The Relationship between Sexual Coping & the Frequency of Sexual Risk among ‘At Risk’ African American Women

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This study examines the relationship between one specific type of avoidant coping behavior—namely, having sex to cope with one’s worries or problems—and the frequency with which ‘at risk’ women engage in risky sexual relations. Face-to-face interviews were conducted with 221 African American women drug abusers in the Atlanta, Georgia metropolitan area. The community identification process was used for recruitment, with additional recruitment done via targeted sampling. A variety of demographic characteristics, background and experiences measures, childhood maltreatment experiences, substance use-related measures, psychosocial and attitudinal items, and relationship characteristics were examined for their influence both on the frequency of engaging in risky sex and the extent to which women had sex to cope.

Multivariate analysis revealed that having sex to cope was a statistically-significant predictor of the frequency with which women engaged in risky sexual behaviors. A separate analysis of the predictors of having sex to cope yielded seven items that were important for understanding the extent to which women engaged in sexual coping: age, number of health information sources, amount of physical abuse, reasons for not using condoms, overall attitudes toward condom use, level of partner communication, and the amount of help available from one’s support network. The intervention-related implications of these findings are discussed, emphasizing the needs: to target younger women, to target and help survivors of childhood maltreatment to deal with unresolved issues.

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During the past few decades, a fair amount of attention has been devoted in the scholarly literature on the nexus of psychological and psychosocial functioning and health behaviors. To some extent, this scientific interest probably can be attributable to such popular and applicable theoretical paradigms as the theory of reasoned action, the theory of planned behavior, and the health belief model (Ajzen, 1992; Fisher & Fisher, 2000; Hale, Householder & Greene, 2003). These theories include belief and attitudinal measures (which, by their very nature, are affected closely by people’s psychological states of being) as integral parts of the equation with respect to how they explain people’s involvement in various behaviors and risk practices. Ostensibly, the underlying assumption is that how people are feeling and faring psychologically will affect their decisions, including those regarding their actual behaviors. Along these lines, researchers have demonstrated that psychological and psychosocial measures such as lower levels of self-esteem, higher levels of depression, lower levels of assertiveness are associated with adverse behavioral outcomes such as more drug use/abuse (Bohnert & Miech, 2010; Stein & Nyamathi, 1999), more eating disorders (Gluck, Geliebter & Satov, 2001; Striegel-Moore et al., 2010), poor exercise and nutritional habits (Lane, Crone-Grant & Lane, 2002; Timmerman & Acton, 2001), and more involvement in risky sexual behaviors (Parks et al., 2009; Somlai et al., 2000), among others.

Coinciding with these studies, some scholars have also shown an interest in people’s coping skills, to ascertain the relationship between coping ability and health behaviors. As these studies have grown more sophisticated, many researchers have come to make a distinction between two very different types of coping: healthy—or active or adaptive—coping and unhealthy—or avoidant or maladaptive—coping. The former is characterized by exercising to reduce stress, actively engaging in one’s hobbies or interests to avoid the triggers for depression or behavioral relapsing, spending time with members of one’s support network to bolster ‘feeling good’ time, and a variety of other positive behaviors. Maladaptive or avoidant coping, on the other hand, is characterized by behaviors in which the principal goal tends to be escapism: using drugs to avoid dealing with one’s issues or problems, overeating because food provides instantaneous yet temporary comfort, working very long hours in a misguided attempt to redirect one’s psychic energies away from the underlying unresolved issues or problems with which one is dealing, and so forth. Scientific evaluations of the effects of adopting or employing these styles of coping frequently
have found that adaptive coping is associated with positive health outcomes (Nyamathi et al., 2003; Ryden et al., 2003) whereas maladaptive or avoidant coping is associated with adverse health outcomes (Heckman et al., 2004; Sanchez et al., 2010; Vickers et al., 2003; Vosvick et al., 2003).

Attempts to understand more about the specific nature of avoidant coping styles have led some social psychologists to explore the concept of cognitive escape, a process by which people are able to engage in behaviors that they know are unhealthy for them. Cognitive escape helps to explain how people who are highly knowledgeable about HIV can continue to engage in risky behaviors that they know might lead them to contract HIV, how people who are aware of the dangers of smoking continue to use tobacco products, how drug abusers rationalize the continued use of their substance(s) of choice, how overeaters or anorexics or bulimics continue to engage in disordered eating, etc. (McKirnan et al., 2001; Williams, Elwood & Bowen, 2000). In fact, the presence of cognitive escape probably helps to explain why so many studies have shown a lack of association between knowledge and relevant behaviors—why, for example, increases in knowledge about HIV have not been found to relate consistently to reductions in HIV risk practices (Kennedy & Roberts, 2009; Maynard et al., 2009), or why smokers’ awareness of the dangers of smoking has not deterred them from continuing to smoke (Markowitz, 2000; Romer & Jamieson, 2001).

