lived in two different group homes until about age 17. The participant admitted that she had a lot of anger at that time and would get into fights with female peers. She attributed her anger and her “reckless” sexual behavior during her teenage years to her feeling betrayed by her family when her mother put her in the group home:

I was reckless. I was running around like a chicken with his head cut off. I was very sexually active, like I always wanted to have sex. I was always cheating on my boyfriend with the next one. But I wasn't having unprotected sex with everyone. And I was always fighting. Like I didn't care. Nothing really meant anything to me. I felt like my family, they betrayed me because they let me go into this system [group home]. Anyway so I felt like it was nothing to look forward to.

She learned that her body got attention from men and used it to feel desired and wanted. “It was mostly like the guys that liked me. They was like, ‘...you pretty, you got big titties, you got a fat butt,’ and all that. But their girlfriends hated me.” She believed she had been infected by her boyfriend, who she had dated on and off for almost 4 years, and who at the time of the interview was in prison. Although she had heard rumors that he was HIV-positive and she confronted him about this, he denied being positive, and so they continued having unprotected sex. When she later diagnosed as HIV-positive, she described felling,

“...mad about it and just hated everybody.” Despite strongly suspecting he had infected her, she did not disclose her status to her boyfriend for several months. When she finally did confront him, at first he again denied being HIV-positive, but eventually admitted that he was infected and claimed he had only lied because he was afraid of losing her. Although initially she felt betrayed by her boyfriend, at the time of the interview, she was planning to marry him after his discharge from prison, despite having another sexual partner who was also HIV positive and was her baby’s father. She had conflicted feelings for her boyfriend, including anger, love, resentment and forgiveness:

Because I love him – like even now me and him is making plans to get married and stuff like that. I believe even if he would’ve told me ahead of time I believe I would have stuck with him. But it’s like I feel that he gave me a death sentence. I mean it’s not really a death sentence, it’s just a wakeup call, but it’s like you did that without my knowledge. You didn’t give me a choice. You was being selfish because you thought you had to do what you had to do for you; you wasn’t thinking about my feelings so you must not really love me that much if you would jeopardize my life like that. And we discussed it and stuff like that. I was mad at him for a while, but I got over it.

Despite recognizing that she has been victimized by this boyfriend, her need to feel desired and loved drives her to convince herself that this relationship fulfills her needs as well:

I’m just a victim. But I still stuck by him regardless. So he now all of a sudden he wants to be all sweet and lovey-dovey and I don’t mind it. That’s what I always wanted anyway.

The only two people she disclosed her status to are her boyfriend and her baby’s father. She had not disclosed it to any of her family members or friends. She described her current relationship with her mother by saying, “It’s not much of a relationship,” adding that very rarely did her mother call to inquire about how she and the baby, her grandchild, were doing.

Another 21-year-old Black female participant (#213), diagnosed at age 19, was pregnant at the time of her interview. She had had a childhood rife with parental neglect. She described her mother as a “crackhead”, which had necessitated her living with her grandmother since she was very young. She felt abandoned by her parents who were no longer together and had gone onto have other children who became their focus. She explained:

So I really don’t have any relationship with my mother that much. She got other kids, so really her attention is on her other kids. And my father he’s, he’s around but he got other kids, so he say, so it’s like he be... we don’t really communicate that much so... Basically since I was living with my grandmother I just learned to survive on my own. Do for my own and all that stuff so.

She had felt unwanted by her grandmother and believed she regarded the participant as a financial burden. Her grandmother rarely gave her any money, “to go get something to eat or go outside just to have money in my pockets...” Further, the grandmother, especially when drunk, verbally abused her and told her she would be alone in her life. The participant recalled:

...when I was living there all she wanted to do was make me stronger which was [by] picking on me and all that stuff. Telling me I ain't gonna have nobody and all that stuff... And then she drink beer too so... I didn't like growing up around that... when she drunk and she get mad... and I be the target of getting picked on...

When young, the participant was also sometimes physically abused by her grandmother. She reported, "When I was growing...I used to get beaten like...for saying I want to, you know, get up and watch TV. You know like just for a stupid thing I used to get beat for."

By the beginning of high school, she was already smoking marijuana and having sex. She reported that she "always had a boyfriend" and spent most of her time "in the streets hanging out" rather than at her grandmother's home. Although she did poorly the first couple of years of high school, she managed to graduate, but afterwards continued smoking, drinking and getting into fights. She had unprotected sex with one brief partner, who she had assumed was "clean" or free of STIs because he had recently gotten out of jail. Soon afterwards she heard a rumor that he had HIV, but when she confronted him about it, he denied it. She believed him, tested negative for HIV, and they continued to have unprotected sex. However, a few months later when she registered for a federal program, the mandatory HIV test came back positive. She felt certain that her partner had known he was positive, but had lied. When she was diagnosed, they were no longer together and she did not confront him about his HIV status or reveal to him her serostatus.