In the present study of ‘at risk’ women, we focus our attention on one specific type of avoidant coping strategy—namely, engaging in sexual relations as a way of coping with one’s stresses—and examine its relationship to HIV risk behavior outcomes. This study is important because the relationship between coping ability—specifically, engaging in sex as a coping strategy—and HIV risk has received little attention in the scholarly literature. Most published studies of the nexus of coping and HIV have focused on how people who have been diagnosed as being HIV-positive or as having full-blown AIDS cope with such diagnoses (see, for example, Gore-Felton et al., 2003; Inouye, Flannelly & Flannelly, 2001; Pittiglio & Hough, 2009). Virtually nothing appears in the literature regarding how different styles of coping are related to people’s involvement in the risky behaviors that could lead them to contract HIV or, for that matter, their practice of protective behaviors that could help them to avoid becoming HIV-infected.

We believe that it is important to point out that sexual behaviors tend to be emotionally charged and, compared to many other behaviors, are driven less by rationality and purposeful thought/decision-making than they are by impulse and temporary context. This makes sexual behavior practices particularly susceptible to the influence of avoidant coping strategies, because sex can be a highly effective way of feeling
good ‘in the here and now’—that is, a highly effective, temporary way of avoidantly coping with or cognitively escaping from one’s life issues and problems. Understanding the way in which having sex as a coping strategy relates to HIV-related risky behaviors is one of the principal goals of the present study. For intervention purposes, it is also important to gain an understanding of the precursors of this type of avoidant behavior. By identifying those factors that underlie the practice of having sex to cope, we not only come to understand the nature of the practice itself better, but also to identify specific steps that might be taken to reduce this practice and, in the process, reduce attendant HIV risk behaviors.

Accordingly, in this study, we also examine a variety of potential types of predictors of the extent to which women engaged in sex as a coping strategy. In addition to being guided by the notion of individualized understandings of risk when selecting predictor variables, the present research is guided by a conceptual framework that is derived from commonly applied psychological theories such as the theory of planned behavior, the theory of reasoned action, and the health belief model. In addition, this study is guided by the theory of gender and power (Connell, 1987), which recognizes the importance of sexual dynamics in heterosexual relationships. A main thesis of this theory is that women who are involved in heterosexual relationships tend to have less power and are less likely to be in decision-making roles than men due to gender role expectations in society-at-large. Such power disparities may result in unsafe or avoidance coping sex. Recently, this theory has been applied to studies on HIV, specifically pertaining to HIV risk practices/involvement among women (Alleyne & Gaston, 2010; Mallory, Harris & Stampley, 2009; Wingood & DiClemente, 2000). A number of studies have shown that HIV risk behaviors differ, often quite dramatically, based on demographic characteristics such as race/ethnicity, age, marital status, and homelessness (Semple et al., 2009; Taylor, Adimora & Schoenbach, 2010; Wayment et al., 2003). Previous research has also documented a variety of background experiences measures that are also relevant to understanding the extent to which people are involved in risk practices (Beadnell et al., 2000; Stoskopf, Kim & Glover, 2001; Wyatt et al., 2000). Examples of such measures include, among others, sexually transmitted disease history, HIV testing history, relationship characteristics, mental health diagnosis, and health information sources. Moreover, childhood maltreatment variables have been shown to be relevant to HIV risk in adulthood (Bensley, Eenwyk & Simmons, 2000; Morrill et al., 2001), and therefore we include measures of physical abuse, sexual abuse, emotional abuse, and/or neglect in this research. Psychological and psychosocial functioning (e.g., self-esteem, depression, anxiety, impulsivity) have also been shown in many studies
to be predictive of HIV risk practices (Schroeder et al., 2001; Somlai et al., 2000; Stoskopf, Kim & Glover, 2001) and, accordingly, are included in this study. For the same reason, several substance use/abuse measures are examined as potential predictors in this research as well. Numerous studies have shown that different types of drug use or abuse are risk factors for HIV and sexually transmitted diseases (Cheng et al., 2010; Deren et al., 2001; Roberts et al., 2003). Finally, we included several variables assessing the quality and nature of relationships with friends, family members, and sexual partners. Generally, these items focused on the supportiveness of women’s interpersonal relationships and social networks, because previous studies have shown such relationships to be relevant to the extent to which they engage in risky behaviors (Beadnell et al., 2000; Tortu et al., 2000).

METHODS

Sample

The data for this paper come from a formative research study conducted in the Atlanta, Georgia metropolitan area. This research was conducted with 221 adult ‘at risk’ African American crack cocaine abusers who were given face-to-face interviews in preparation for the implementation phase of the HIV intervention study known as the Health Improvement Project. ‘At risk’ was defined broadly so as to represent being at risk for a variety of health-related problems and life challenges. Among the key defining criteria for designating a woman as ‘at risk’ in this study’s context were the following characteristics: (1) recent illegal drug use, (2) living at or below the poverty line, (3) having no health insurance and/or not seeking needed medical care, (4) low level of education, (5) unemployed or not working due to disability, and (6) criminal history. Most of the women participating in this research (81%) met three or more of these criteria.

The women taking part in this study ranged in age from 20 to 54, with a mean age of 36.9 (S.D. = 7.4). Approximately one-third of the women had not completed high school (35.8%), another one-third (39.8%) had earned their high school diploma or its equivalent, and the remainder of the women in the sample (24.4%) had some college education. Most of the women (61.5%) were not married or cohabiting with anyone at the time of their participation in this study.

Community Selection, Eligibility & Recruitment

The initial phase of recruitment entailed conducting a community assessment based on relevant epidemiological indicators and expertise among social and health care professionals from a wide range of agencies. The subsequent phase involved ethnographic mapping and
windshield surveys, conducted by ethnographers and indigenous outreach workers. These assessments yielded baseline information to identify study communities, blocks, specific locations in communities, and potential members of the target population (Tashima et al., 1996; Sterk, 1999a). Upon the selection of sampling sites, targeted sampling was employed to ensure the inclusion of a wide representation of African American women at risk for HIV infection. Targeted sampling was complemented with chain referral and theoretical sampling (Glaser & Strauss, 1967; Kaplan, Korf & Sterk, 1987; Strauss & Corbin, 1990).

To be eligible, women had to be 18 years of age or older, reside in the one of the study communities, be out of drug treatment or any other institutional setting, be proficient in English, and be heterosexually active, measured as having had vaginal sex with a man at least once during the month prior to the interview. In addition, women needed to meet the definition of being considered ‘at risk’ for HIV infection, as described above. The drug use criterion required the women had smoked or injected crack cocaine at least three times during the 30 days prior to interview, injected drugs at least three times during the past 30 days. Exclusion criteria were having a cognitive impairment or being intoxicated at the time of the interview.

The outreach workers, two men and two women (all African American), used a screening form in the field to identify potential participants. Women who met the criteria and expressed an interest in the study were scheduled for an initial appointment at a centrally-located research field site, at their home, or at other community locations selected by the respondents such as fast food restaurants or community centers.

Prior to the interview, trained staff informed the respondents of the nature of the study, the time required, and other informed consent procedures. The interview took approximately one hour to complete, and respondents received $15 for the completed interview. Of the three female interviewers, two were African American and one was Caucasian.

**Measures Used**

The principal variable of interest in these analyses was the frequency with which women reported having sexual relations to cope with worries or problems in their lives. This was a five-point ordinal measure with responses ranging from ‘never’ to ‘always.’

The dependent variable assessed the frequency with which women reported engaging in risky sexual relations. It was a composite measure (Cronbach alpha = .75) derived from five items asking whether women ‘never,’ ‘rarely,’ ‘sometimes,’ ‘almost always,’ or ‘always’ engaged in sex while high, had sex with a partner who was high, traded
sex for needed commodities, engaged in sex with more than one person, and had sex with someone who procured sex from others. Higher scores indicated more frequent involvement in risky sexual practices.

A variety of demographic variables were examined, including age (continuous variable), educational attainment (continuous variable), marital status (categorical measure), employment status (two measures: full-time employment versus all others, and unemployed versus all others), and religiosity (continuous variable based on the interaction of frequency of worship service attendance and perceived impact of religion on one’s behaviors).

Several background and experiences measures were considered too. These included: HIV serostatus (HIV-positive versus HIV-negative), number of sources of health-related information used during the previous year (continuous scale measure, Cronbach alpha = .76), age of first sexual experience (continuous measure), and perceived chance of contracting HIV (ordinal measure).