She had not told her grandmother about her disease, or her father, with whom she had had little communication. The family members she had disclosed to were not supportive. Her mother initially made an effort to comfort her, but since then does not discuss the participant's health:

She [her mother] felt a little sad but then she also told me something that she have which is herpes. So in a way I felt a little connection and a little bit better. It still wasn't the same 'cause we don't really talk about nothing...like she only asks me how the baby doing now and that's it. Like she don't ask me how am I doing with my situation and stuff like that.

She felt that her female cousins, who she felt close to before her diagnosis, blamed her for her situation. She said, "...they [her cousins] seem happy that I got it in a way. Cause they, it's like when I do stuff, 'Oh you shouldn't be doing that. You should be careful about that', and stuff like that." She felt betrayed by one of these cousins who revealed to the participant's friends her HIV infection. These friends, the participant felt, subsequently distanced themselves from her and this amplified her social isolation. She had told a previous partner, a 30-year-old man, about her HIV infection who she felt also had begun to take her for granted. She explained:

...I think he was just looking for like something free and stuff like that 'cause once I told him... he started slipping away more... he'll disappear for like two, three weeks and come back and all that stuff... it's like he was like, 'All right she ain't going nowhere... She sick. She ain't going nowhere.'...So it's like he looked at me as something that he could use.

One of the ways she felt he was using her was to stay at her apartment, which she had because of her HIV housing benefits. She added that she believed that many older men took advantage of younger girls, especially once the girls were HIV-infected. At the time of the interview, she was pregnant by a current partner, a 28-year-old man. Although he had advised her not to have the baby because he feared for its health and her not living to raise it, he was still present and made it a point to remind her to take her antiviral medications and to keep her doctor appointments. However, she expected him to eventually abandon her: “He probably just waiting for when I give birth, make sure the baby’s all right and then probably disappear or something.” This expectation, in part, might be attributed to feeling abandoned by her parents, especially her mother, which probably undermined her belief that she was worthy of others’ support.

An indicator of the profound bitterness she still felt toward her mother was when she explained that after her daughter was born if she became unable to care for her, she would rather put the child in foster care than have family members or her mother raise her. She explained:

...I would put her in the system... ‘Cause I really don’t want my family to take care of her. They so negative. I don’t want her growing bad...because the fact that she’s my daughter nobody would be looking out for her the way I would. ...And then my mother...I definitely don’t want her with her because the fact that what she did with me growing up...I was her first child and she just abandoned me like that...I would rather for her to be in foster care...

She had learned early in life not to expect any help from other people, or share her feelings, “Asking for something; I get turned down. Or you know needing something; I get turned down and stuff, so I just learned growing up to just deal with it and just forget about it.”

These cases illustrate the early adversities or disadvantages in the family domain that many of the young HIV-infected women in this study shared and that typically co-occurred rather than exist in isolation. The constellation of these early family life experiences caused them to feel unloved and unwanted, betrayed by parents and family, and anxiously insecure about the permanence of relationships. In many cases, one or both parents were physically absent due to divorce, separation, abandonment or death. When their parents were divorced or separated, the participants often had sporadic or no contact with the non-custodial parent and this severely restricted the opportunity to build a meaningful parent-child relationship. Participants often felt abandoned or rejected by that parent. Many of the female participants who grew up without a father seemed to assign considerable significance to being deprived of their guidance, care, and protection from exploitive men. Some seemed to engage in sex in an effort to achieve emotional closeness with a man who cared for them. Not surprisingly, several became sexually involved in their teens with men many years their senior who clearly served as a substitute father figure.

Even when parents had been physically present while participants were growing up, they often were emotionally and practically unavailable. As a result, they were unable to provide love, consistent caregiving, guidance, protection and the sense of security so important to healthy development. The young women often felt that while growing up, and in some cases

even currently, that their parents valued and invested more in their relationships with their boyfriends, girlfriends, new spouses and/or the children they had with them. This left them feeling rejected and devalued and possibly more accepting of abuse or mistreatment by others.