Women’s experiences with childhood maltreatment were also examined. Measures here pertained to the period before women turned age 18 and indicated the extent to which they had experienced sexual abuse, physical abuse, emotional abuse, and/or neglect. One other measure examined whether or not the women had been maltreated in all four of these ways. Although they pertain to the period of women’s adulthood, two other similar variables were examined here as well. These indicated whether or not the women had ever been harmed physically or sexually (yes/no), and whether or not they feared being harmed physically or sexually now (yes/no).

Seven substance use-related items were also analyzed in conjunction with this research. These included: living with any substance abusers (yes/no), amount of illegal drug use (continuous measure), problem drinker status (yes/no, with a ‘problem drinker’ defined as getting drunk more than once per week and failing to meet one’s responsibilities more than once per week), and the number of drug-related problems experienced in the past year (continuous scale measure, Cronbach alpha = .74).

A number of psychosocial and attitudinal measures hypothesized to relate to women’s sexual practices were examined too. Several of these were continuous scale measures and they assessed women’s levels of depression (Cronbach alpha = .88), anxiety (Cronbach alpha = .75), impulsivity (Cronbach alpha = .81), self-esteem (Cronbach alpha = .83), reasons for not using condoms (Cronbach alpha = .84), attitudes toward using condoms (Cronbach alpha = .78), condom use self-efficacy (Cronbach alpha = .84), and perceived need to change one’s risk behavior practices (Cronbach alpha = .75).
Finally, we evaluated a number of variables assessing the characteristics of relationships women had with their sexual partners, family members, and friends. These included: level of partner communication (continuous scale measure, Cronbach alpha = .80), level of support/bonding with family members (continuous scale measure, Cronbach alpha = .93), level of support/bonding with friends (continuous scale measure, Cronbach alpha = .93), level of support/bonding with main partner (continuous scale measure, Cronbach alpha = .94), amount of help that can be gotten from family members during times of need (continuous scale measure, Cronbach alpha = .85), and the amount of help that can be gotten from friends during times of need (continuous scale measure, Cronbach alpha = .85).

**Analysis**

The analysis for this paper was undertaken in two parts. In the first part, the ‘sex to cope’ variable was included as an independent variable in the model examining the predictors of the frequency of risky sex. In the second part, the ‘sex to cope’ measure was the dependent variable, with the analysis focusing on examining what variables were relevant to understanding how often women reported having sex to cope with their worries or problems.

For both parts of the analysis, initially, the bivariate relationships between the predictor variables and the dependent variable were examined. This entailed the use of Student’s t tests whenever the independent variable was dichotomous in nature, analysis of variance whenever the independent variable was ordinal with fewer than five response levels, and simple regression whenever the independent variable was a continuous measure. Variables that were found to be related significantly (i.e., $p<.05$) or marginally (i.e., $0.10>p>0.05$) to the dependent measure in question were selected for initial entry into a multiple regression equation, and then removed in stepwise fashion until a final ‘best fit’ model could be derived, consisting only of significant predictors. Both forward selection and backward elimination procedures were utilized, to make sure that the order of entering the items did not affect the final outcome. In the following section of the paper, only the final multivariate analysis results (i.e., those that were found to be statistically significant) are presented. Throughout the remainder of this paper, results are reported as statistically significant whenever $p<.05$. 
RESULTS

Prevalence of Having Sex to Cope

Nearly 40% of the women in the study reported having sex to cope ‘sometimes,’ ‘almost always,’ or ‘always’ whereas the remaining 60% said that they did this either ‘never’ or ‘rarely.’ This was, therefore, a fairly common occurrence among the women comprising this study sample.

Part 1 – Predictors of Frequency of Sexual Risk

Table 1 presents the results of the multivariate analysis focusing on the predictors of women’s involvement in sexual risk behaviors. In all, nine statistically-significant predictors were identified. Older women reported less frequent risky sex than their younger counterparts ($\beta = - .18, p<.01$). Educational attainment also predicted sexual risk frequency, with more frequent risk reported by people who had not completed high school or its equivalent when compared to those who had at least a high school education ($\beta = .14, p<.05$). Another demographic variable, marital status, was also noteworthy: Married women acknowledged less frequent sexual risk than women who were not married ($\beta = -.13, p<.05$). Two of the substance use/abuse measures examined were also found to be related to sexual risk taking. Problem drinkers reported engaging in more frequent sexual risk than people who were not problem drinkers ($\beta = .14, p<.05$), and the more drug problems women experienced, the more often they said that they practiced risky sex ($\beta = .19, p<.001$). Two of the predictors were psychosocial or attitudinal measures. The recognition of a need to reduce one’s overall level of risk for HIV was found to be related directly to the frequency with which women said that they had risky sex ($\beta = .24, p<.001$). Greater anxiety was also associated with more frequent sexual risk ($\beta = .13, p<.05$). The data also revealed that the closer women reported being to their friends—that is, the more reliable and intimate their friendship relationships were—the less often they engaged in sexual risk ($\beta = -.12, p<.05$). Finally, the variable of principal interest in this paper, having sex to cope, was found to be associated with sexual risk taking as well ($\beta = .18, p<.01$). The more often women engaged in sex as a way of coping, the more often they engaged in risky sex. Together, these nine variables explained 45.3% of the total variance in the frequency with which women engaged in risky sexual behaviors.
Table 1: Predictors of the Frequency of Sexual Risk Taking

<table>
<thead>
<tr>
<th>Predictor Variable</th>
<th>Standardized Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.18 **</td>
</tr>
<tr>
<td>Educational Attainment = Less than High School</td>
<td>.14 *</td>
</tr>
<tr>
<td>Marital Status = Married</td>
<td>-.13 *</td>
</tr>
<tr>
<td>Problem Drinker</td>
<td>.14 *</td>
</tr>
<tr>
<td>Number of Drug Problems</td>
<td>.19 ***</td>
</tr>
<tr>
<td>Recognition of a Need to Change Risky Behaviors</td>
<td>.24 ***</td>
</tr>
<tr>
<td>Anxiety Level</td>
<td>.13 *</td>
</tr>
<tr>
<td>Overall Closeness of Friendships</td>
<td>-.12 *</td>
</tr>
<tr>
<td>Having Sex to Cope with Worries or Problems</td>
<td>.18 **</td>
</tr>
<tr>
<td>R-Squared</td>
<td>.453</td>
</tr>
</tbody>
</table>

* p < .05  ** p < .01  *** p < .001

Part 2 – Predictors of the Frequency of Having Sex to Cope

Since having sex to cope with worries or problems was, as hypothesized, found to be a significant contributor to women’s overall frequency of sexual risk-taking, we then wanted to identify what variables were relevant to understanding how often women engaged in sex as a way of coping. The results of this analysis are presented in Table 2. Seven statistically-significant predictors were identified that, taken together, explained 23.8% of the total variance. First, age was found to be a relevant predictor (β = -.14, p < .05), with older women reporting less frequent sex as a way of coping than their younger counterparts. Second, the more information sources women felt that they had available to them for health-related matters, the more frequently they reported having sex to cope (β = .15, p < .05). Third, the more physical abuse that women endured prior to adulthood, the more often they said that they engaged in sexual coping behaviors (β = .15, p < .05). Two of the attitudinal measures were also found to be predictive of how often women had sex to help them cope with their worries and problems. The more reasons
women cited for not using a condom the last time they had sex, the more often they also reported engaging in sexual coping ($\beta = .18$, $p<.01$). Coinciding with this, the more oppositional in general their attitudes toward using condoms were, the more often they said that they had sex to cope ($\beta = -.19$, $p<.01$). Partner communication was found to be associated with having sex to cope, such that women who had stronger or more frequent communication with their partners reported having sex to cope less frequently than their counterparts whose partner communication was less consistent ($\beta = -.20$, $p<.01$). Finally, the more help that women felt they could receive from their friends or family members during times of need, the less frequently they had sex to cope ($\beta = -.17$, $p<.01$).

**Table 2: Predictors of Having Sex to Cope with Worries or Problems**

<table>
<thead>
<tr>
<th>Predictor Variable</th>
<th>Standardized Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.14 *</td>
</tr>
<tr>
<td>Number of Health Information Sources</td>
<td>.15 *</td>
</tr>
<tr>
<td>Amount of Physical Abuse</td>
<td>.15 *</td>
</tr>
<tr>
<td>Reasons for Not Using Condoms during Unprotected Sex</td>
<td>.18 **</td>
</tr>
<tr>
<td>Overall Condom Attitudes</td>
<td>-.19 **</td>
</tr>
<tr>
<td>Level of Partner Communication</td>
<td>-.20 **</td>
</tr>
<tr>
<td>Amount of Help from Support Network</td>
<td>-.17 **</td>
</tr>
<tr>
<td>R-Squared</td>
<td>.238</td>
</tr>
</tbody>
</table>