Many participants were sent to live for periods ranging from months to years with relatives who were often reluctant or resentful custodians. When relatives were unavailable, they ended up in foster care or group homes. The seeming ease with which their parents and other relatives sent them off to live with others or placed them in “the system” communicated to the participants that they were not valued by or have any meaningful bond with their parents; they were treated and felt like throw away children. The constant relocations they experienced also contributed to their feeling insecure and anxious about investing in relationships, which were usually hurtful and impermanent. Most seemed never to have forged a secure attachment to a parent or parent surrogate who they felt was a reliable source of love and emotional support. As a result, many sought to fulfill these needs in their “romantic” relationships with boyfriends.

With little parental control or supervision many participants became easy targets for sexual exploitation and emotional manipulation. Their unmet need for love and attention rendered them easy prey for men, who often were considerably older, and who psychologically manipulated and sexually exploited them having recognized these young women’s emotional vulnerability. As participants were often quite young when their sexual abuse began, they were traumatized or psychologically overwhelmed by the experience. Some coped by denying, repressing or dissociating from their feelings. Those with the courage to reveal the abuse to an adult, were usually not believed, and in some cases even punished for supposedly fabricating a story. Understandably, these young women felt deeply betrayed and discredited by the adults who had failed in their role of protecting their physical and emotional well-being. Many responded to their abuse by becoming sexually promiscuous, since their experience had revealed to them that at least as sexual beings, they were wanted. Many of the young women seemed to have conflated being loved and cared for with being the object of a man’s sexual desire.

The profound need many participants had to believe that their partners truly cared for them and would not expose them to danger trapped them in unhealthy relationships. Some were so desperate for love and acceptance by others that they denied the harm posed by their predatory and abusive sexual partners. Many of the participants constructed and maintained the vital lie that their sexual partners offered them the true love and attention they had been deprived **of by** their parents and families. Unfortunately, the outcome of preserving this lie was acquiring HIV.

Discussion

In recent years investigators have emphasized the need for family-based interventions to prevent high risk sexual behavior that places adolescents at risk for HIV (Caruthers, Van Ryzin, and Dishion, 2013; Donenberg, Paikoff, & Pequegnat, 2006; Malow, Rosenberg, Donenberg, & Dévieux, 2006; Wight & Fullerton, 2012). Clearly efforts must be made to

identify chaotic and dysfunctional family settings when children are still young, so interventions can aim at primary prevention. One way to identify such families is to institute an annual assessment of the family situation of all children enrolled in elementary and middle school, prior to dropping out of high school. Families with risk factors could then be referred to appropriate services. Targeting vulnerable families and providing parents with guidance and support to promote more effective monitoring and parenting of their children is definitely one component of HIV prevention efforts. However, many children growing up in chaotic or dysfunctional families sustain psychological insults and forms of abuse that leave them psychologically damaged, anxious, angry, depressed, and with no self-esteem. For these at-risk adolescents and young adults, educational interventions alone will not suffice to prevent HIV/STI. They require therapeutic interventions to deal with underlying anxiety and depression and attain a sense of self-worth. There is also a need for these adolescents to develop critical self-regulations skills (Raffaelli & Crockett, 2003) that their parents, due to their own psychosocial problems, absence or neglect, did not impart.

In the absence of parents or other adult family members who can serve as positive role models, many of the adolescents in this study might have benefitted from programs that linked them to an adult mentor (e.g., Big Brothers or Big Sisters). Community or religious organizations might also offer such programs to neighborhood children. Clearly many of these young women had little sense of any self-worth primarily because of their feeling that they were unlovable and devalued by adults. Many felt invisible in their own families. Several concluded that the only thing they had to offer to get attention and become visible was their bodies and sexual favors.

The data also suggest the need for interventions that challenge at-risk female adolescents' romantic notions about "love" and their self-deceptions about their male partners' sincerity and fidelity, especially older male partners. While some might regard this as encouraging distrust of partners in relationships, it seems prudent to at least raise the consciousness of female adolescents about the possibility that they are being taken advantage of by partners who are selfish or manipulative. Perhaps bringing them into contact with other young women with similar background, who have become HIV-infected, for example, through relationships with older partners who were deceptive and insincere in their expressions of love and concern could sharpen their skills to critically evaluate their sexual partners' sincerity. We must also recognize that adolescent girls experience strong social and peer pressure to be coupled (Collins, 2003; Raiford, Seth, & DiClemente, 2013), and moreover, this urge might become amplified by their HIV infection. Indeed, for many of the young women in our sample, being diagnosed with HIV, a stigmatizing disease with the potential to taint their identity, further diminished their low sense of self-worth. As a result, they often seemed to have a stronger, more positive relationship identity than self-identity as an individual and this probably motivated them to endure the physical and psychological harm to preserve the relationship (Banister, Jakubec, & Stein, 2003; Raiford et al., 2013). It is important that even after being diagnosed and believing that their boyfriend had betrayed them by knowingly exposing them to HIV, they often did not confront him, but rather clung to the relationship, most likely because for the first time in their lives, they felt noticed and emotionally connected to another person. They probably also questioned whether any other man would want them now in light of their HIV-positive status. Interventions must be

developed to support at-risk and HIV-positive young women in constructing a firm and positive sense of self independent of being part of a couple. This task, unfortunately, becomes very challenging in families where the parents are substance users, mentally ill, incarcerated or physically and emotionally unavailable.