* $p<.05$  ** $p<.01$  *** $p<.001$

**DISCUSSION**

In this formative research study of cocaine-using African American women, we discovered that engaging in sexual relations to cope with one’s worries or problems was a fairly common occurrence. Nearly half of the women said that this was something that they did ‘sometimes,’ ‘almost always,’ or ‘always.’ Clearly, this finding indicates a need to work with women engaging in this practice to teach them more-
adaptive ways of coping with the challenges they face in their everyday lives. This is no easy task, particularly when one considers the intertwined nature of the challenges they face based on their gender, race/ethnicity, and socioeconomic status. In a society such as ours, in which females experience routine power struggles compared to their male counterparts, in which African Americans are economically and politically disadvantaged compared to their Caucasian counterparts, and in which persons with lower levels of education face significant, often life-long economic hardship, the interplay of factors such as gender, race, and socioeconomic status is likely to lead to consequential, ongoing challenges in women’s lives. Women like those comprising the sample for the present research have many difficulties to overcome and many adversities with which they must cope. Numerous published reports have spoken about the importance of considering structural factors (e.g., race/ethnicity, socioeconomic status, gender) and the interaction of these factors when attempting to understand and/or ameliorate health problems, particularly among racial minority group women (Bowleg, 2008; Jipguep, Sanders-Phillips & Cotton, 2004; Newman et al., 2008). It is also worth noting that many of these authors have written about the need to consider both the structural and psychological/psychosocial factors affecting women’s health, as well as the interplay of both types of factors when examining health-related outcomes.

Consistent with the notion of a relationship between cognitive escape and HIV risk, our analyses revealed that the frequency with which the participants engaged in risky sex was related to the frequency with which they reported having sexual relations to help them cope with their worries or fears. Based on a multifaceted multivariate analysis that considered a myriad of factors that could help to explain sexual risk-taking frequency, this coping measure was one of the predictors retained in the final model. That so many women (and probably many men, too, although this falls outside of the purview of the present study’s data) turn to sex to help them cope with their problems—40% of the participants in this study said that they did this ‘almost always’ or ‘always’—indicates a great need to help them learn healthier, more adaptive coping skills. Granted, sexual relations will provide many of the women with the escapism that they seek, and temporarily, it will enable them to forget about their problems. This relief is short-lived, however; and once the sexual encounter has ended, the underlying problems persist and remain unresolved. As we mentioned earlier, other researchers have documented a positive relationship between adaptive coping and positive health outcomes (Nyangithi et al., 2003; Ryden et al., 2003) as well as a direct relationship between maladaptive or avoidant coping and adverse health outcomes (Heckman et al., 2004; Sanchez et al., 2010; Vickers et al., 2003; Vosvick et al., 2003). Our findings are
consistent with these studies and they highlight the relevance of coping skills to health risk behaviors. At the same time, our findings contribute something new to this literature by documenting an association between avoidant coping (i.e., having sex to cope with one’s worries or problems) and HIV risk practices.

Knowing that having sex to cope with one’s problems is related to more frequent involvement in risky sex, we are left with the question of what factors affect the extent to which women engage in sexual coping behaviors. Learning more about this aspect of their behaviors may help researchers to identify higher-risk persons and to design appropriate interventions that can benefit such women. The second part of our analyses are quite useful in this regard.

First, we discovered that age was a relevant factor, such that younger women were more likely to report having sex to cope with their worries or problems than older women were. Clearly, this indicates a need to target younger women in HIV educational and intervention efforts, and in particular, to provide them with training to enhance their coping skills. Other published reports, too, have found that younger African American women were engaging in high rates of risky behaviors and, thus, are in need of more effective HIV-related educational and intervention efforts (Boyer et al., 2000; Braithwaite & Thomas, 2001; Seth et al., 2009). Our findings are consistent with these studies and they reinforce the importance of providing culturally-appropriate skills training techniques and HIV interventions to younger minority women. Several years ago, DiClemente and Wingood (1995) conducted a community-based HIV intervention project targeting 18-29 year old black women in the San Francisco area. Their program included sessions emphasizing gender and ethnic pride, strategies to prevent HIV risk behavior involvement, sexual assertiveness, partner communication skills, proper and consistent condom usage, and coping/adaptive skills to handle difficult risk-involved situations with sexual partners. Women receiving this multi-session intervention were found to demonstrate greater condom use, more sexual assertiveness, better communication, and better coping skills than women receiving other, less-comprehensive interventions offered to other study participants. Innovative, effective projects like this appear to offer promise with regard to helping women to develop improved coping skills that, in turn, can lead to reduced involvement in HIV risk behaviors.

Second, consistent with previous researchers who have documented a link between childhood maltreatment experiences and HIV risk practices in adulthood (Arriola et al., 2005; Chin et al., 2004; Greenberg, 2001), the present research also found that physical abuse experiences during the childhood and/or adolescent years corresponded with greater avoidant coping during adulthood. Moreover, studies have
also shown that childhood maltreatment leads to such psychological and psychosocial problems as increased depression (Nelson et al., 2002; Rohde et al., 2008), reduced self-esteem (Stein, Burden & Nyamath, 2002; Whealin & Jackson, 2002), poorer coping skills (Fortier et al., 2009; Wright, Crawford & Sebastian, 2007), heightened levels of anxiety (Carlson, McNutt & Choi, 2003; Nelson et al., 2002), and increased levels of pessimism (Romans, Martin & Mullen, 1996). Clearly, these findings as well as our own are suggestive of the presence and continued negative influence of unresolved issues pertaining to earlier-life abuse experiences on women’s lives. Providing counseling for survivors of abuse to enable them to overcome the adverse effects of their abusive experiences, and helping them to develop healthier psyches by improving their overall levels of functioning vis-a-vis their levels of self-esteem, depression, etc. are necessary and worthwhile endeavors. Future HIV intervention programs targeting women, especially ‘at risk’ minority women, would be well-advised to consider incorporating components designed specifically to bolster psychological and psychosocial functioning.

Third, in this study, we discovered that there is a link between how women think and feel about using condoms and the frequency with which they reported having sex to cope with their problems or worries. Generally speaking, women who were more averse to using condoms and those who cited a larger number of reasons for not using condoms were the ones who also reported engaging in sexual coping the most. A number of published studies have shown a relationship between condom-related attitudes and involvement in risky sexual practices (Bogart & Bird, 2003; Posner et al., 2001), including a paper that we ourselves published based on findings from a different study focusing on a different population of ‘at risk’ women (Sterk, Klein & Elifson, 2004). Typically, these studies have shown that the more negative attitudes are toward using condoms, the greater people’s practice of risky behaviors tends to be. This highlights the importance of trying to alter the way people think and feel about condom use, so that the practice seems less obtrusive, less impersonal, less disruptive, and more enjoyable. In our other work (Sterk, Klein & Elifson, 2004), we provide a detailed discussion of specific strategies that might be undertaken to accomplish that goal; and we encourage interested readers to consult that work. Related specifically to the present study’s findings, we simply wish to emphasize the point that negative attitudes toward using condoms were linked with the practice of more frequent avoidant sex, and that, in turn, was related to more frequent sexual risk-taking. Improving the former may be an effective way of reducing the latter. This also links to the theory of gender and power (Connell, 1987). Men tend to be more powerful than women in American society, thereby
leaving women in heterosexual couples with less decision-making power than their male counterparts. This lack of parity often results in avoidance coping among persons in the disadvantaged power position (Sterk, 1999b).

Finally, our analyses revealed that two variables relating to women’s support systems were related to their tendency to—or not to—have sex to help them cope with their worries or problems: level of partner communication and the amount of help they felt they could receive from the members of their support network during times of need. Regarding the former, we found that women who engaged in more communication with their sexual or dating partners had sex to help them cope less frequently than women whose partner communication was not as strong/frequent. It may be that the ability to converse openly with one’s partner(s) about important, salient matters like relationships or sexual concerns helps women to feel less of a need to turn to sex as a coping mechanism. That is, open pathways of communication equate with effective decision-making and positive coping and, in the process, diminish the desire to use sex as a way of handling daily stresses. In another work based on a different population of ‘at risk’ women, we discovered that partner communication was a key predictor of HIV risk behavior practices (more communication = less risk involvement) (Klein, Elifson & Sterk, 2004). Other studies, too, have shown that good communication skills can play a very powerful role in helping people—particularly women—to reduce their risk for HIV (El-Bassel et al., 2001; Salazar et al., 2004). In the context of the present study, these findings suggest that providing women with techniques to facilitate more and higher-quality communication with their partners may be an effective way of indirectly reducing their HIV risk, by virtue of the expected direct effects on their frequency of having sex to cope with their problems. Particularly promising approaches to improving partner communication have included individualized case management (Reif, Wechsberg & Dennis, 2001; Stevens & Hall, 1998) and role playing exercises (El-Bassel et al., 2001; Hoffman et al., 1999).