Finally, the factors that placed the young women in this study at risk for HIV also place them at risk for intimate partner violence, coercive sex or rape, and unintended pregnancy. When young women enter relationships with older men rather than age peers, the gender power differentials become even more pronounced. This in turn may enhance the risks of engaging in higher risk sexual behavior (Raiford et al., 2013). Programs developed to address these problems have a longer history than HIV, and therefore, HIV prevention programs need to be integrated in existing programs to maximize the opportunity to empower young women.

Although the relationships between inadequate parent monitoring, sexual abuse, unstable housing and risky behaviors, including sexual behavior, have been well established statistically, there have been relatively few qualitative investigations. To our knowledge this is the first report in which these relationships are looked at in HIV-infected adolescents and young adults and interpreted through their accounts of early life experiences. This analysis provided valuable and novel insights into the meanings behind the sexual behaviors and the unmet emotional needs sexual relationships played in the lives of the young women in our study. As Crockett, Raffaelli and Moilanen (2003) have noted, the research literature on adolescent sexuality has focused primarily on behaviors. They argue, “While this approach, helps to define the scope of the ‘problem’ it fails to address the intrapsychic and interpersonal processes that influence whether intercourse occurs and whether protection is used. Understanding these subjective dimensions is key to developing effective interventions to reduce risky sexual behavior...” (p. 372).

We believe the findings reported here make an important contribution redressing this limitation of the extant literature and arguably strongly support their position that understanding meaning is critical to designing efficacious interventions. This manuscript demonstrates that the relationships these young women establish with their male partners, even exploitive ones, often meet powerful and very fundamental needs for love, attachment and safety. Being in a sexual partnership, for these young women, meant that they were lovable, valuable and worthy of protection. Their unquenched thirst for feeling loved and cared for was deeply rooted in their neglectful or even abusive upbringing. Given that their sexual relationships met such basic and important human needs, getting young women to risk losing them by insisting on condom use against their partners’ will requires far more than educating women about the importance of condom use and imparting negotiation skills. It is imperative that interventions provide insight into how short-sighted and self-destructive their unsafe sexual behavior is and support in finding healthier more adaptive ways to meet the fundamental needs of love and emotional closeness.

Three important limitations of the study must be noted. First, the findings are based on a convenience sample of HIV-infected adolescents and young adults. While qualitative research is well suited for generating novel insights and providing rich description of

phenomena it is not a firm basis for statistical generalization. Thus while the findings provide new and important insights into the ways certain early life adversities can place females on a pathway to HIV infection they need to be confirmed by a larger more representative sample. Another limitation of the sample is that all of the participants were receiving care in HIV clinics and therefore were engaged in the care system and had access to supportive services alongside medical care. The third limitation is associated with the focus of the study being on adjustment to living with HIV as an adolescent and young adult and not on how early experiences might have set participants on a pathway to HIV infection. Therefore, the data presented in this manuscript emerged largely spontaneously in the stories adolescents told when we asked about their relationship with parents and the circumstances surrounding their diagnosis. We were struck by the strong similarities we saw in the adversities many have faced in early childhood and adolescence prior to becoming infected. However, because these issues had not been a principal focus of the research, we had not asked all the questions to exhaustively explore these phases of the participants' lives. Given that we could not find a similar report in the literature, we believed an important contribution could be made. We hope this report will motivate other investigators to further address these early life adversities and how they contribute to becoming HIV-infected.

In conclusion, the multiple intolerable conditions these female participants encountered when they were children and adolescents certainly qualify as a "cascade of events," that is, adverse events that accumulate and build over time and expose individuals to a cluster of risks and disadvantages (Williams, 2003). These participants' infection with HIV appears to be the culmination of such a cascade of disadvantages – dysfunctional parenting, constant dislocations, death of significant people, and sexual and emotional abuse – they experienced in childhood and adolescence. As Williams (2003) and the insights from this analysis suggest, future studies on HIV risk among young adults must elicit through in-depth interviews the participants' "lay knowledge", that is, the ways they make sense of the risks, opportunities and locales in which they live, in order to understand how their biographies crystalize into particular lifestyles.

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