Regarding our finding pertaining to support networks, it makes sense to us that avoidant coping such as having sex to deal with one’s problems would be less likely to occur among people who feel that they can turn to friends and family members for support during times of need than among those who do not feel that their friends or family members can be relied upon to provide such assistance to them. When relationships with them are strong and healthy, friends and family members constitute very important sources of adaptive coping. Indeed, for many people, these relationships are the core of their support systems and their primary way of seeking solace, advice, and assistance during times of stress, worry, and difficulty. Therefore, we believe that
the main implication of our finding here is that strengthening women’s intimate, interpersonal relationships would be likely to be an effective way of reducing their HIV risk. Better relationships equate with reduced avoidant coping, and reduced avoidant coping, in turn, corresponds with diminished sexual risk taking. This supposition has some support in the empirical literature, too. For instance, in their study of urban drug abusers, Latkin and colleagues (2003) reported that HIV risk practices were lower among study participants reporting stronger support networks than among those who had fewer members in their support network. Nyamathi and colleagues’ (2000) research on homeless women demonstrated that social support from healthy models (i.e., those who were not using drugs) corresponded with better health behaviors. In their study of women opiate users, Miller and Paone (1998) found that social isolation was related to a variety of HIV risk practices. All of these studies as well as our own emphasize the importance of bolstering support network relationships, as this appears to be an effective way of reducing ‘at risk’ persons’ involvement in HIV risk behaviors.

Finally, the present authors would like to point out that efforts to improve the situation with regard to coping, particularly as coping pertains to involvement in HIV-related risk-taking, would be beneficial if undertaken both at the individual level (where coping skills can be addressed and techniques to develop more-adaptive coping procedures can be taught) and at the community/societal level (where the structural factors that cause people stresses that require the development of coping strategies in the first place need to be addressed). Other authors have spoken about the importance of considering both individual-level and more macro-level, structural factors when attempting to improve health conditions and HIV risk-taking women (Jipguep, Sanders-Phillips & Cotton, 2004; Newman et al., 2008). The findings of the present study support this type of approach. Moreover, this study’s findings support the adoption of a syndemics theory approach (Singer, 2009; Singer et al., 2006) to studying and intervening in risk behaviors, because this theoretical model offers an effective way of conceptualizing the interplay amongst various types of factors that enhance risk-taking. This theoretical paradigm posits that it is the specific way that certain types of factors (e.g., gender, race/ethnicity, socioeconomic conditions, childhood maltreatment experiences, the potential for currently experiencing domestic violence, substance use/abuse), both at the individual level and at the structural level, interact with one another that leads to effects that are greater than any one or two of these factors alone might have. That is, it is the specific way that these various factors interact with one another when they co-occur that makes them particularly harmful. Although relatively new to the scientific community, syndemics theory is growing in popularity and, in a few recent reports has been applied to
health practices among women (Gielen et al., 2007; Romero-Daza, Weeks & Singer, 2003). It may very well offer important insights into the types of relationships observed in the present study regarding having sexual relations as a way of coping with life’s stresses, and it can offer researchers using a feminist perspective in their work an effective way of conceptualizing the complex interactions of the various factors that influence women’s health.

**Potential Limitations of the Present Research**

We would like to acknowledge three potential limitations of this research. First, the data collected as part of the *Health Improvement Project* were all based on uncorroborated self-reports. Therefore, the extent to which respondents underreported or overreported their involvement in risky behaviors is unknown. In all likelihood, the self-reported data can be trusted, as numerous authors have noted that persons in their research studies (which, like the present study, have included fairly large numbers of substance abusers) have provided accurate information about their behaviors (Anglin, Hser & Chou, 1993; Higgins et al., 1995; Miller, Turner & Moses, 1990; Nurco, 1985).

A second possible limitation pertains to recall bias. Respondents were asked to report about their beliefs, attitudes, and behaviors during the past 30 days, the past 90 days, and the past year, depending upon the measure in question. These time frames were chosen specifically (1) to incorporate a large enough amount of time in the risk behavior questions’ time frames so as to facilitate meaningful variability from person to person, and (2) to minimize recall bias. The exact extent to which recall bias affected the data cannot be assessed although other researchers collecting data similar to that captured in the *Health Improvement Project* have reported that recall bias is sufficiently minimal that its impact upon study findings is likely to be small (Jaccard & Wan, 1995).

A third possible limitation of these data comes from the sampling strategy used. All interviews were conducted in the Atlanta, Georgia metropolitan area. There may very well be local or regional influences or subcultural differences between these women and those residing elsewhere that could affect the generalizability of the findings. Additionally, the chain referral sampling approach used to identify study participants is not a random sampling strategy, and there may be inherent biases in who was/not identified as potential study participants in the *Health Improvement Project*. A good discussion of the issues pertinent to this issue may be found in Heckathorn (1997), along with strategies that can be employed to minimize any bias that could result from the use of a chain-referral sampling approach.
REFERENCES


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